Detroit Wayne Integrated Health Network (DWIHN)

Quality Assurance Performance Improvement Plan Annual Evaluation FY 2019

Submitted by:

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Presented to QISC on 2/4/20 and Approved

Presented to PCC on 2/12/20 and Approved

Presented to the Full Board on 2/19/20 and Approved

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Introduction

The Quality Improvement (QI) Unit of the Detroit Wayne Integrated Health Network (DWIHN) is pleased to present the Annual Quality Assurance Performance Improvement Plan (QAPIP) Evaluation Report for FY 2019. The QAPIP evaluation assesses the results, improvements and outcomes DWIHN has made with respect to the 2019 Annual Work Plan.

The QAPIP evaluation is based on six (6) pillars that are identified in DWIHN's Strategic Plan. The QAPIP evaluation reflects ongoing activities throughout the year and addresses areas of timeliness, accessibility, quality and safety of clinical care, quality of services, performance monitoring, member satisfaction and performance improvement projects. The data collected analyzes and evaluates the year to year trends analysis of the overall effectiveness of the QI program, indicating progress for decision making to improve services and the quality of care for members served.

The PPC Board is responsible for oversight of DWIHN's QAPIP. The QAPIP is reviewed and approved biennial by DWIHN's governing body. Through this process, the governing body gives authority for implementation of the plan and all of its components. The QAPIP evaluation report is submitted to the Program Compliance Committee (PCC) of the Board, for review and approval annually.

Quality Improvement Program

DWIHN's QAPIP supports the values of a managed care system in which access to services, clinical care, efficiency and positive outcomes, including member satisfaction and consumerism are foremost. Consistent with DWIHN's Strategic Plan and mission, the plan embraces the pillars, philosophy and methodology of continuous quality improvement to identify opportunities to increase the effectiveness and efficiency of care and services to its members. The goal of the QAPIP brings all the parts of our system together by providing a structure that include opportunities to:

- ⇒ Encompass the six Pillars and Focus Areas in the Board's Strategic Plan.
- ⇒ Provide an objective and systematic approach to the ongoing monitoring and continuous improvement of processes based on the collection, review and analysis of data relative to indicators of importance to DWIHN functions.
- ⇒ Ensure accountability
- ⇒ Ensure an objective, systematic and fair method for monitoring performance of network providers against contract obligations and service outcomes.
- ⇒ Support a system in which members and advocates have input into the evaluation of clinical care and quality of service.

Quality Improvement Structure

DWIHN has an organizational structure which allows for clear and appropriate administration and evaluation of the QAPIP. DWIHN's Quality Improvement Steering Committee (QISC) is the decision-making body of the QAPIP and the evaluation. The QISC has the leadership with oversight of the Chief Medical Officer (CMO) to ensure the following:

- ⇒ Provide oversight to DWIHN's QAPIP and QI activities.
- ⇒ Provide recommendations and feedback on process improvement, program planning, implementation and program evaluation, through data collection and analysis.
- ⇒ Examine quantitative and qualitative aggregate data and make recommendations for courses of action.
- ⇒ Monitor the planning and implementation of specific plans in response to recommendations identified for DWIHN by regulatory organizations.
- ⇒ Ensure systemic communication and implementation of mechanisms or procedures for use in adopting and communicating process and outcome improvement.
- ⇒ Ensure involvement, participation and collaboration amongst staff, including practitioner, stakeholders and members.

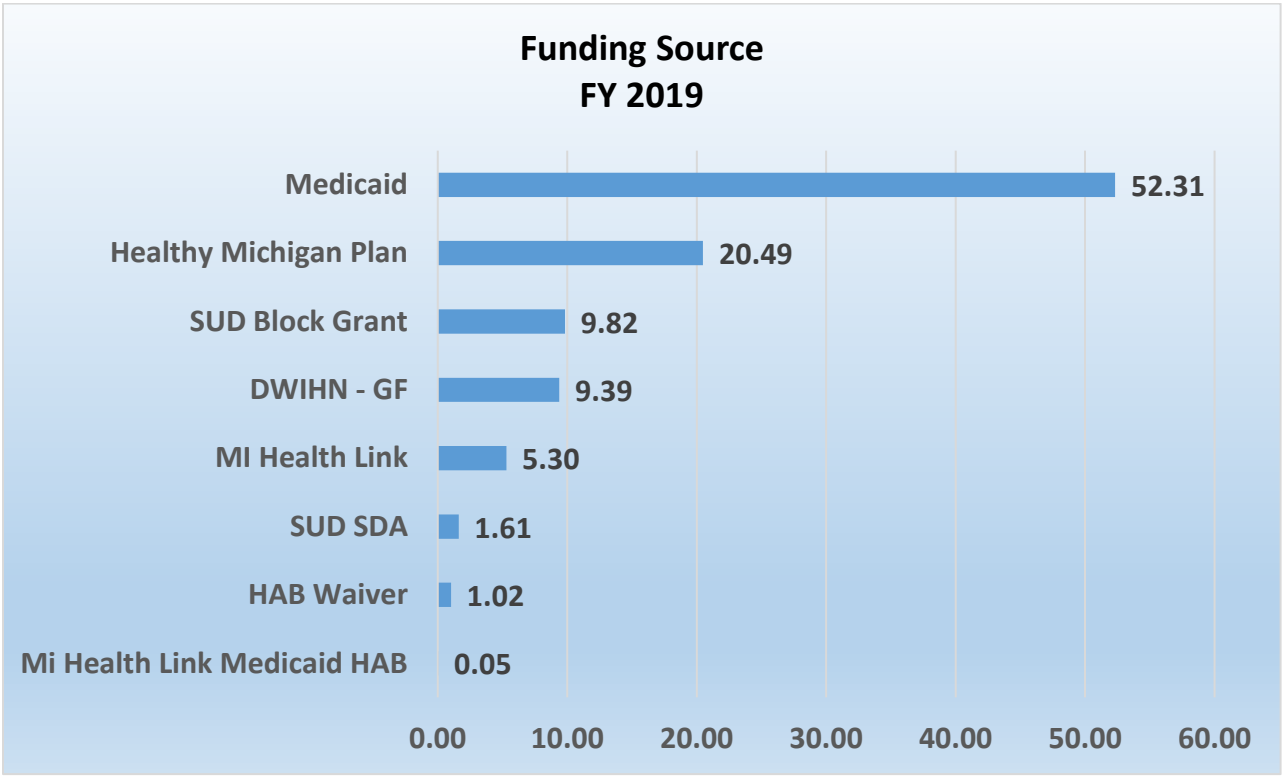
Strategic Plan Pillars by Definition

- ⇒ **Customer** – Maintaining a mutually respectful relationship with members and providers.
- ⇒ **Access** – Affordability, Availability, Accessibility, Accommodation, and Acceptability.
- ⇒ **Workforce** – Competent and engaged employees and providers.
- ⇒ **Finance** – Commitment to financial stewardship and to the optimal prioritized allocation of scarce resources across a plethora of growing and competing needs to best fulfil its mission, vision and values.
- ⇒ **Quality** – Safe, Patient Centered, Efficient, Equitable, Timely, and Effective.
- ⇒ **Advocacy** – Raising awareness on mental health issues to improve policy, legislation and service development.

DWIHN is proud of its full three-year accreditation as the Managed Behavioral Healthcare Organization by the National Committee on Quality Assurance (NCQA). This accreditation means that DWIHN maintains the highest quality standards and practices when it comes to clinical performance and consumer experience. NCQA uses measurement, transparency and accountability when measuring and accrediting organizations.

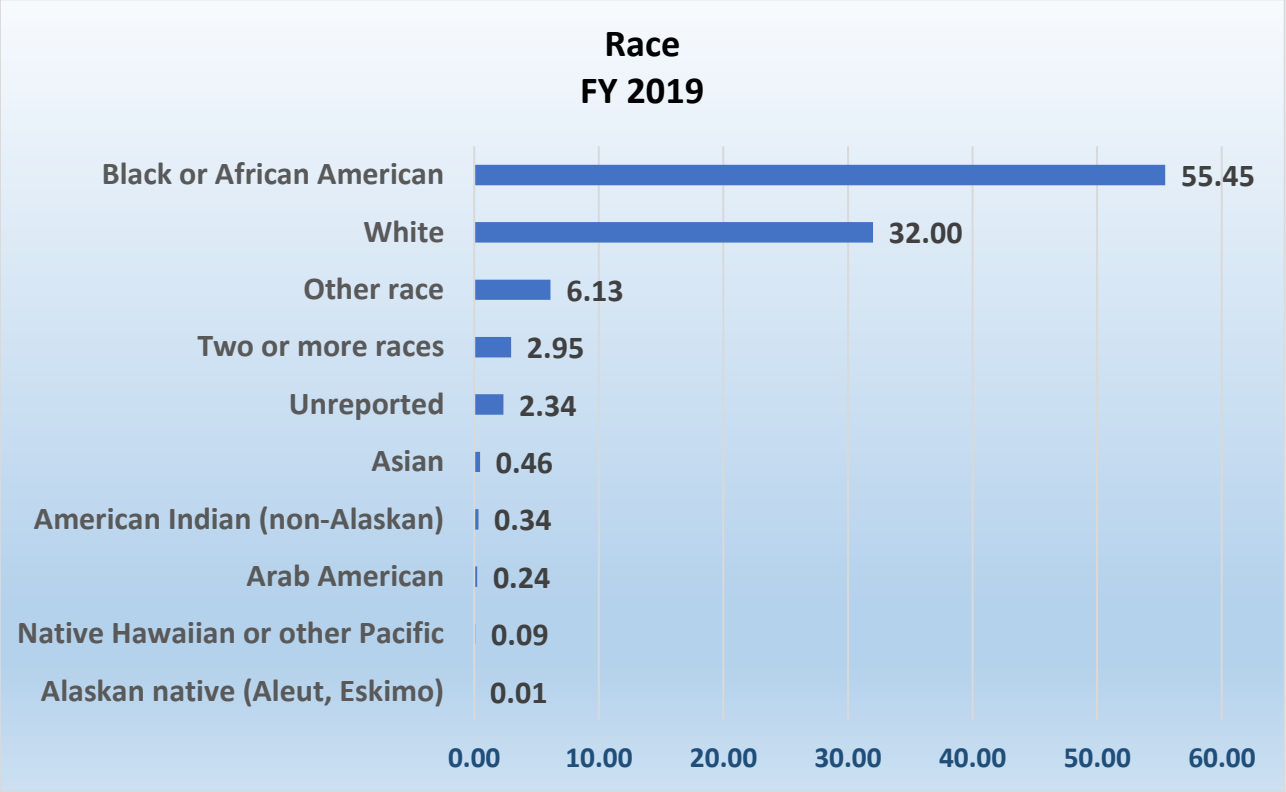
Population Served by Funding Source

DWIHN provided services to an unduplicated count of 73,429* during FY 2019, which represented a decrease of 252 (0.34%) from FY 2018. Of those served 48,380 (52.31%) received services through Medicaid funding, 18,948 (20.49%) received services through Healthy Michigan Plan funding, 8,688 (9.39%) received services through General Fund, 9,081(9.82%) through SUD Block Grant, 4,903 (5.30%) through MI Health Link, 1,490 (1.61%) through State Disability Assistance (SDA), 940 (1.02%) through Habilitation Supports Waiver and 47 (0.05%) through MI Health link Medicaid HAB which is a decrease of 20 (35.08%) from the previous year.



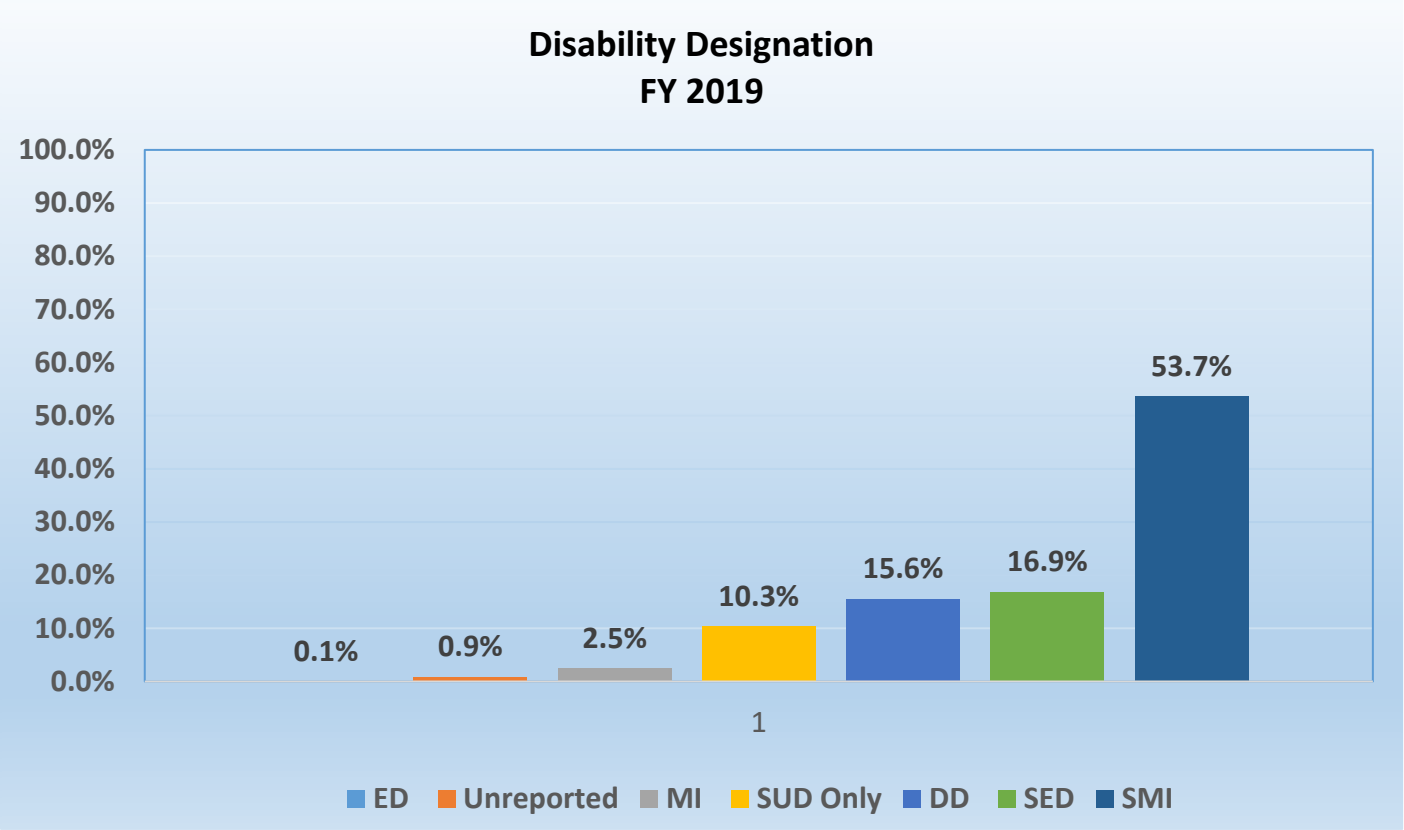
Race

Of those served, 40,717 or (55%) were of African American decent. This reflect an increase of 1,800 (4.6%) from FY 2018. The Caucasian count was 23,495 or (32 %). The remaining (13%) were identified as other, two or more races, unreported, Asian, American Indian, Native Hawaiian and Alaskan.



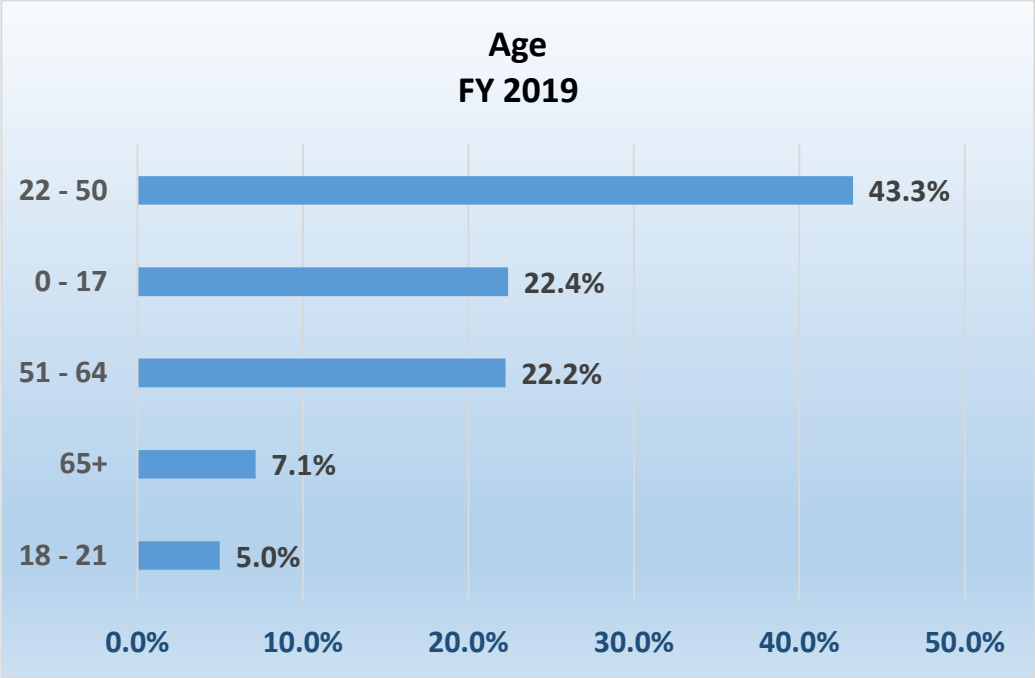
Disability Designation

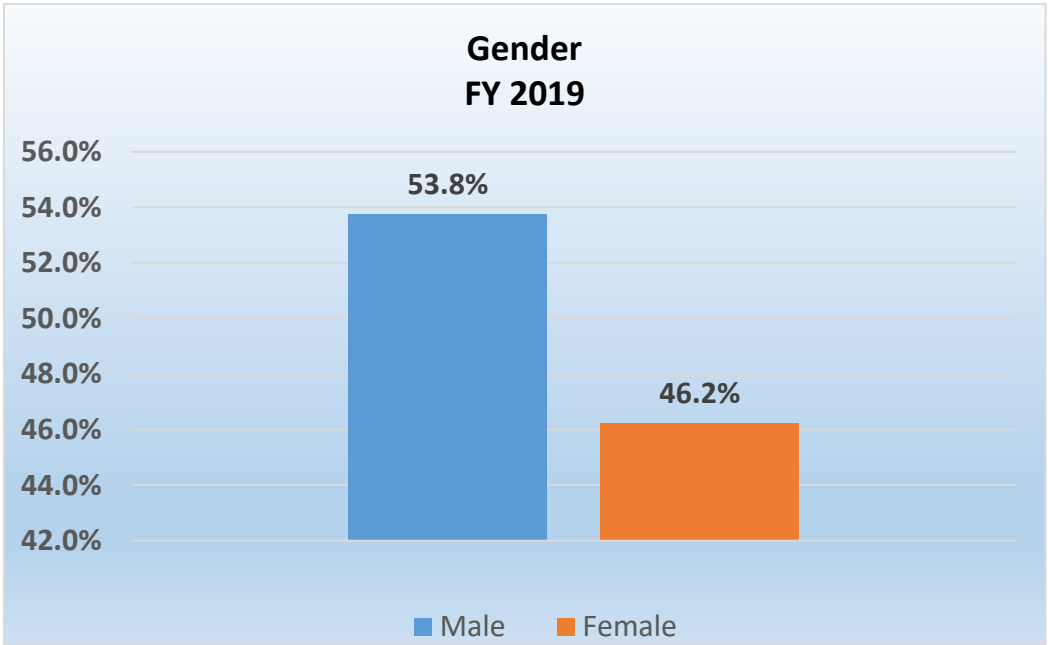
The percent of adults who reported having a severe mental illness in FY 2019, has steadily remained the same with no significant deviation from the previous year. Followed by 16.9% Serious Emotional Disturbance (SED), 15.6% Intellectual/Developmental Disability (IDD), 10.3% Substance Use Disorder (SUD), 2.5% Mental Illness (MI), and 0.9% unreported. Experiencing psychological distress in the past year has been associated with higher rates of substance abuse.



Age and Gender

The largest group of individuals served are in the age group of 22-50 years-old 31,757 (43.3%), demonstrating a slight decrease of 567 (1.76%) from FY 2018. Followed by the age group of 51-64 years-old, 16,332 (22.2%), and the age group of 0-17 years-old, 16,444 (22.4%). The growth of persons served 65 and over slightly increased from the previous year by (0.1%). An estimated 53.8% of DWIHN's population is male; 46.2 % is female. MDHHS reports the state's population is 50.8% female and 49.2% is male.



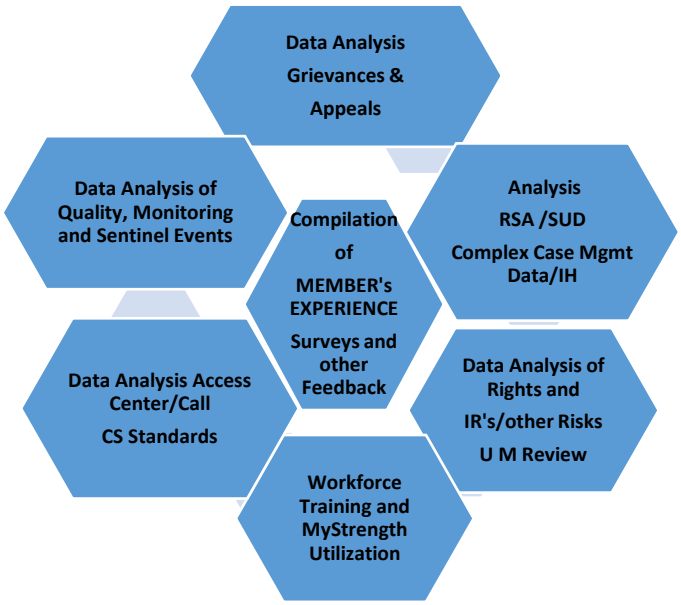


Goal I - Customer Pillar

Member Satisfaction: ECHO Survey

Member evaluation of the services offered by DWIHN is critical to the identification of opportunities to improve all aspects of care to the people we serve. During FY 2019, the Children and Adult Echo Surveys were not submitted to members due to the contract with Wayne State not being finalized until January 2020. The surveys were mailed to members in January 2020 with an expected return date of April 2020. Once data is available DWIHN will identify an area (or areas) of focus across all activities to target actions steps and interventions to improve satisfaction. The information will be presented to QISC for planning and implementation as needed.

For FY 2019, DWIHN completed an analysis of member experience trends and occurrences through review of Grievances, Appeals, Recipient Rights, Sentinel Events and data analysis of Quality Monitoring as illustrated in the diagram below.



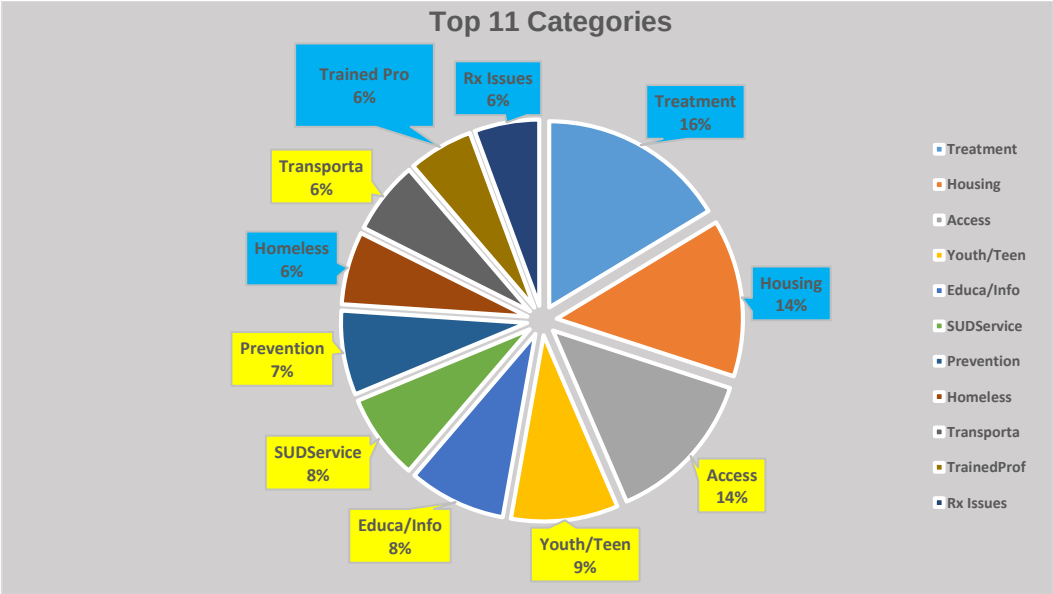
Results and Analysis

The analysis was completed to get an accurate account of Member's Experience with services through surveys and grievance data, such as member satisfaction surveys, focus groups, member interviews and feedback from customer advisory council. The analysis include several areas of our system in a comprehensive overview of trends and occurrences that depict experiences that may impact Quality of Care, Access to Services, Attitude of Services, Billing, Financial Issues and Quality of Providers Environment.

In review of the outcomes, homelessness is a priority (indicated by 6% of respondents). The lack of affordable housing is noted as a quality of care issue (14% of respondents). Treatment issues (16% of respondents) which include follow up care and concerns addressing lack of nutrition, dental care, spiritual care, and recidivism due to the inability to close the gap on basic-needs not being met. Nonetheless, it remains that homelessness and housing issues are identified factors that prevent quality engagement. Barriers identified for achieving member satisfaction goals:

- ⇒ Transportation
- ⇒ Lack of places to buy groceries in the community
- ⇒ Financial Problems
- ⇒ Lack of family and social support
- ⇒ Stigma of the disease
- ⇒ Lack of follow-up

In reviewing the top 11 categories of the *Needs Assessment Survey 2018*, there was a clear correlation of issues related to either treatment, quality or access to care as depicted in the pie chart below.



Planned Interventions for FY 2020

- ⇒ Meet or exceed results from Member Echo Survey from 2018. The focus will be directed toward addressing member satisfaction in the particular areas below.
  - Treatment after benefits are used up (48%)
  - Overall rating of counseling and treatment (46%)
  - Getting treatment quickly (37%)
  - Office wait and Access (33%)
  - Member's perspective on perceived improvement (29%)
- ⇒ Conduct periodic qualitative assessments of member experience with services
- ⇒ Develop and implement interventions to improve survey response rates
- ⇒ Continue direct contracts with NSO Path Program to assist members with affordable housing.
- ⇒ Continue partnership with Salvation Army to assist with food, clothing and housing needs for members.

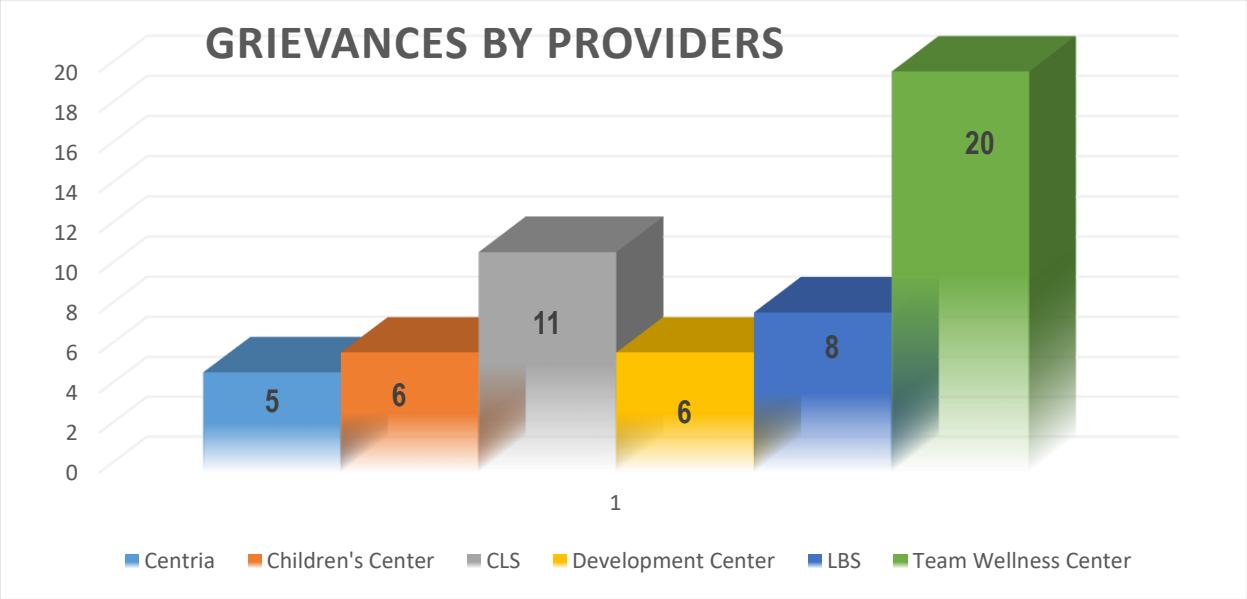
National Core Indicator Survey (NCI)

The NCI survey is a collaborative effort between the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Services Research Institute (HSRI) to establish indicators that measures the performance of IDD services and supports within the state. For FY 2019, DWIHN delivered to MDHHS a total 164 interview consents and 149 pre-surveys to members, 20% above the identified goals for members to participate in the survey. While the survey results are not DWIHN specific, DWIHN will use the results to identify and investigate areas of dissatisfaction and implement interventions for improvement. Once data is available and analyzed information will be presented to QISC for development of interventions as needed. The core indictors are standards measures used across states to assess the outcomes of services provided to individuals and families.

Member Grievances

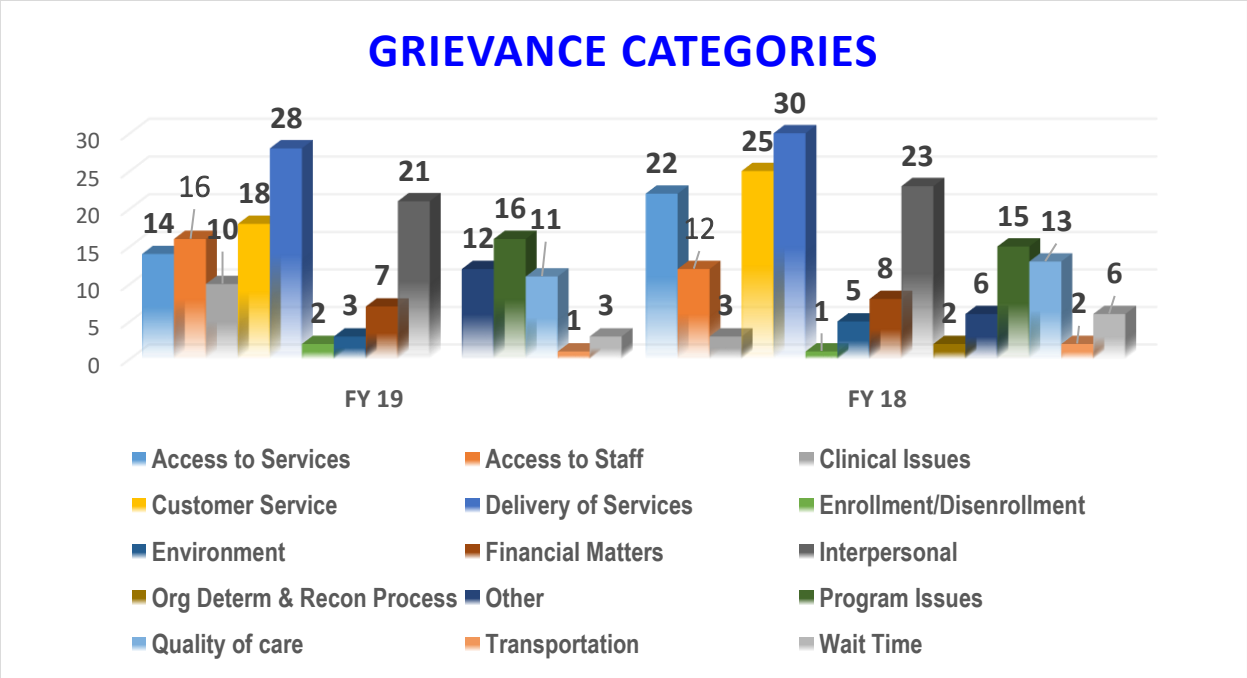
The grievance system is an important element in identifying how providers function in various areas. It serves as a source to identify opportunities for improvement in the quality and delivery of behavioral health service within DWIHN's provider system. The process empowers individuals receiving services to become self-advocates which makes the system better for all members served. Member grievance data is aggregated quarterly with review by the Quality Improvement Steering Committee (QISC).

Results and Analysis
During FY 2019, a total of 97 grievances were processed, which is a 12.7% increase from the previous FY 2018. Grievances originated either at the Service Provider level or at DWIHN. Grievances reported were against 34 different Providers (both Service and AFC) in FY 2019 compared to 35 Providers in FY 2018. The table below is reflective of the six (6) Providers with the most reported grievances during FY 2019.



Grievances Reported
The review of Grievances, Appeals and Recipient Rights are critical data elements for the overall analysis of Member Experience. Administering surveys, facilitating focus groups, seeking resolutions, analyzing the use of services through Utilization Management (UM), Access Center, monitoring and Crisis Line are all additions to the comprehensive review that compiles the information contained for getting an accurate view of the consumer-member's total sum experience.

Results and Analysis
During FY 2019, there were 162 different issues identified within the 97 grievances reported. Whereas in FY 2018, there was a 173 (6.7%) decrease with identified issues reported. Transportation and enrollment related issues were the two categories with the lowest number of grievances reported in FY 2019 and FY 2018.



Delivery of Service, Interpersonal relations and Customer Services were three categories in which there were high numbers of grievances reported in FY 2019. Whereas in FY 2018, Access to Services were a category in which there were a large number (22) of grievances reported. There was a decline of 59% for Access to Services grievances and a decrease of 68% in the number of grievances related to Customer Service in FY 2019. However, there was an increase of 75% in the number of Access to Staff grievances in FY 2019.

Planned Interventions for FY 2020

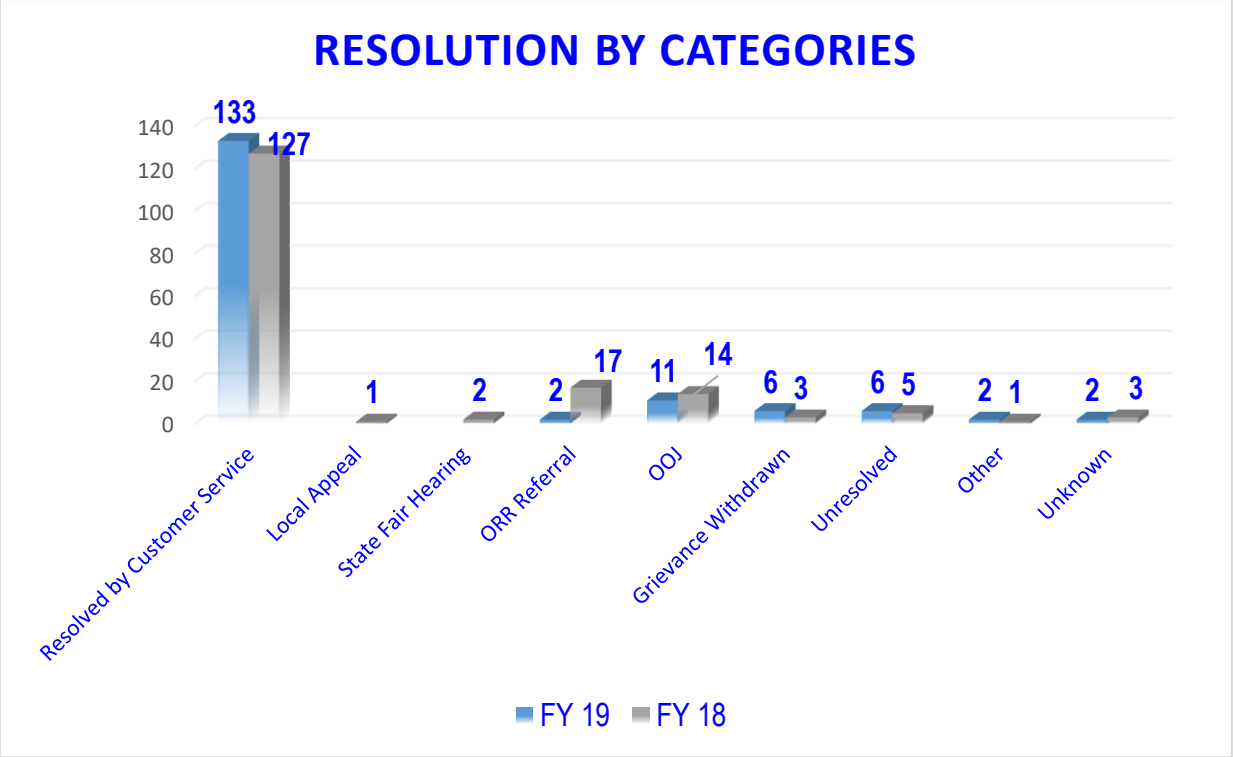
- ⇒ Continue to work with our Member Engagement division to provide outreach, education, advocacy, peer development, and surveying member experiences.
- ⇒ Continue the Constituents' Voice Advisory Committee which addresses consumer legislative issues including the delivery of service, interpersonal relations and customer service.
- ⇒ Continue with the Ambassadors Program. This charge has been to promote system's transformation and to support individual's efforts of navigating their rights and services. This was accomplished through over 70 outreach engagements in the community.

Time Frame of Resolution

In order to conform to the Code 42 of the Federal Regulations (CFR), effective October 1, 2017, Medicaid and MI Health Link grievances are required to be resolved within ninety (90) calendar days, whereas the Non-Medicaid member grievances are still required to be closed within sixty (60) calendar days. No grievances exceeded the required resolution timeframes in FY 2019. There were no 14-day extension required to extend the resolution timeframes. The average number of days a grievance remained open in FY 19 was 51 days.

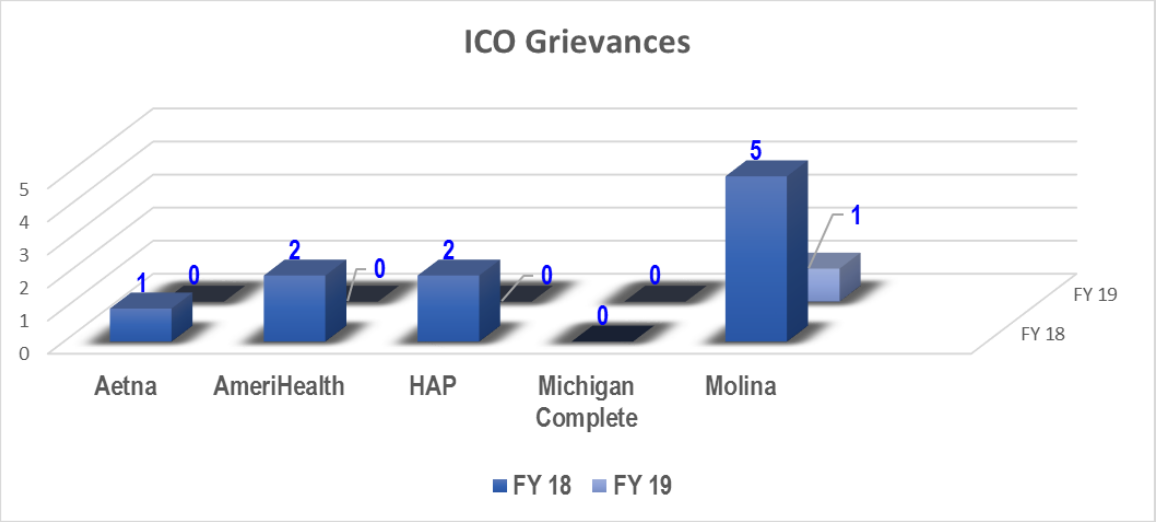
Results and Analysis

Of the 162 grievance categories reported in FY 2019, 133 (82%) were resolved within the Customer Service unit in coordination with other departments. Two (2) of the complaints consisted of suspected recipient rights violations and therefore, were referred to ORR for further investigation. Six (6) grievances or 3.7 % were withdrawn by the Grievant. 6.8% were issues deemed to be out of jurisdiction. In comparison, during FY 2018,127 (73%) of the 173 grievance categories were resolved within the Customer Service unit, 17 which is (9.8%) of those categories were referred to the ORR for additional follow-up and investigation. The table below is reflective of the resolution by categories.



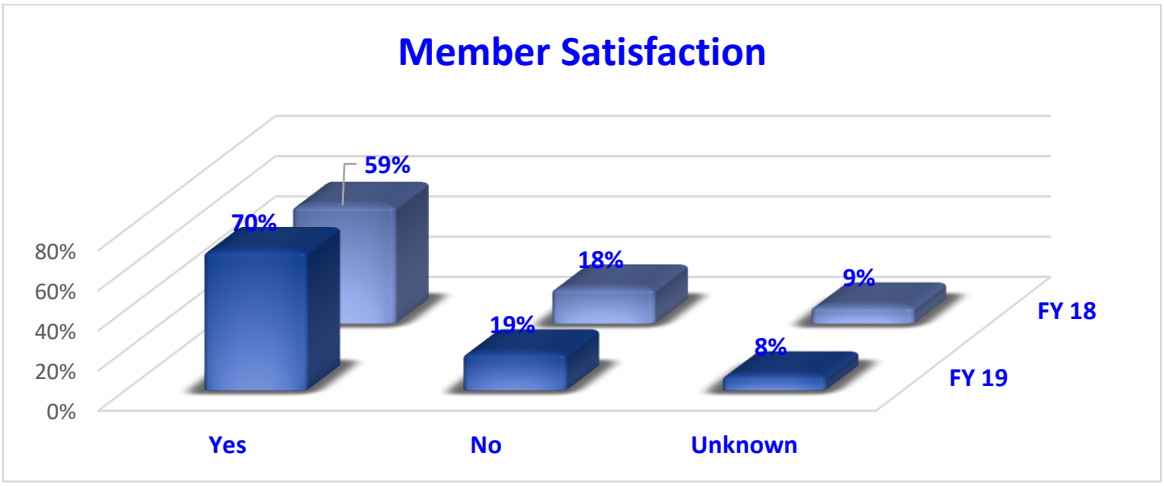
MI Health Link Grievance Activity

There was only one (1) grievance reported for the five ICOs in FY 2019, which was a decrease of 99% from FY 2018 at which time there were ten (10) grievances reported. MI Health Link members have the option to report grievances to the Ombudsman's office. The Ombudsman's office did not contact DWIHN regarding any grievances received through their office. The graph below reflects the number of grievances processed for each ICO during FY 2019.



Member Satisfaction

70% of the individuals who filed a grievance expressed satisfaction with the resolution of his/her grievance in FY 2019 compared to 59% in FY 2018. In 2019, 19% expressed dissatisfaction with the outcome of the resolution of their grievances, compared to 18% in FY 2018. Satisfaction disposition was unable to be obtained for 8% in FY 2019 compared to 9% in FY 2018.



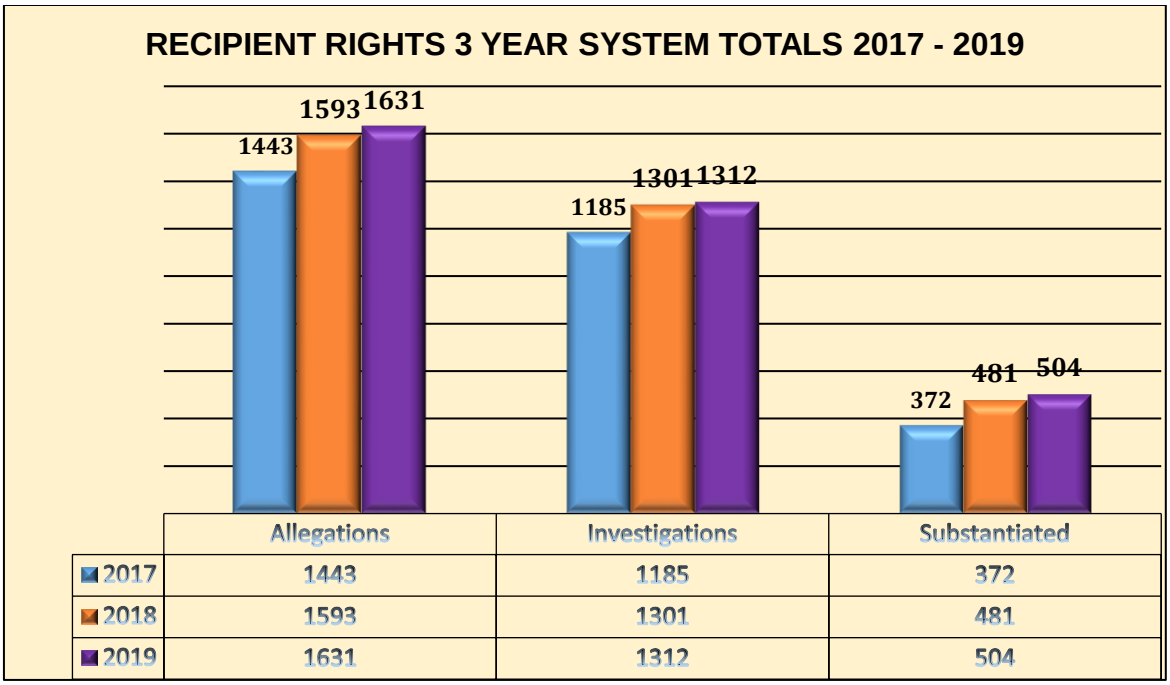
Planned Interventions FY 2020

- ⇒ The Customer Service Department will continue to conduct site reviews at the Provider level. Prior to FY 2019, it was the MCPNs' responsibility to conduct site reviews. The site reviews provided significant insight into the lack of Providers having Grievance policies and procedures in alignment with the federal guidelines. Providers were placed on corrective action plans as needed.
- ⇒ Continue to assess any significant trends or patterns in the data outcomes.
- ⇒ Increase on-site grievance process trainings for Providers.
- ⇒ Identify additional outreach opportunities to ensure that all members are well informed and educated on the Grievance Process.

⇒ Develop and conduct two-part training modules for Grievance Policy and MH-WIN sessions.
⇒ Continue to identify quality improvement opportunities in the delivery of services to members and stakeholders.
⇒ Continue collaborative working relationships with the Ombudsman Program staff.

Office of Recipient Rights

During FY 2019, the Office of Recipient Rights (ORR) received 1,631 allegations of rights violations demonstrating a slight increase of 32 (2.0%) from FY 2018. ORR investigated 1,312 and substantiated 504 rights violations. This represents a 1.0% increase from FY 2018. ORR also monitored than 600 service sites including hospitals and provided New Hire Recipient Rights training to more than 5,000 staff working in the DWIHN Network of Care. The chart below illustrates the number of allegations received, substantiated and investigations over the past 3 years.



	Allegations	Investigations	Substantiated
2017	1443	1185	372
2018	1593	1301	481
2019	1631	1312	504

Linguistic and Cultural Competency

DWIHN culturally diverse network provides services to members that account for cultural norms, language differences and other special needs. DWIHN strives to determine and ensure that its' provider network is inclusive enough to serve specific populations and meet special treatment needs. This belief allows system, agency and professionals to come together and enable effective work to be done while serving children, youth and families.

Interventions Implemented during FY 2019

- ⇒ DWIHN Children's Initiatives hosted the Cultural and Linguistic Competency Summit on June 28, 2019 at the Westland City Hall. The theme was “Honoring and Supporting Cultural Identities.” There were 113 participants. The keynote speaker was Bethany Hedden, LLMSW, and she spoke on “Turning toward a Relationship with Reality: How Understanding Social Work Concepts is Just a Part of the Picture.” Ms. Hedden is a Ph.D. student in Social Work and Anthropology and Graduate Research Assistant in the School of Social Work at Wayne State University.
- ⇒ DWIHN has contracts with agencies with a variety of specialized cultural expertise and linguistic competency.
- ⇒ DWIHN has Medversant software that will allow for identification of group affiliation as well as check credentials of DWIHN and the provider network staff. The software is set for full implementation by September 2020.

Results and Analysis

- ⇒ DWIHN ensures that members and family members are informed of their right to have information and services provided in a language or format they are able to understand. DWIHN also informs members of the availability of interpretive services and other resources through the member handbook and provider directory. When services cannot be delivered in a member’s primary language with existing resources, DWIHN and its core providers maintain contractual arrangements with agencies providing interpretation services.

Number of DWIHN’s Providers Offering Languages		
English 236	Russian 6	Serbo-Croatian 3
Spanish 53	French 6	German 3
Arabic 30	Korean 5	Bengali 2
Hindi 8	Punjabi 5	Tagalog 2
Italian 6	Polish 3	Japanese 1
Chaldean 1	Chinese 1	Filipino 1

Planned Interventions for FY 2020

- ⇒ The full implementation of Medversant
- ⇒ Continue efforts toward the recruitment and retention of providers and practitioners with cultural, linguistic, or special needs expertise.
- ⇒ Continue Cultural Competency training to staff and network providers as required.
- ⇒ Continue to meet the cultural, ethnic, and linguistic needs of members by assuring a diverse provider network.

Goal II - Access Pillar

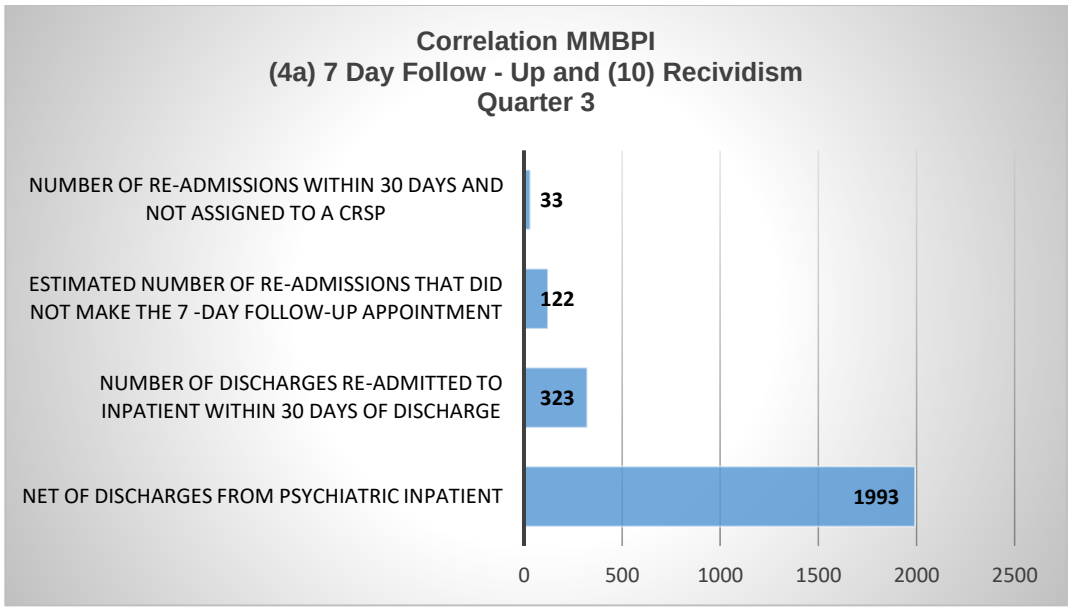
Michigan Mission Based Performance Indicators (MMBPI)

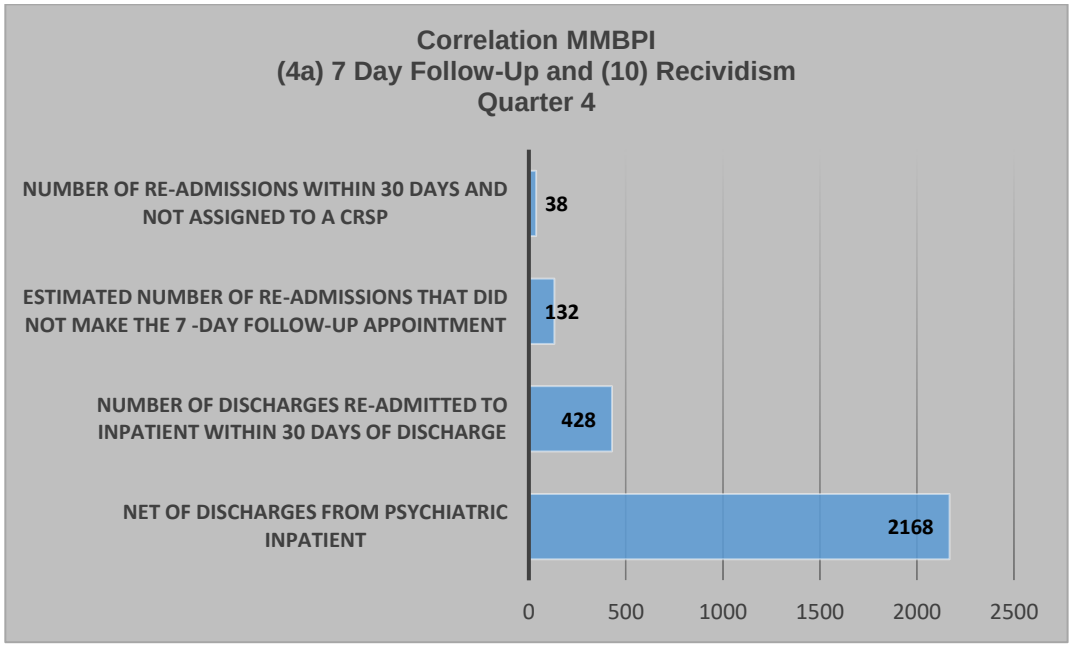
DWIHN measures its Michigan Mission Based Performance Indicators (MMBPI) using standardized indicators based upon the systematic, ongoing collection and analysis of valid and reliable data as required by the Michigan Department of Health and Human Services (MDHHS). A crucial part of the member satisfaction / data collection piece involves striving to surpass the benchmarks set for the MMBPI data in the areas of access, efficiency, and outcome. MMBPI data is submitted to MDHHS on a quarterly basis.

Results and Analysis

During FY 2019, based on the analysis of Q1, Q2 ,Q3 and Q4 the data indicates a steady increase in performance for Indicator # 4a and #4b with an overall compliance score of 96% and 95% from the previous quarters. This increase can be contributed to ongoing efforts which include educating our provider network. Ongoing efforts to include review of potential barriers for members that are not following through with their 7-day follow up appointments.

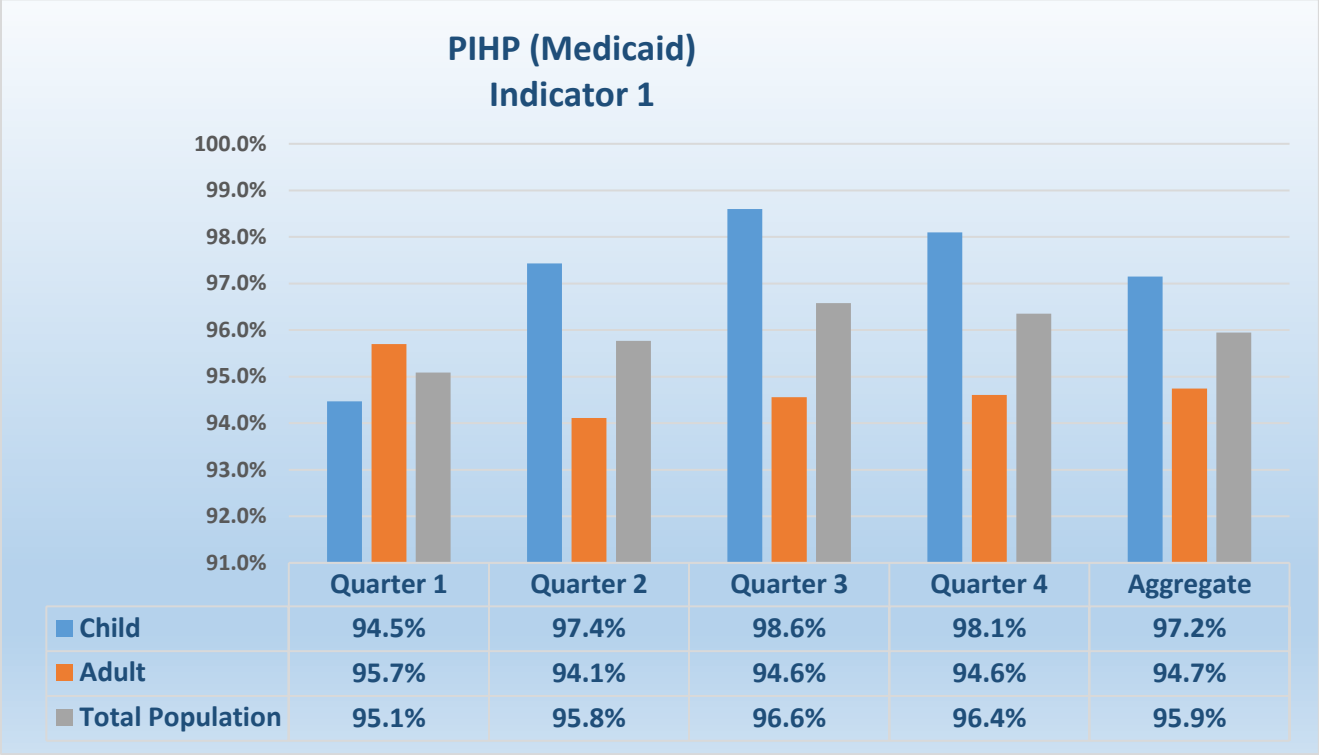
For Indicator #10 (Recidivism), DWIHN failed to meet the threshold of 15% or less during each quarter. The correlation between Indictor 4a (follow-up care within 7 days) and Indicator 10 (Recidivism) for Q3 identifies that 33 (10%) members are readmitted and have not been assigned to a Clinically Responsible Service Provider (CRSP). The correlation also shows, as illustrated below, 122 (38%) members did not make 7-day follow up appointment and were readmitted within 30 days. Q4 identifies that 38 (9%) members are readmitted and have not been assigned a CRSP, 132 (31%) members did not 7-day follow up appointment.


Correlation MMBPI
(4a) 7 Day Follow - Up and (10) Recividism
Quarter 3
NUMBER OF RE-ADMISSIONS WITHIN 30 DAYS AND NOT ASSIGNED TO A CRSP
33
ESTIMATED NUMBER OF RE-ADMISSIONS THAT DID NOT MAKE THE 7 -DAY FOLLOW-UP APPOINTMENT
122
NUMBER OF DISCHARGES RE-ADMITTED TO INPATIENT WITHIN 30 DAYS OF DISCHARGE
323
NET OF DISCHARGES FROM PSYCHIATRIC INPATIENT
1993
0
500
1000
1500
2000
2500


Correlation MMBPI
(4a) 7 Day Follow-Up and (10) Recividism
Quarter 4
NUMBER OF RE-ADMISSIONS WITHIN 30 DAYS AND NOT ASSIGNED TO A CRSP
38
ESTIMATED NUMBER OF RE-ADMISSIONS THAT DID NOT MAKE THE 7 -DAY FOLLOW-UP APPOINTMENT
132
NUMBER OF DISCHARGES RE-ADMITTED TO INPATIENT WITHIN 30 DAYS OF DISCHARGE
428
NET OF DISCHARGES FROM PSYCHIATRIC INPATIENT
2168
0
500
1000
1500
2000
2500

Indicator 1

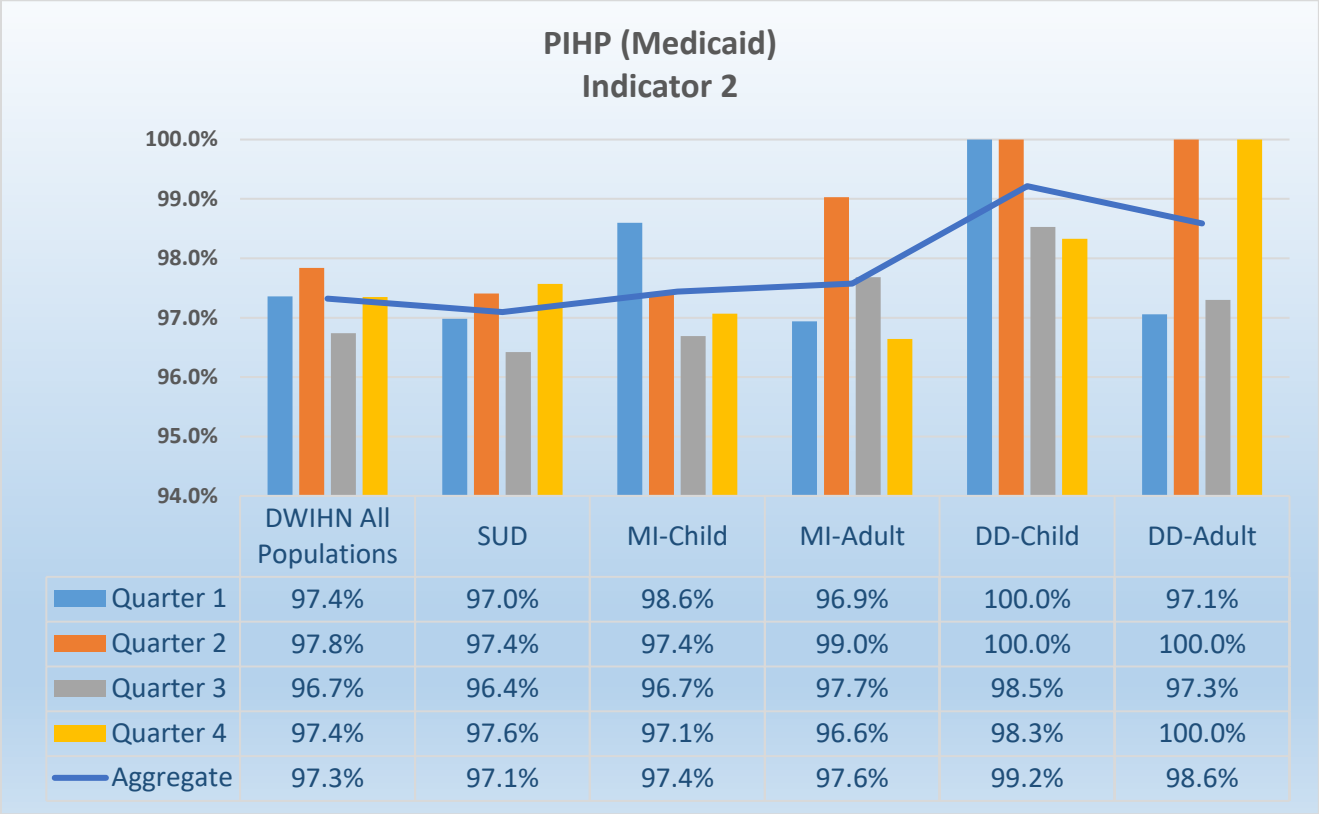
The percentage of persons during 2019 receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. 95% is the standard***. Outcome****: FY 2019 standard met for adult population Q1 only. Standard met for children for Q2, Q3 and Q4. Total population met standard for all quarters.* ***Note: The COPE program is responsible for data collection of Indicator 1b***



	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Aggregate
Child	94.5%	97.4%	98.6%	98.1%	97.2%
Adult	95.7%	94.1%	94.6%	94.6%	94.7%
Total Population	95.1%	95.8%	96.6%	96.4%	95.9%

Indicator 2

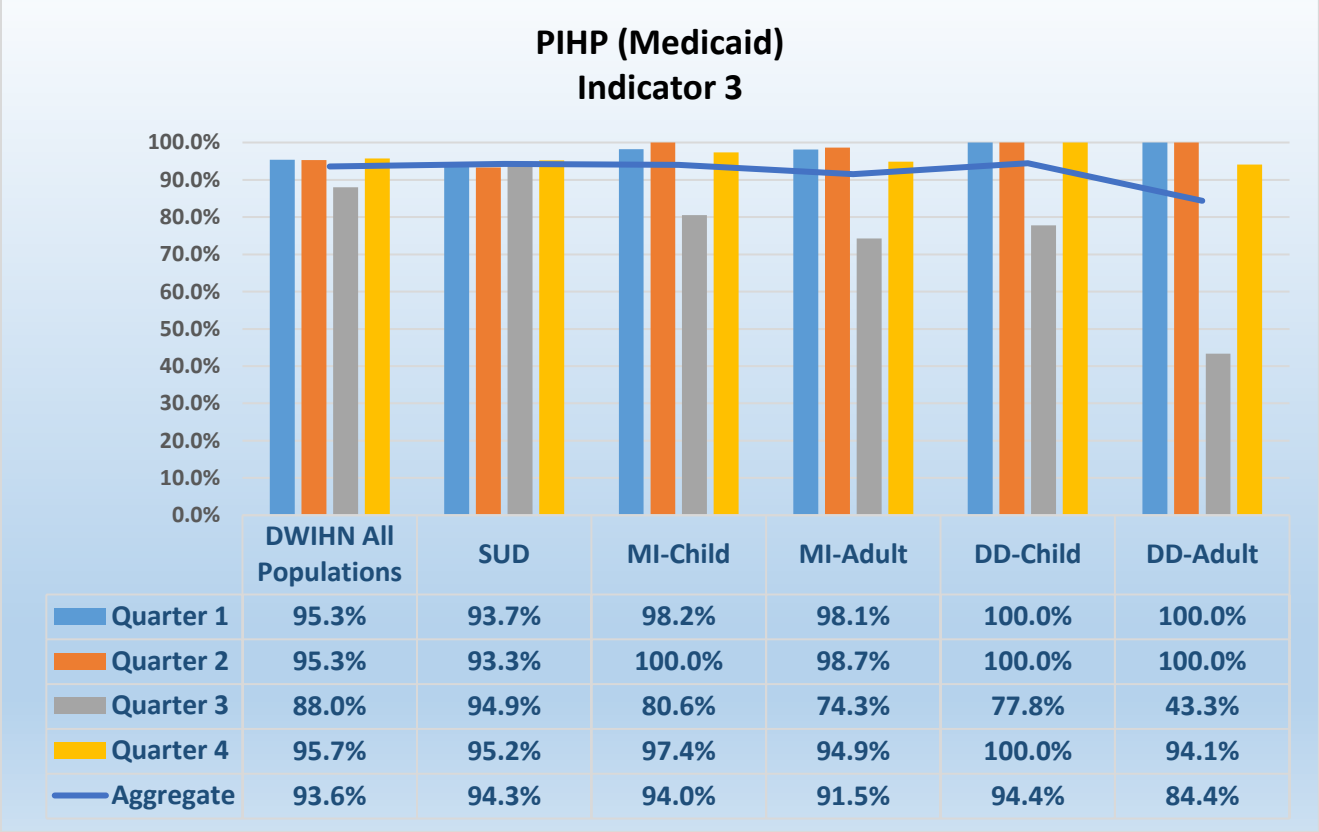
The percentage of persons during FY 2019 receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.
95% is the standard. ***Outcome:*** *FY 2019 standard met for all populations Q1, Q2, Q3 and Q4.*



	DWIHN All Populations	SUD	MI-Child	MI-Adult	DD-Child	DD-Adult
Quarter 1	97.4%	97.0%	98.6%	96.9%	100.0%	97.1%
Quarter 2	97.8%	97.4%	97.4%	99.0%	100.0%	100.0%
Quarter 3	96.7%	96.4%	96.7%	97.7%	98.5%	97.3%
Quarter 4	97.4%	97.6%	97.1%	96.6%	98.3%	100.0%
Aggregate	97.3%	97.1%	97.4%	97.6%	99.2%	98.6%

Indicator 3

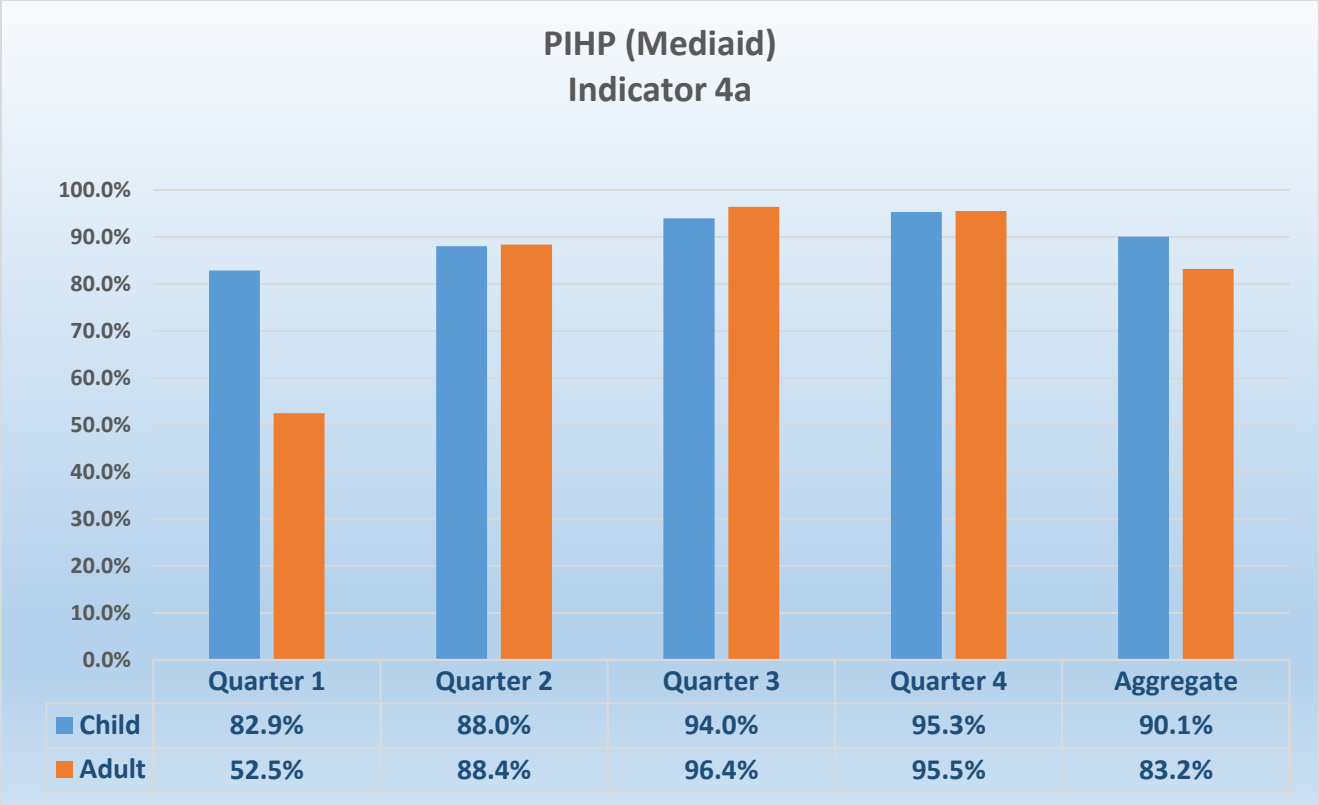
The percentage of persons during FY 2019 needed on-going service within 14 days of a non-emergency request for service 95% is the standard. ***Outcome****: FY 2019 standard met for all populations Q1, Q2 and Q4. Q3 did not meet the expected outcome for MI-Child (80.6%), MI-Adult (74.3%), DD-Child (77.8%) or DD-Adult (43.3%).* Q3 did not meet the outcome of 95.0% due to the methodology change that was done in error. For Q4, the initial assessment date methodology was changed to zero days for accurate reporting.



	DWIHN All Populations	SUD	MI-Child	MI-Adult	DD-Child	DD-Adult
Quarter 1	95.3%	93.7%	98.2%	98.1%	100.0%	100.0%
Quarter 2	95.3%	93.3%	100.0%	98.7%	100.0%	100.0%
Quarter 3	88.0%	94.9%	80.6%	74.3%	77.8%	43.3%
Quarter 4	95.7%	95.2%	97.4%	94.9%	100.0%	94.1%
Aggregate	93.6%	94.3%	94.0%	91.5%	94.4%	84.4%

Indicator 4a

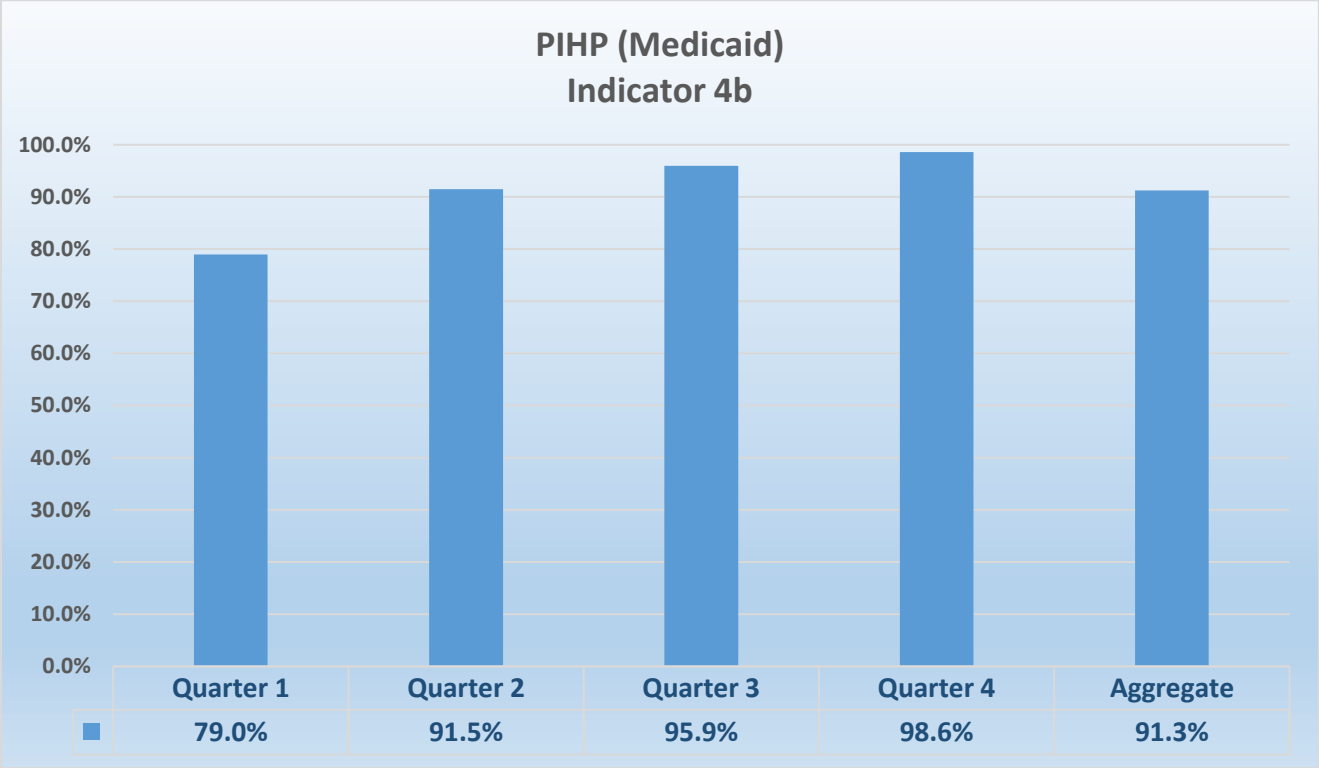
The percentage of discharges from a psychiatric inpatient unit during FY 2019 who are seen for follow-up care within seven days 95% is the standard. ***Outcome****: FY 2019 standard met for all populations for Q3 and Q4. Q1 did not meet the expected outcome for children (82.9%), adult (52.5%) or Q2 children (88.0%), adult (88.4%).*



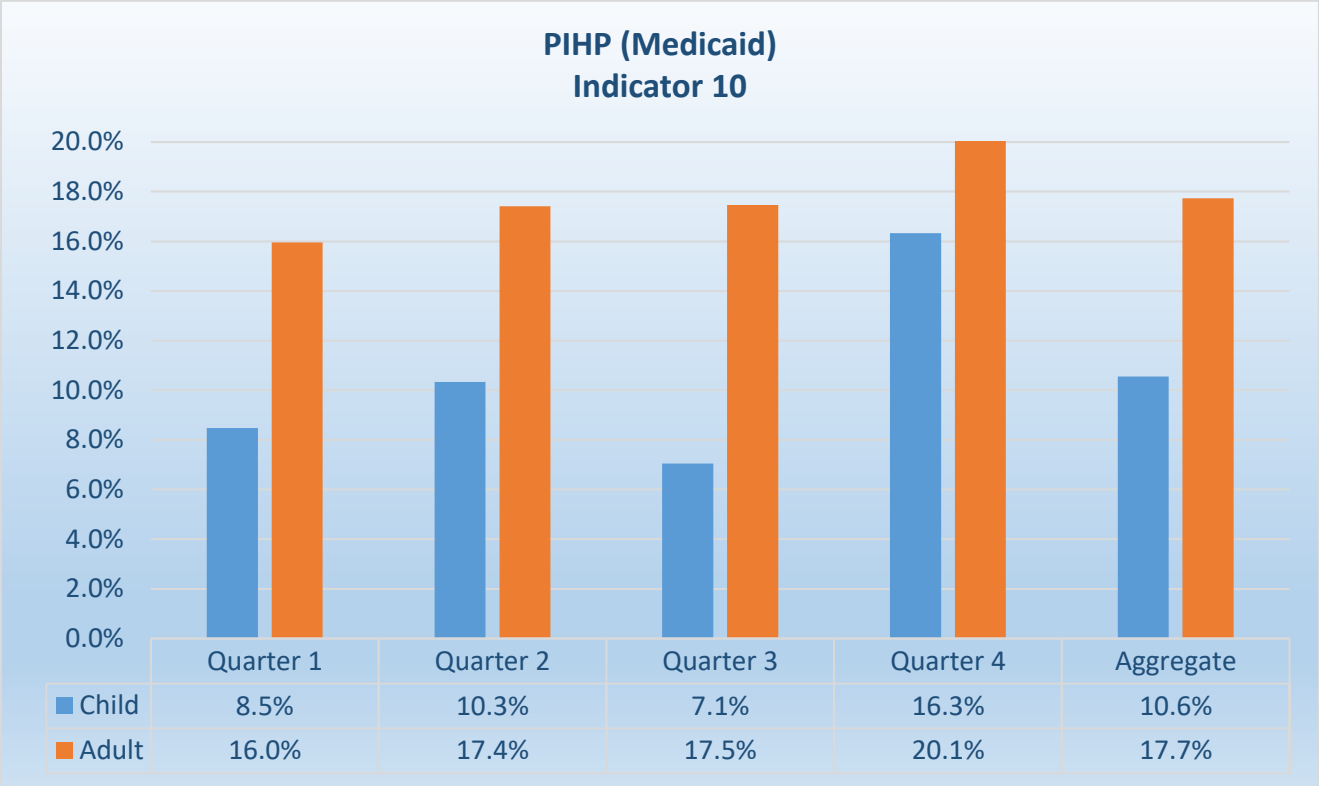
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Aggregate
Child	82.9%	88.0%	94.0%	95.3%	90.1%
Adult	52.5%	88.4%	96.4%	95.5%	83.2%

Indicator 4b

The percentage of discharges during FY 2019 from a Substance Abuse Detox Unit who are seen for follow-up care within 7 days 95% is the standard. ***Outcome****: FY 2019 standard met for all populations for Q3 and Q4. Q1 did not meet the expected outcome (79.0%) or Q2 (91.5%).*



Indicator 10
The percentage of readmissions of children and adults during FY 2019 to an inpatient psychiatric unit within 30 calendar days of discharge from a psychiatric inpatient unit. 15% or less within 30 days is the standard. ***Outcome:*** *FY 2019 met goal for Q1, Q2 and Q3 for children population. Standard did not meet for adult population for Q1, Q2, Q3 or Q4.*



Planned Interventions for FY 2020

- ⇒ Identify members that are readmitted more than once during each quarter.
- ⇒ Collaborate with Integrated Health and Access/Crisis Units to review if members that continue to be readmitted, or admitted more than once during a quarter are enrolled in the Complex Case Management Program (voluntary) or assigned to a Clinical Responsible Service Provider (CRSP).
- ⇒ Engage the CRSP's to conduct Interdisciplinary meetings for members that have multiple readmissions.
- ⇒ Monitor the Quality Improvement Project (PIP) data for improving the attendance at Follow-up Appointments with a Mental Health Professional after a Psychiatric Inpatient Admission.
- ⇒ Provide technical assistance and training as required.
- ⇒ Review and monitor the correlation between Indictor 4a (follow-up care within 7 days) and Indicator 10 (Recidivism).

⇒ Ensure continuity of care by increasing compliance to outpatient follow up care helps detect early post-hospitalization medication problems and provides continuing support that improves treatment outcomes and reduces health care costs.

⇒ Notify providers in real time when members are seen in the Emergency Department and or admitted.

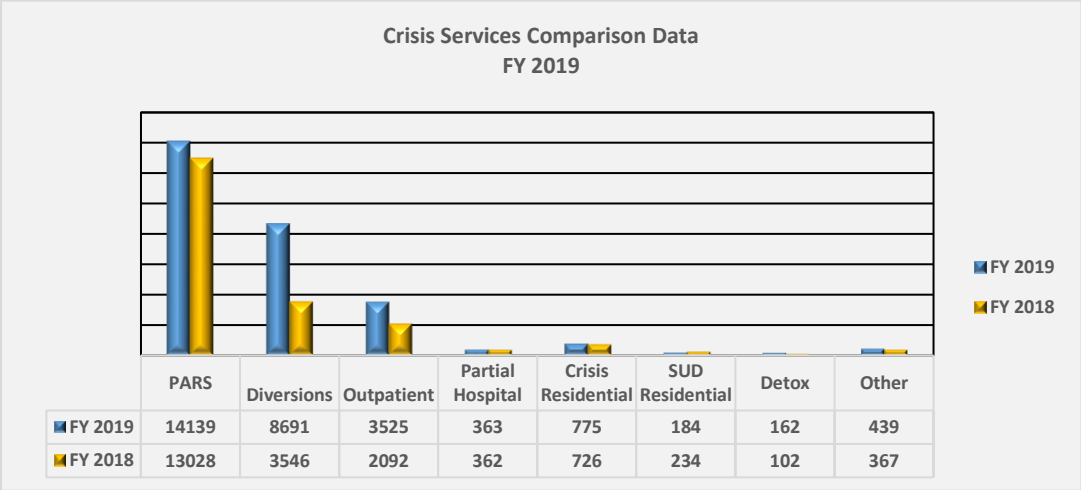
⇒ Implement MedDrop Program Pilot March 2020
- Lincoln Behavioral Services
- Community Care Services
- Northeast Guidance Integrated Services

Crisis Services

DWIHN has contracted with Community Outreach Psychiatric Services (COPE), a component of Hegira Programs to conduct Pre-Admission Reviews for Inpatient Hospitalization and Crisis Stabilization. The change in the pre-admission review process provided members to be screened within three hours of their request for crisis/urgent services upon entry into the emergency department/emergency room and DWIHN the ability to capture better data.

Results and Analysis

During FY 2019, there were a total of 14,139 PARS, which represented an increase of 1,111(8.17%) from FY 2019. Of those served 8,691 were diversions 3,525 Outpatient, 363 Partial Hospital, 775 Crisis Residential,184 SUD Residential Short Term, 162 Detox, and 439 identified as other. This increase is mainly attributed to an increase in hospitalizations.



	PARS	Diversions	Outpatient	Partial Hospital	Crisis Residential	SUD Residential	Detox	Other
FY 2019	14139	8691	3525	363	775	184	162	439
FY 2018	13028	3546	2092	362	726	234	102	367

Planned Interventions for FY 2020

- ⇒ Collaborate with DWIHN's provider network to monitor members that present at the Emergency Department (ED).
- ⇒ Providers must be notified in a real time of members seen in ED or admitted.
- ⇒ Ensure members schedule a 7-day and 30 day follow-up appointment
- ⇒ Understand and educate providers to work members that are at greatest risk of hospital admissions and or readmissions.

Needs Assessment

Enhance Mental Illness Services to Justice involved members is a need and a priority that has been part of an ongoing effort by DWIHN, to work more collaboratively with the Corrections System, Spiritual Leaders, Community Organizations, Business Employment, Providers and Peers. 83% of people in Wayne County jail have been a part of the mental health system. This has led to gaps in the provision of mental health services and the potential for recidivism. Returning citizens have challenges in housing and economic instability which is a critical factor in recidivism. To address this issue, DWIHN plans to create a collaboration with key stakeholders to create a strategy to effectively improve the mental health corrections system from a holistic need viewpoint:

- ⇒ Establish effective partnerships with providers, correction system leadership, and community organizations.
- ⇒ Ensure linkages and coordination of services, including access to medication, peer support and housing.
- ⇒ Better discharge planning between local jail system and outpatient treatment.
- ⇒ Identify housing programs already in the community that serve ex-offenders.
- ⇒ Create economic opportunities and develop employment strategies in the community
- ⇒ Address other needs which have been shown to contribute to recidivism.

There is a new program called Youth Advocate Program (YAP) that will start next year. YAP will look at reducing incarceration rates for youth. Data analysis and evaluation of the overall effectiveness, including progress toward influencing network wide safe clinical practices will be available for reporting in FY 2020.

DWIHN staff completed a comprehensive review of Wayne County Jail on October 1-3, 2019. Results and data analysis will be available for reporting in FY 2020.

Clinical Practice Guidelines

DWIHN adopts evidence-based and nationally recognized standards of care clinical practice guidelines based on the needs of the people we serve. The clinical practice guidelines are reviewed every two years and approved by the Chief Medical Director. Improving Practices Leadership Team (IPLT) meetings are used to discuss and disseminate the guidelines. The practice guidelines are available to members and providers on DWIHN's website.

Planned Interventions for FY 2020

- ⇒ Continue to implement and disseminate evidence-based nationally recognized guidelines that promote prevention and recommended treatment.
- ⇒ Promote access to and increase usage of recommended guidelines through provider and member education/outreach.

Goal III – Workforce Pillar

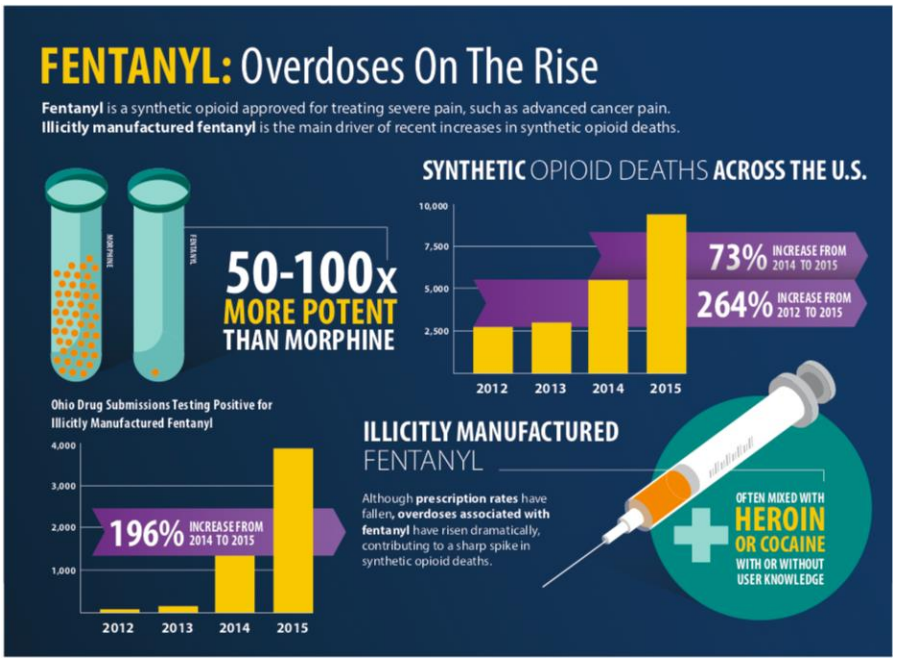
To ensure a network of qualified practitioners, DWIHN utilizes Detroit Wayne Connect (DWC) for ongoing training requirements. For FY 2019, there were 65,460 individuals that actively utilize DWC with 56,633 completing the required online courses and 38,755 taking optional online courses. The total number of individuals trained demonstrates an increase of 10,602 (23%) compared to FY 2018. Those trained included professional healthcare staff comprised of social workers, psychologist, physicians, nurses and counselors. The continuing education credits associated with these trainings accounted for: Child Mental Health Professionals (CMHP), Qualified Mental Health Professionals (QMHP), and Qualified Intellectual Disability (QIDP), and Substance Use Professionals (MCBAP). In addition, over 2,000 people were trained in recognizing trauma, mental illness, risk and protective factors of suicide, resiliency, and conflict management and de-escalation.

Interventions Implemented during FY 2019

- ⇒ The Behavioral Health Consultant (BHC) completed a certificate program in Integrated Behavioral Health and Primary Care, Mindfulness for Children/Adolescents and Psychophysiology of Trauma.
- ⇒ New Resident training program in partnership with Beaumont Health at the Westland Clinic includes educational lectures by the Behavioral Health Consultant and the supervisor on Social Determinants of Health (with a focus on the needs of the population served by the clinic), Trauma, Integrated Health Care and Brief Interventions.
- ⇒ New Resident training program includes ½ day shadowing of the BHC 4 New Center One Clinic: medical student is shadowing the BHC.
- ⇒ Training of Master's Level intern from the University of Michigan School of Social Work: Detroit Scholars program.

Credentialing

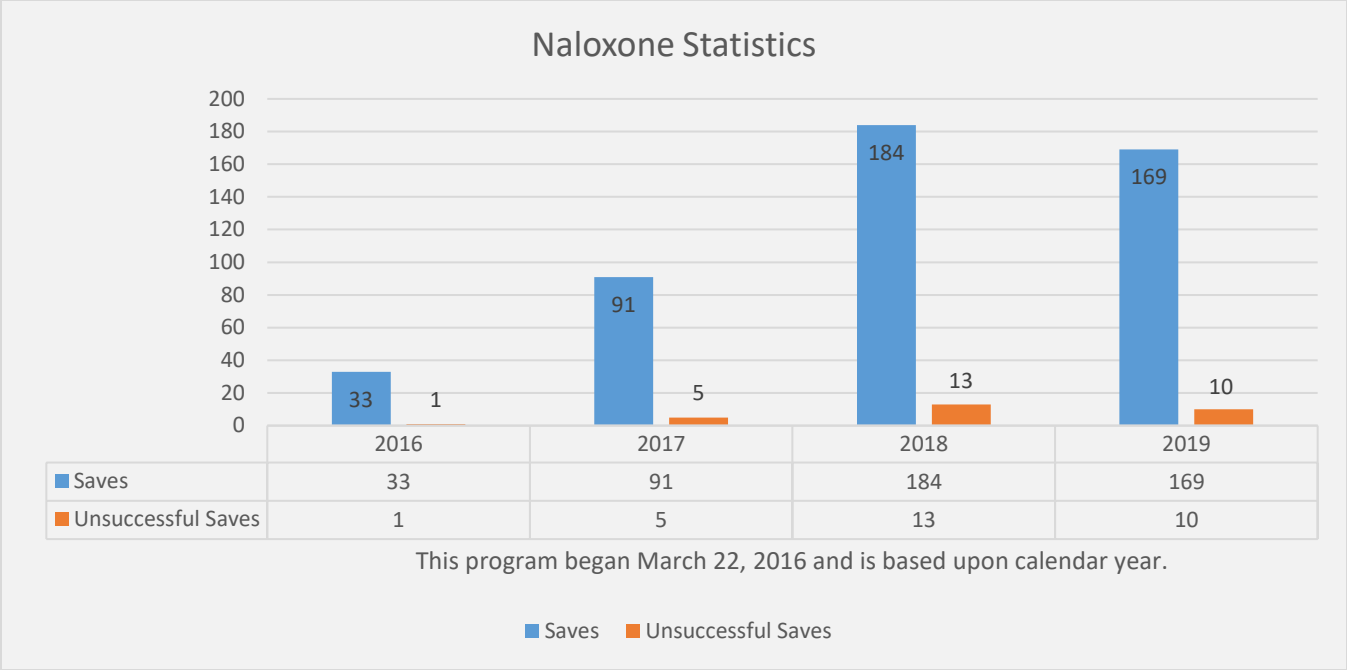
Staff are credentialed through Wellplace and reviewed through DWIHN's credentialing committee process. Wellplace is a NCQA accredited organization for credentialing.
In FY 2019, DWIHN was to implement Medversant software as the data channel for the credentialing process. Full implementation of Medversant software is expected in FY 2020. Baseline data analysis will be available for reporting in FY 2020.



Naloxone Initiative

DWIHN began providing free training and distributing Naloxone kits March 22, 2016 to Wayne County law enforcement, our provider network, and the community. Naloxone blocks or reverses the effects of opioid medication, including extreme drowsiness, slowed breathing, or loss of consciousness. This initiative was implemented to respond to the increase in opioid overdose related deaths and to save lives in the Detroit Wayne County area.

DWIHN have trained 9,911 people this includes a variety of law enforcements officers, providers and people in the communities we serve as of September 30, 2019. DWIHN's Naloxone Initiative program has saved **477** lives since its inception. The saved lives are under reported. DWIHN only reports those saves that we have documentation to support this initiative. Fentanyl is the driving force in the drug overdose deaths.



Heroin/Opioid Efforts

Deterra Bags:

⇒ DWMHA purchased the Deterra Bags to aid in addressing the prescription abuse problem in the Detroit/Wayne County area. Deterra bags provide a convenient, discreet, environmentally and socially responsible method for getting rid of unused, unwanted, or expired prescription pills, liquids, and patches. Medications are deactivated, rendering them ineffective for misuse or abuse. The biodegradable bags contain an activated carbon that breaks down chemical compounds in the drugs, making them safe for landfill disposal.

⇒ DWMHA launched the Deterra bags in the summer of 2016 that deactivates and dissolves unused prescriptions. It is eco-friendly just add water and throw in the kitchen trash. It is for patches, pills and liquids. We have distributed to senior citizens facilities. Distributed at town hall meetings and at health fairs. Baseline data analysis will be available for reporting in FY 2020.

Goal IV – Finance Pillar

During FY 2019, DWIHN Quality Improvement staff completed 12 compliance reviews of utilization data to identify potential under and over utilization issues due to the hybrid funding model. As a result, recoupment occurred for identified providers. Reports are available upon request.

Planned Interventions for FY 2020

- ⇒ Continue to investigate and resolve quality of care concerns.
- ⇒ Continue to identify patterns of potential or actual inappropriate utilization of services.
- ⇒ Continue to work with Finance to ensure that all quality of care concerns are identified and forwarded to Quality for investigation.

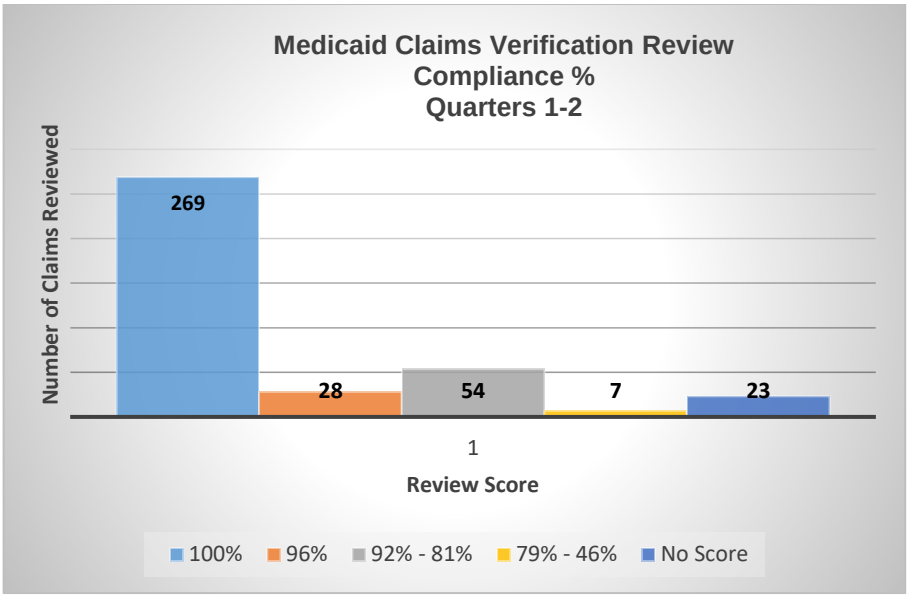
Medicaid Claims Service Verification

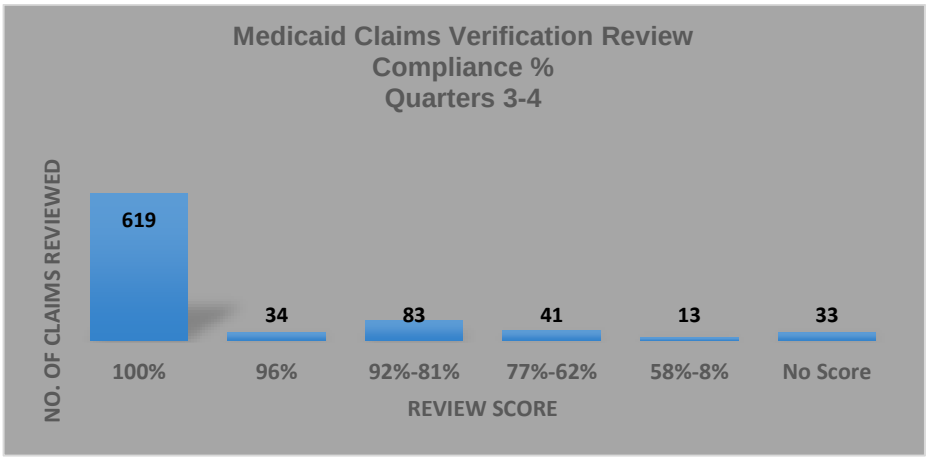
DWIHN is required to perform annual Medicaid Claims Service Verification audit to access the validity of claims and encounters submitted by Network Providers. In FY 2019, DWIHN Quality Improvement staff conducted two (2) Medicaid Claims Verification Reviews. During Quarters 1-2, there were a total of 125 Providers / Sites reviewed through desk and on-site reviews to ensure compliance with the Medicaid Services Verification Technical Requirements.

Results and Analysis

DWIHN QI staff reviewed a total of 1,204 claims through the Medicaid Claims Verification Reviews, of which 254 were not validated due to lack of evidence to support the claim. During FY 2018, a total of 457 claims were reviewed, of which 55 were not validated.

A further quantitative analysis for FY 2019, Quarter 1-2, 297 (78%) of the randomly selected providers were in compliance scoring 95% or better, 61 (16%) were non-compliant scoring less than 95%, and 23 (6%) failed to submit required documentation which will result in full recoupment of funds related to the claim. For Quarters 3-4, 182 Providers were reviewed. Of those providers 653 (79%) were in compliance scoring 95% or better, 137 (17%) were non-compliant, 33 (4%) failed to submit required documentation. The charts below illustrate the findings from the Medicaid claims review for FY 2019.


Medicaid Claims Verification Review
Compliance %
Quarters 1-2
Number of Claims Reviewed
269
28
54
7
23
1
Review Score
100%
96%
92% - 81%
79% - 46%
No Score


Medicaid Claims Verification Review
Compliance %
Quarters 3-4
NO. OF CLAIMS REVIEWED
619
34
83
41
13
33
100%
96%
92%-81%
77%-62%
58%-8%
No Score
REVIEW SCORE

Goal V – Quality Pillar

Annual Site Reviews

The Quality Improvement staff conducts case record reviews annually in order to ensure clinical appropriateness of care, staffing, contractual requirements and all other regulatory requirements involving the target population to be served.

Results and Analysis

During FY 2019, DWIHN staff conducted on-site and remote reviews of 18 (75%) of CRSP providers to ensure full compliance with contractual requirements. Provider's compliance scores ranged from 90% to 97%. This is a substantial increase from the previous fiscal year. Challenges remain in the following areas:

- ⇒ Current and signed Individual Treatment Plans (IPOS) for members
- ⇒ In-service training on the IPOS
- ⇒ In-service training on the Crisis Plan
- ⇒ In-service training on the Behavior Treatment Plan
- ⇒ Having the supports coordinator/case management provide case notes in the case file

For FY 2019, a total of Eighty-eight (88) Specialized Residential reviews were completed. . The compliance scores range from 51.0% to 99% for each individual provider, with an overall aggregate score of 83%. The table below is an aggregate display of each area reviewed.

Planned Interventions for FY 2020

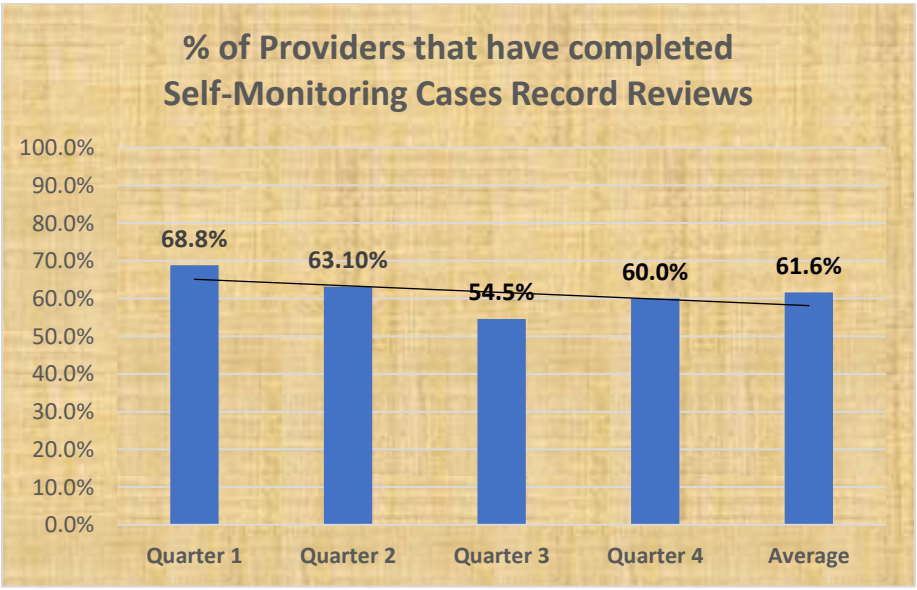
- ⇒ Ensure providers have signed Individual Treatment Plans (IPOS) for members
- ⇒ Ensure In-service training on the IPOS by providers.
- ⇒ Ensure In-service training on the Crisis Plan
- ⇒ Ensure In-service training on the Behavior Treatment Plan
- ⇒ Ensure implementation of the Home and Community Based Final Rule requirements.

Performance Measurement Validation

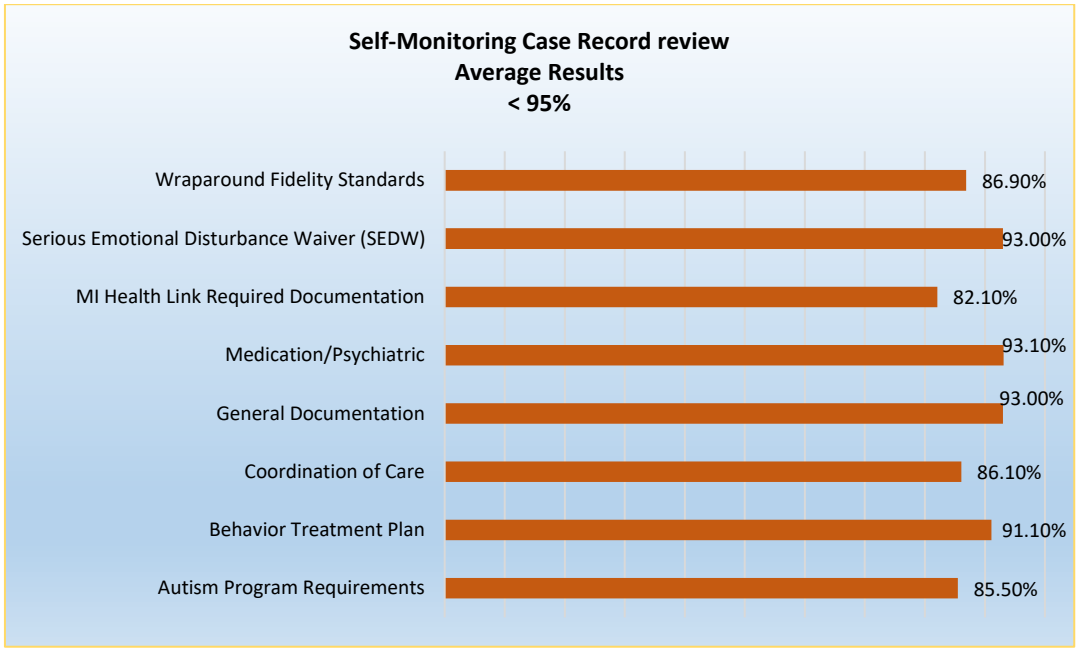
The Quality Improvement (QI) Department has implemented a self-monitoring/self-regulating plan as a component of the Continuous Quality Improvement (CQI) process. DWIHN Quality Improvement (QI) inter-rater reliability analysis is conducted to objectively assess the level of consistency within the Provider network. The provider self-monitoring review is a multilevel approach, which begins at the service provider level and cascades up to DWIHN's QI Department.

Results and Analysis

The chart below represent the percentage of providers that completed the quarterly case record reviews self-monitoring as required for FY 2019. The results demonstrate a decrease in the percentage of provider's participation from Quarter 3 (54%) and Quarter 4 (60%).



The chart below represents the average compliance score for areas that scored < 95% for programs reviewed. During FY 2019, compliance scores ranged from 82% to 100%, which is a slight decrease 88% to 100% from FY 2018.



Planned Interventions for FY 2020

- ⇒ Increase the self-monitoring for all non-residential providers and continue efforts of enhancing coordination through the use of managing a self-monitoring process.
- ⇒ Compare provider self-monitoring results to the quality monitoring of the programs.
- ⇒ Root Cause Analysis will be requested from providers scoring < 95%.
- ⇒ Develop a “Deemed Status” process that will allow for providers to submit their self-monitoring reviews to QI, thus not allowing for annual on-site reviews to occur each year if applicable.

Autism Benefit

FY 2019, DWIHN Applied Behavioral Analysis (ABA) Benefit has shown a minimal growth of 2 to 4% for members enrolled in the ABA Benefit. As the safety net organization, one significant area in which DWIHN strive to improve is to increase equitable distribution of services across Wayne County. There are currently 1,656 open cases receiving services with the largest concentration of enrollee's age ten or younger, as the DWIHN open cases by age graph indicates.

Cases Served 2013 to Present

Status	*Level Of Care*		*Did Not Receive ABA Direct Services**	*Grand Total*
	FBI(Lower Level of Care)	*CBI (Higher Level of Care)*		*Total*
Closed	420	794	2898	**4112**
Open	435	1002	219	**1656**
Pending Intake	*0*	*0*	*114*	***114***
Total	**855**	**1796**	**3231**	**5882**

DWIHN added 3 new ABA providers during FY 2019 for a total of 15 ABA providers throughout Wayne County. DWIHN continues to receive approximately 100 referrals a month and the number of enrollee's has increased for the second quarter by 36%.

Interventions Implemented during FY2019

- ⇒ DWIHN hosted an Autism Conference *Ability & Assets from Adolescence through Adulthood* on April 10, 2019 at Burton Manor in Livonia. Attendees had the opportunity to learn about relevant topics and best practices in the Autism field that spanned across the lifespan.
- ⇒ DWIHN hosted 10 Autism Disorder Spectrum (ADS) trainings with a total of 244 attendees in FY 2019. Some of the training topics include: *Effective Supervision of Behavior Technicians, Helping Your Clients Prepare for Independent Living Today, and Behavior Technician Learning Series: Ethics in Behavioral Analysis*.
- ⇒ DWIHN ASD provider network has collaborated with the University of Detroit Dental School to provide Continuing Education Credits (CEU's) for dentists. The training will prepare practicing dentists to work with members on the spectrum.
- ⇒ DWIHN ASD provider network is working with the Arc of Western Wayne County on expanding the impact of their Lekotek program which offers a play library to members where they can check out toys for one month at a time and schedule play sessions. This is the only play library in the state of Michigan.

⇒ DWIHN ASD Benefit hosted The Color of Autism which focuses on bringing awareness to African-American families affected by autism.

Results and Analysis

DWIHN staff conducted on-site and remote reviews of case records to ensure full compliance with the ASD regulatory requirements. Provider's compliance scores ranged from 56% to 82%. This is a substantial decrease from the previous fiscal year. Challenges remain in the following areas which had a combined score of below 60%.

⇒ The annual consent for treatment is current, signed and dated (56%)
⇒ There is evidence the members Medicaid was active at the time of service delivery (50%)
⇒ The average hours of ABA services during a quarter were within the suggested range of service intensity (+/-25%) (50%)
⇒ There is evidence that the ABA assessment (ABLS, VB-MAPP, and AFLS) was uploaded to MHWIN within seven (7) calendar days of the completed assessment (47%)
⇒ When more than three appointments in one week were missed, inactivity was entered in the WSA and there was evidence of multiple attempts to keep the family engaged (52%)

The overall staff compliance score is 92% with provider scores ranging from 80% to 99%. Providers were placed on aggressive plans of correction to address both clinical and staff compliance citations. Through continuous quality improvement processes the following interventions and strategies have been established

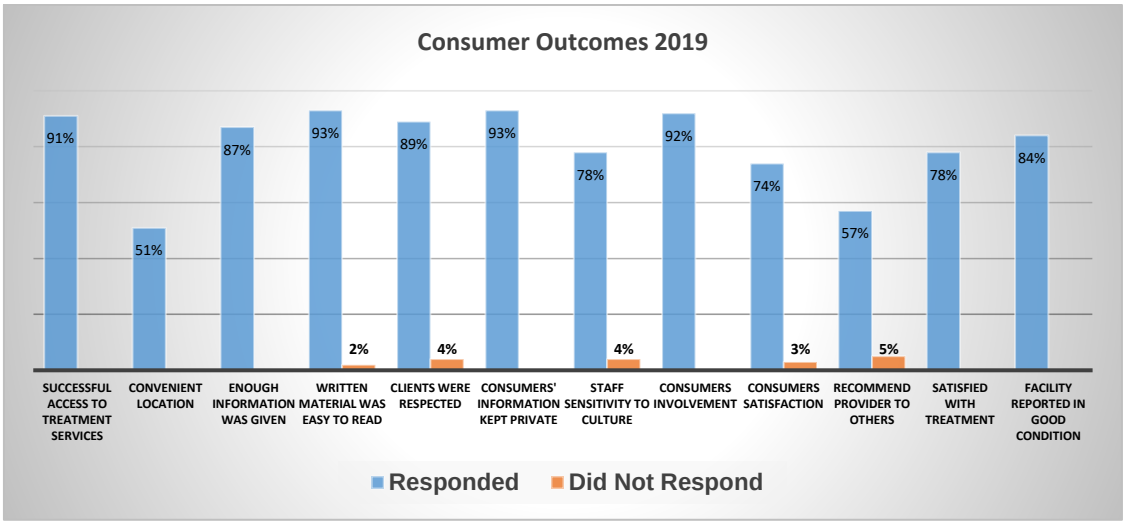
⇒ Increase monitoring of the providers corrective active plans
⇒ Provide technical assistance as needed
⇒ Ensure providers are self-monitoring through quarterly reviews
⇒ Monitor the information in the Autism Dashboard to provide continuous feedback to the providers.

Substance Use Disorder (SUD) Efforts

DWIHN's prevention services were provided to 363,656 persons in the Detroit Wayne County area. Prevention services were provided as Individual-Based Programs and Strategies by the Number of Persons Served by Age, Gender, Race, and Ethnicity. During FY 2019, a survey was administered to a sample of 751 members who were receiving substance use disorder service in Detroit Wayne Integrated Health Network programs between the July and September. The purpose was to collect information on consumer satisfaction with treatment in order to assess the extent to which these programs provided high quality service to Wayne County consumers.

Results and Analysis

The overall scores ranged from 57% to 93% this year as compared to a range of 43% to 84% in the previous year. One major component of satisfaction in which providers struggle is they would recommend the Treatment Provider to a friend and the members agreed with the goals in their treatment plan. This review point to the member's perception of the program and could be reviewed as an early indicator of program's performance. The SUD provider network will continue to distribute the surveys quarterly and assess performance in the quality and safety of clinical care and quality of service**.** The chart below illustrates the analysis of the results.



The QI staff completed annual reviews for 100% of the SUD Treatment and Prevention providers. The compliance scores range from 85.0% to 100% for each individual provider, with an overall aggregate score of 96%, which demonstrates a slight decrease from 90% to 100% in FY 2018. Providers that have compliance scores of < 95% have been placed on Plans of Corrections (POC's) in addition to requesting supporting documentation to support compliance.

Planned Interventions for FY 2020

- ⇒ Continue to conduct procedure trainings to educate SUD providers on proper credentialing for billing.
- ⇒ Continue to educate and train our provider system for areas in which compliance scores are less than 95%.

MI Health Link Project

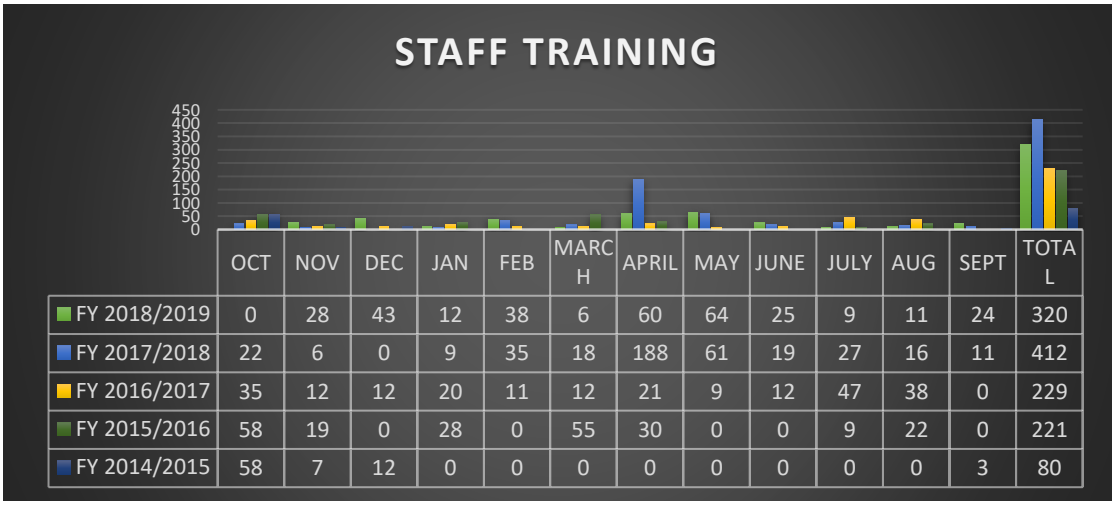
During Fiscal Year 2019, DWIHN received 5,039 referrals for behavioral health services from the Integrated Care Organizations (ICO). DWIHN had an Annual Assessment from ICO Molina HealthCare on April 24, 2019. DWIHN received the results of the assessment in August, 2019. DWIHN received a total score of 95.29% on the assessment. Corrective Actions were requested in the areas of Network Management - Provider Online Directory and Critical Incidents. The Utilization Management File Review did not meet requirements, but a Corrective Action was not requested as the Utilization Management category had an overall score of 91.49%. DWIHN submitted the requested corrective action items by the time frame.

Results and Analysis

- ⇒ DWIHN had a Delegation Audit from ICO Aetna on May 16, 2019. DWIHN was notified in July, 2019 that all areas passed the requirements and that no additional documentation was required.
- ⇒ DWIHN was notified in July, 2019 that ICO Aetna was having an audit with CMS. DWIHN submitted information to Aetna as requested. In September, DWIHN participated in the audit as the behavioral health provider for Aetna MI Health Link members. The CMS audit is still ongoing.
- ⇒ DWIHN was notified in September, 2019 that ICO Molina HealthCare was having an audit with CMS. DWIHN submitted information to Molina as requested. DWIHN is awaiting further notification and/or summary results of the audit.

Critical/Sentinel Events Reporting

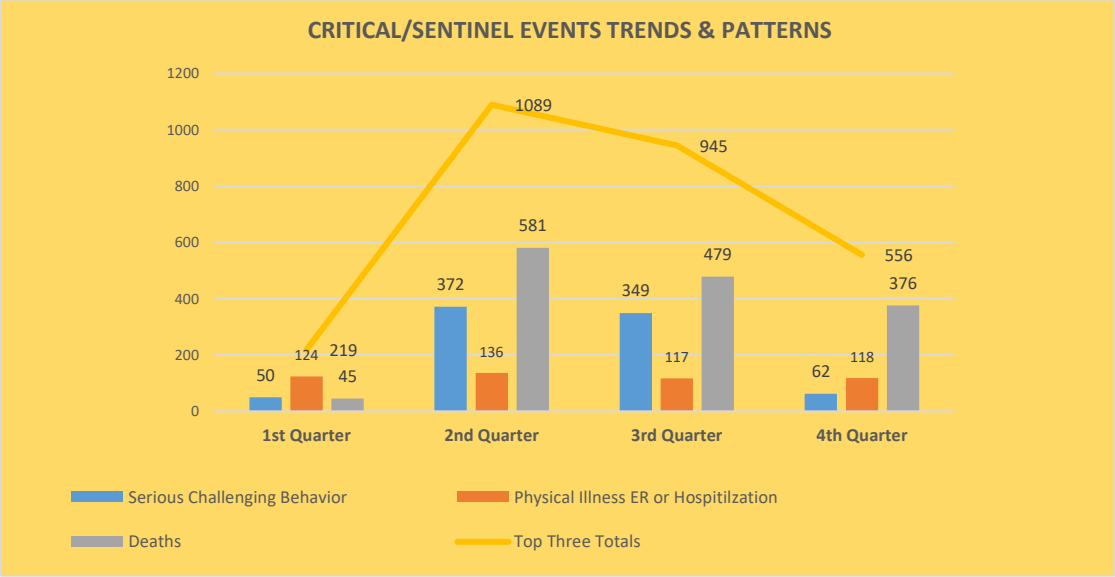
The processing of Critical/Sentinel Events is one element for identifying quality improvement activities and risks. Since FY 2015, as illustrated in the chart below, a total 1,262 staff have been trained on entering data into the Critical/Sentinel Events Module. This quality improvement activity provide a comprehensive picture of DWIHN system as the number of individuals trained increases.



	OCT	NOV	DEC	JAN	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUG	SEPT	TOTAL
FY 2018/2019	0	28	43	12	38	6	60	64	25	9	11	24	320
FY 2017/2018	22	6	0	9	35	18	188	61	19	27	16	11	412
FY 2016/2017	35	12	12	20	11	12	21	9	12	47	38	0	229
FY 2015/2016	58	19	0	28	0	55	30	0	0	9	22	0	221
FY 2014/2015	58	7	12	0	0	0	0	0	0	0	0	3	80

Results and Analysis

QI staff processed a total 5,601Critical/Sentinel Events in FY 2019, compared to 7,083 (21%) in FY 2018. The decrease is attributed to the face to face network trainings, which is required for access to utilizing DWIHN's Critical and Sentinel Event module. The top three categories identified as trends and patterns to assess performance in quality and safety of clinical care and quality of service is illustrated below.



- ⇒ Injuries requiring emergency care was higher in FY18 with 673 reported compared to 498 (26%) decrease in FY19.
- ⇒ The number of reported medication errors requiring medical care decreased, with 172 reported for FY18 compared to 123 (28%) in FY19.
- ⇒ The number of reported injuries requiring hospitalization remained steady, with 83 reported events in FY18 compared to the 88 (6%) reported in FY19.
- ⇒ There were more arrests reported in FY19, with an increase 161 (10%) reported compared to 144 arrests reported in FY18.

Planned Interventions for FY 2020

- ⇒ Quantitative and qualitative analyses to improve members safety and outcomes
- ⇒ Conduct member-specific, provider-specific and systemic trend analysis
- ⇒ Review events related to substance use disorder (SUD) providers and members receiving SUD services.
- ⇒ Conduct an in-depth review of providers who consistently report minimal or no critical incidents, sentinel events, or risk events.

Incident Reporting Module

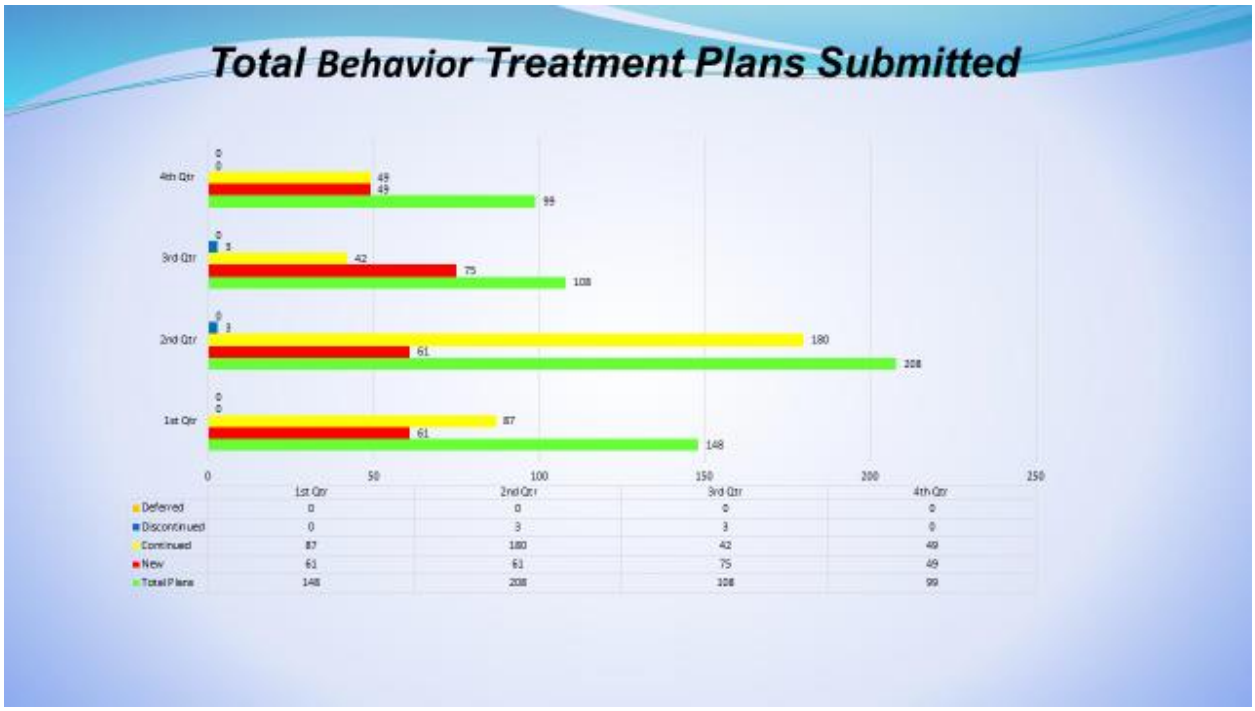
NCQA requirement standard QI 6, requires a process to review and gleam member/customer experiences. An enhanced Incident Reporting (IRR) module process has been developed with an anticipated implementation date for Fiscal Year 2020. The reporting module will allow for internal review from different departments/units within DWIHN. Incident reports will be reviewed no less than quarterly through an ad-hoc review committee. The purpose of the ad-hoc committee will be to review patterns, trends and establish possible Quality Improvement Projects for members served. Baseline data analysis will be available for reporting in FY 2020.

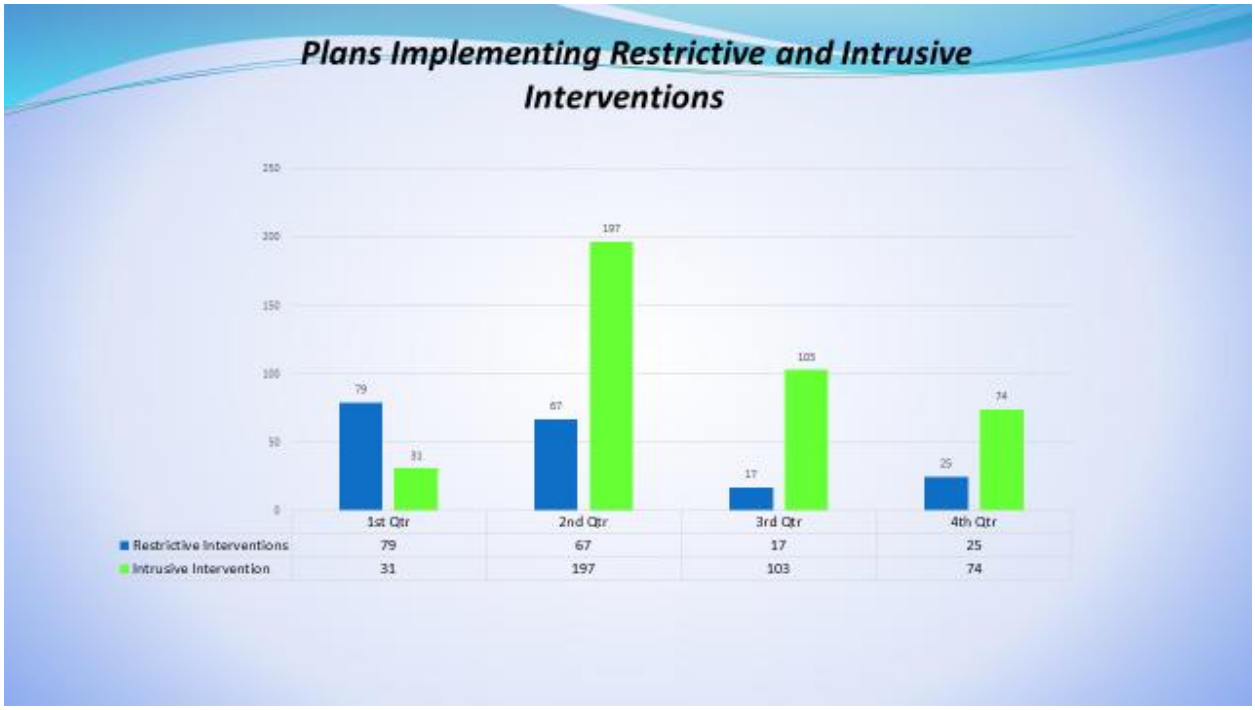
Behavior Treatment Advisory Committee (BTAC)

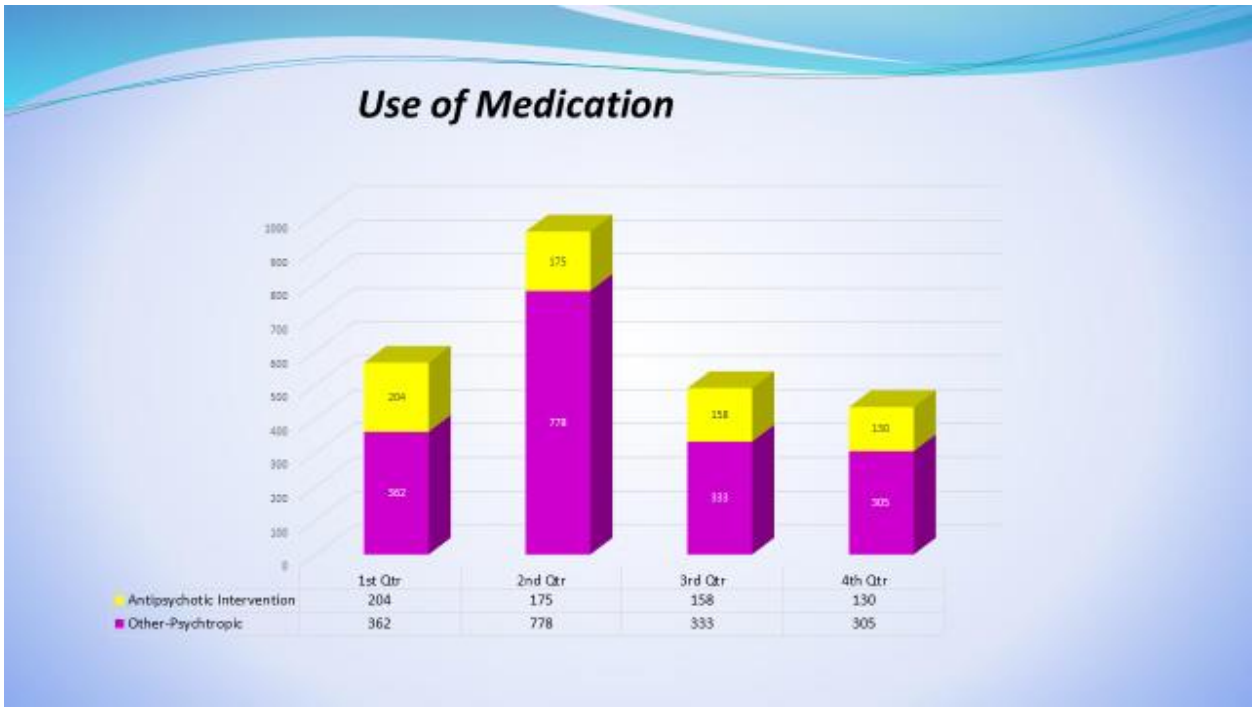
The Detroit Wayne Integrated Health Network (DWIHN) is charged with monitoring and evaluating the integrity of services provided in its direct service provider network. The DWIHN's' Behavior Treatment Advisory Committee (BTAC) started in 2017. The Committee reviews the implementation of Behavior Treatment Plan Review Committees (BTPRC) procedures and evaluate each committee's overall effectiveness and corrective action as necessary. The Committee compares system-wide key indicators such as psychiatric hospitalization, behavior stabilization, reductions or increases in use of behavior treatment plans. DWIHN also conducted a full day training event on Behavior Treatment Plans Procedures for network providers with MDHHS.

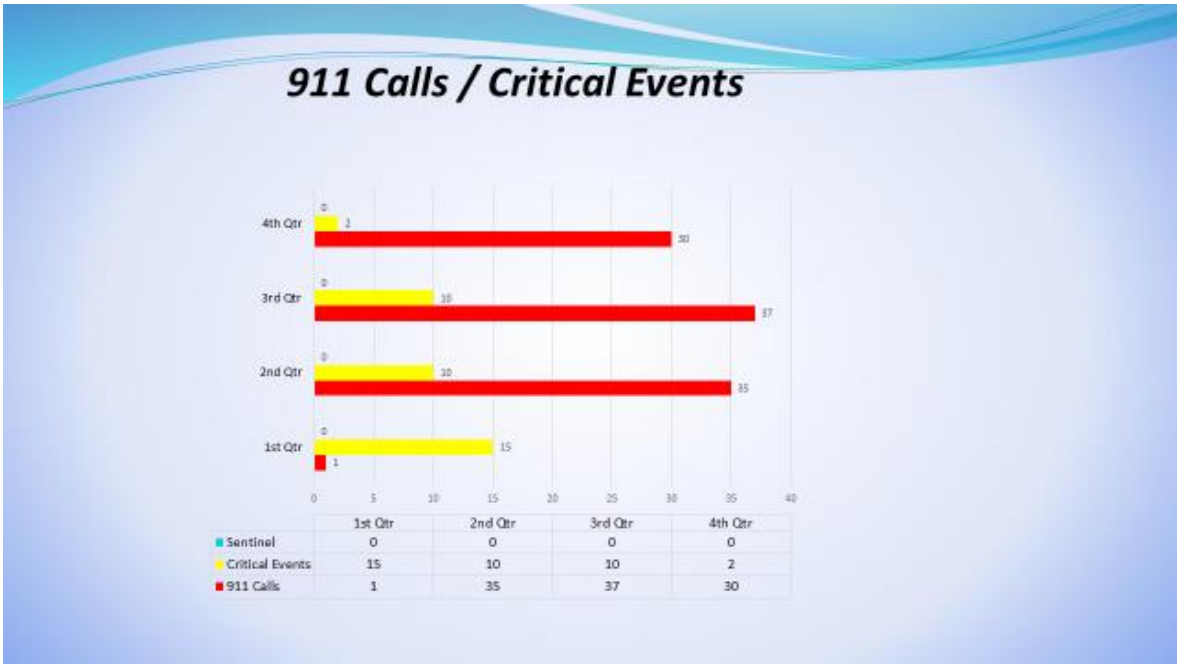
Results and Analysis

In FY19, DWIHN BTPRC reviewed 533 members on Behavior Treatment Plans which is a slight decrease of 32 (5.82%) plans from the previous year. The data below depicts all the use of intrusive and restrictive techniques, 911 calls/critical events and use of medication per Individual receiving the intervention. The quarterly analysis is performed to identify any trends or patterns of behavior that may demonstrate a risk to an individual.


Total Behavior Treatment Plans Submitted
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr
0
50
100
150
200
250
1st Qtr
2nd Qtr
3rd Qtr
4th Qtr
Deferred 0 0 0 0
Discontinued 0 3 3 0
Continued 87 180 42 49
New 61 61 75 49
Total Plans 148 208 108 99


Plans Implementing Restrictive and Intrusive Interventions
1st Qtr
2nd Qtr
3rd Qtr
4th Qtr
Restrictive Interventions 79 67 17 25
Intrusive Intervention 31 197 103 74





Planned Interventions for FY 2020

- ⇒ Conduct Case Validation Reviews
- ⇒ Revisiting BTPs if 3 or more Physical Management Interventions in 30 days
- ⇒ Radar button in MHWIN for the members on BTPs.
- ⇒ In-service trainings on Interventions recommended in BTPs.

Performance Improvement Projects (PIPs)

DWIHN Departments have been engaged in continuous process improvement. Some improvements projects are formalized as Quality Improvement Projects. Improving Practices Leadership Team and Quality Improvement Steering Committee provides oversight of these projects. The guidance for all projects included these areas: improving the identification of both outcome and process measurements, use of HEDIS measures, adding meaningful (and measureable) interventions, and use of cause and effect tools in the analysis of the progress. Clinical care improvement projects meant to improve member outcomes include:

⇒ ***Improving the availability of a follow up appointment with a Mental Health Professional with-in 7 and 30 days after Hospitalization for Mental Illness*.**

NCQA's HEDIS measure the percentage of discharges for members ages 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visits, an intensive outpatient encounter or partial hospitalization with a mental health practitioner (Adult Core Set, appendix C), received follow-up within 30days. Research suggests that follow-up care for people with mental illness is linked to fewer repeat ED visits, improved physical and mental function and increased compliance with follow-up instructions.

Results and Analysis

DWIHN has seen an increase of the HEDIS measurement from the previous FY 2017 of 72.7% for the 7 Day Follow – Up Appointment with a Mental Health Professional. For the 30 Day Follow – Up Appointment with a Mental Health Professional there is an increase of 31.9% from the previous year. The table below illustrates the HEDIS measurements and findings.

Time Period	Measurement	Numerator*	Denominator*	Rate	Goal	Comparison to goal
1/1/2015 to 12/31/2015	Baseline 7 day	4,594	11,775	39.01%	45%	Below
1/1/2015 to 12/31/2015	Baseline 30 day	7,878	11,775	66.90%	75%	Below
1/1 to 12/31 2016	Re-Measurement #1 7 day	4,211	11,196	37.61%	45%	Below
1/1 to 12/31 2016	Re-Measurement #1 30 day	7,265	11,196	64.89%	75%	Below
1/1 to 12/31/2017	Re-Measurement #2 7 day	4,427	11,615	38.11%	45%	Below
1/1 to 12/31/2017	Re-Measurement #2 30 day	7,668	11,615	66.02%	75%	Below
1/1/2018-12/31/2018	Re-Measurement #1 7 day	6146	9,338	65.85%	45%	above
1/1/2018-12/31/2018	Re-Measurement # 2 30 day	8,134	9,338	87.11%	75%	above

Planned Interventions FY 2020

- ⇒ Ensuring members have a 7 and 30 day follow-up visit scheduled before being discharged.
- ⇒ Hospital case managers encouraged to involve members in discharge planning date and time preferences for appointments.
- ⇒ Created follow up post hospital visit checklist for providers/practitioners to help providers prepare for visit as well as targeting key items to cover during visit.
- ⇒ Detroit Wayne Integrated Health Network (DWIHN) has started conducting face to face contact with clients that are hospitalized due to psychiatric complications.
- ⇒ Telephone calls are made to the client as a reminder of the follow up after hospitalization appointment.
- ⇒ DWIHN will mail the Doctors letter stating the importance of follow up care along with the educational material that states the same.
- ⇒ Text messaging members as a reminder of appointment for members that give permission.

⇒ ***Adherence to Antipsychotic Medications for Individuals with Schizophrenia***

DWIHN chose to monitor the results of the HEDIS measure, adherence to anti-psychotropic medications for individuals with schizophrenia: percentage of members 19 to 64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.

The Michigan HEDIS average for Michigan Medicaid HMO health plans for this measure was 63.18 percent. The NCQA HEDIS health plan average results for this measure was 61.06 percent according to the NCQA State of Quality 2017. DWIHN 2017 baseline information was 40.42 and 2018 data run for the same period was 69 percent.

Time Period	Measurement	Numerator	Denominator	Rate	Goal	Comparison to goal
Jan.1 2015-Dec. 31 2015	Baseline	1219	3477	35.06%	40 %	Below
2016 Jan. 1-Dec. 31, 2016	Re-measurement 1-Baseline*	1616	4605	35.9%	40%	Below
2017	Re-measurement 2	**2958**	**7319**	**40.42%**	**40%**	**Above**
2018	Re-measure 3	**3,306**	**4,762**	**69%**	**40%**	**Above**

Results and Analysis

DWIHN is performing below both the Medicaid health plan NCQA average and the Michigan health plan average for the HEDIS measures as well as below their goal. It is important to provide regular follow up therapy to patients after they have been hospitalized for mental illness. An outpatient visit with a mental health practitioner is necessary to ensure that the patients transition to the home and work environment is supported and that gains made during hospitalization are not lost. A follow-up visit also helps healthcare providers detect early post-hospitalization reactions or medication problems, and demonstrates continuing care.

The key to improving performance in this area is managing the transition of care from the hospital to the ambulatory site. This can involve case management and systems that link scheduling of outpatient care within hospital discharge." Some barriers identified include the following:

- ⇒ Relationship with physician
- ⇒ Lack of consistent treatment approach by physicians
- ⇒ Stigma of the disease
- ⇒ Disorganized thinking/cognitive impairment
- ⇒ Enrollee/member's lack of insight about presence of illness or need to take to medication.
- ⇒ Lack of family and social support
- ⇒ Medication side effects and/or lack of treatment benefits
- ⇒ Patients forget to take their medications
- ⇒ Patients forget to re-fill their medications.
- ⇒ Lack of follow-up
- ⇒ Financial Problems

Planned Interventions FY 2020

- ⇒ Reinforce with the practitioners/providers the importance of a good clinician/ patient relationship in addressing the importance of disease management.
- ⇒ Address client's fear of taking medication as well as the risks and benefits of taking the medication.
- ⇒ Offer support groups for enrollee/member and family members.
- ⇒ Developed handouts with referral information on the National Alliance on Mental Illness of Michigan (NAMI) along with telephone number and website information.

- ⇒ ***Improving Diabetes Monitoring for People with Schizophrenia and Bipolar Disorder***

NCQA's HEDIS measure *Diabetes Screening for People with Schizophrenia and/or Bipolar Disorder* measures the percentage of patients 18-64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening during the measurement year.

Results and Analysis

DWIHN has seen an increase of the HEDIS measurement from the previous FY 2017 of 72.7% for the 7 Day Follow – Up Appointment with a Mental Health Professional. For the 30 Day Follow – Up Appointment with a Mental Health Professional there is an increase of 31.9% from the previous year. The table below illustrates the HEDIS measurements and findings.

Time Period	Measurement	Numerator	Denominator	Rate	Goal	Comparison to Goal and Statistical Significance
1/1-12/31 2016	Baseline	3,574*	4,709*	75.90%	80.10%	
1/1-12/31 2017	Re-measurement 1	4,076*	5,277*	75.90%	80.10%	Below Not statistically significant improvement
1/1-12/31 2018	Re-measurement 2	No new numbers	No new number	78.6%	80.10%	

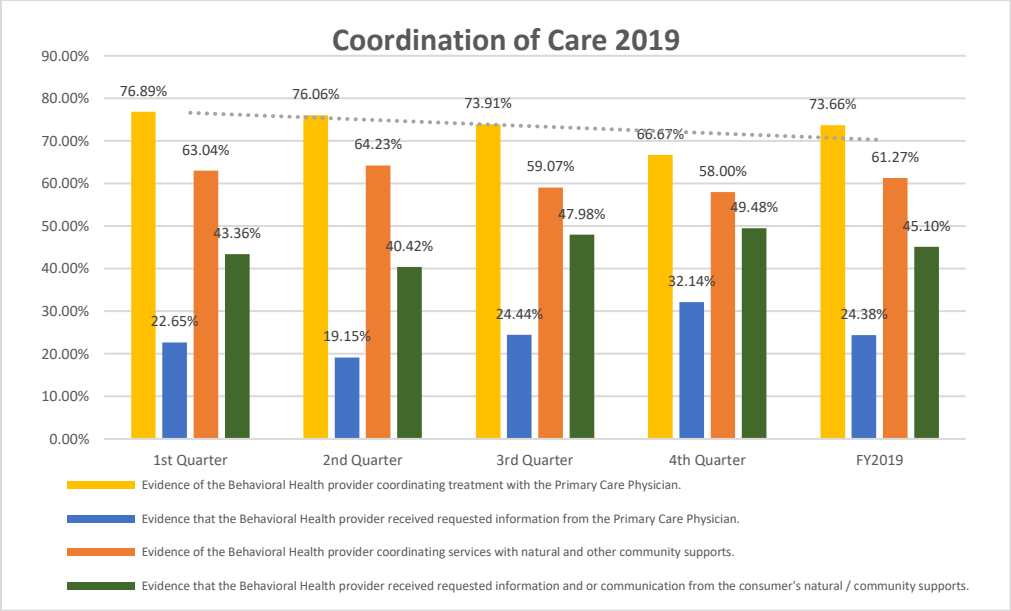
DWIHN will require a baseline assessment of HgA1C or FBS for clients prescribed psychotropic medications that are known to cause elevated blood sugar levels. Clinical Practice Guidelines developed by DWIHN will require that medications, labs and weight are monitored and education be provided to the enrollee/member regarding weight management, exercise and healthy living and that psychiatrist consider changing the medication if enrollee/members labs are not within normal limits and/or the enrollee/member experiences weight gain.

Planned Interventions for FY 2020

- ⇒ Continued trainings to providers on MyStrength which is DWMHA's self-management tool vendor in which there are healthy eating and exercise modules
- ⇒ Quality Improvement Unit will continue to audit compliance with the Diabetes Screening clinical guidelines for Schizophrenic and/or Bipolar disorder enrollee/members on antipsychotic members in 2017 (need to pull 2018-2019 data)
- ⇒ Continue to educate and post clinical practice guidelines for Improving Diabetes Monitoring for People with Schizophrenia and Bipolar Disorder

⇒ ***Coordination of Care***

Through the provider self-monitoring for Coordination of Care providers continuously score > 95% with linking and coordinating with the Primary Care Physician (PCP), Natural and other Community Supports. During FY 2019, provider's scores range from 19% to 76%, which is a decrease from the previous FY in which scores ranged from 84 % to 94%. This decrease is mainly attributed to the lack of the Behavioral Health Providers not receiving evidence of requested documentation from the PCP, Natural and other Community Supports.



Planned Interventions for FY 2020

⇒ Require providers to continue to document request and follow - up more than one time per year with the PCP and or Community Supports.

⇒ Continue training and technical assistance with our CRSP providers to help improve the effectiveness, efficiency, and sustainability of integrated services, which ultimately improves the health and wellness of individuals living with behavioral health disorders.

Goal VI - Advocacy Pillar

Home & Community-Based Services Rule (HCBS) Implementation

The HCBS provide opportunities for Medicaid Beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. DWIHN's Quality Improvement (QI) unit maintains a directory of all contracted service providers that are HCBS compliant within the network. This directory is posted to the DWIHN HCBS webpage. Through this directory, individuals and families can get compliance information regarding a DWIHN provider related to HCBS to make treatment and services decisions. This activity will continue as a goal on the work plan for FY 20 to measure full compliance in the network**.**

Planned Interventions for FY 2020

- ⇒ Identify providers who have made the cultural shift to meet the HCBS standards to share best practices.
- ⇒ Create a residential provider report card that offers an overall view of performance and tracks compliance with standards, policy and procedures with the final rule.
- ⇒ Advise providers on strategies to address the three core elements of implementation: assessment, remediation, outreach
- ⇒ Post HCBS resource materials on DWMHA website including direct linked resources from MDHHS
- ⇒ Work with other PIHP Leads in the regions through on-going training and sharing of best practices.

Youth United

Youth Involvement is a system approach designed to promote meaningful youth participation in all aspects of System of Care. Decision making should start within a youth's personal treatment. Over time, youth leaders can advance to actively participating in agency activities, sitting on committees, and providing feedback for new and/or existing policies and programs. Youth involvement is simply a group of young people coming together to make a difference on various topics.

Interventions Implemented during FY 2019

- ⇒ Increased system involvement in Wayne County Youth Involvement meetings by engaging new partners
- ⇒ Engaged community youth and parents in SOC events
- ⇒ Participated in the hiring of new SOC staff
- ⇒ Partnered with system partners and provider agencies to plan and host youth events and activities
- ⇒ Created two one-minute videos highlighting personal stories and developed a Memorandum of Understanding (MOU) for the use of the videos at partner agencies
- ⇒ Celebrated youth involvement with the 3rd Annual Youth Spotlight Award Banquet
- ⇒ Hosted the statewide Youth M.O.V.E. Summit
- ⇒ Lead Children's Mental Health Awareness Day activities

⇒ Shared the impact of youth involvement in Wayne County at state and national conferences

⇒ Youth United participated in the Walk a Mile Rally 2019 with DWMHA in advocating for mental health services for youth at the state capital

⇒ Shared the impact of youth involvement in Wayne County at state and national conferences Youth United participated in the Walk a Mile Rally 2019 with DWMHA in advocating for mental health services for youth at the state capital

COMMUNICATION & OUTREACH

Updated Youth United flyer

Youth United created a youth-friendly general flyer that is being distributed to schools within the community, and to agency partners.

Youth United Newsletter

Youth United distributed 3 publications that highlight important resources, activities and topics, identified by youth such as: money management tips, current job opportunities and current issues that impact youth.

"Reflections"

A book created for youth by youth including personal stories of current or previous youth consumers and motivational/inspirational quotes. A total of 89 personal stories were collected to publish in the book.

"Remind" Text Message Alert

Northwest Region is now using the Remind text message app to deliver reminders, upcoming events, and job opportunities to 318 youth and 91 stakeholders.

EVENTS

Stigma Busting Workshops

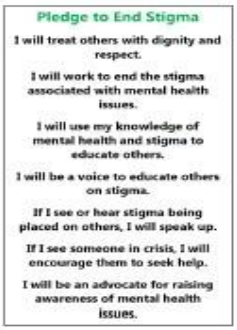
These events are designed to help youth spread anti-stigma messages through discussion and activities regarding stigma. This fiscal year 40 participants attended two workshops at Black Family Development, Inc. and The Children's Center. An additional 639 Stigma Pledges were collected this fiscal year.

Stigma Busting Bash

The Stigma Busting Bash is an end-of-the-year bash filled with activities to help spread awareness about the impact of stigma associated with mental health. The event was held at Golightly Technical High School in Detroit, and Davis Aerospace Technical High School (also in Detroit) with 166 participants.

STIGMA PLEDGE

1359 Youth, stakeholders, community leaders, and partners have signed a pledge to end the stigma associated with mental illness since 2014.



Family Alliance for Change Transition

For the last seven years. FAFC has been the primary voice for parents at many levels within Wayne County systems. Beginning September 1. 2017, services were restructured to create a more effective and efficient program model. The System of Care work will continue with the *Parent Involvement Resource Center,* and Parent Support Partners (PSPs) will continue to be placed in local CMH providers across the county. CMH agencies will employ the PSPs. fully integrating them in their organization. Having PSPs on staff will assure better access to services for all members. Improve coordination of services including but not limited to treatment, training, quality oversight. and record keeping. PSPs employed by providers will help meet an overall goal of parent voice and involvement at an organizational level.

Parent Management Training-Oregon (PMTO)

The Parent Management Training-Oregon model (PMTO) is an evidence-based intervention to help parents and caregivers manage the behavior of their children. Tailored for serious behavior problems for youth from preschool through adolescence, PMTO empowers parents as primary treatment agents to promote and sustain positive change in families.

Results and Analysis

- ⇒ Cheryl Greer, Michigan and Wayne County's Lead PMTO Coach received the Golden Loop Award at the PMTO State Conference which recognized her passion and dedication to PMTO across the state.
- ⇒ Wayne County welcomed a PMTO coach from Oakland County and they are in the process of becoming fully certified in Wayne County.
- ⇒ Incorporated Parenting Through Change (PTC) PMTO group model with the Regional Coaching day. Welcomed 2 new PTC candidates from Black Family Development, Inc.
- ⇒ Wayne County Coaches, Cheryl Greer, Susanna Hathaway, and Khalea Foy have held consistent Regional Coaching days with maximum number of attendees.
- ⇒ Three parents represented Wayne County by sitting on the parent panel at the state conference in Kalamazoo in June, 2019.
- ⇒ Three PMTO Informed two-day trainings were held in Wayne County.
- ⇒ Three new candidates went through the individual state training.
- ⇒ Wayne County Coaches continue to present PMTO information at Community Mental Health agencies throughout Wayne County to engage new therapists

Screening Kids in Primary Care Plus (SKIPP)

Screening Kids in Primary Care Plus (SKIPP) continues to work successfully in two clinic sites, Beaumont Family Medicine in Westland and Henry Ford New Center One pediatrics. The embedded Pediatric Behavioral Health Consultant works on the medical team to detect mental health and other needs during the pediatrician visit and co-manages patient care within the medical team.

Health and Wellness Center

In partnership with Henry Ford Health System, the HWC provides a range of primary and medical care to LGBTQ+ young people which includes:

- ⇒ Quick visits for general medical issues (sore throat, rash, ear infection, cough/ cold) 4 Medical management of asthma, weight, diabetes and high blood pressure
- ⇒ Vision and hearing screening tests with referrals
- ⇒ Sexual health services including birth control and Sexually Transmitted Infection testing and treatment 4
- ⇒ HIV prevention, testing and guidance
- ⇒ Transition care for transgender youth
- ⇒ Screening for the need for emergency services
- ⇒ For FY18-19, the HWC Medical team served 420 youth under 21 years old

Data Sharing Care Coordination

DWIHN continues to have a successful data sharing relationship with one hundred (100%) of all the Medicaid Health Plans in Wayne County and one hundred (100%) of all the Medicare Integrated Care Organizations in Wayne County. In FY 2019, the data sharing relationships continue to demonstrate an increase in the collaboration and communication between the behavioral health and physical health systems for the consumers. The results have demonstrated timely appointments between both systems, the monitoring of medications, and scheduling of follow-up appointments steadily remained the same with no significant deviation from the previous year.

Goal VII – Compliance with Applicable National Accreditation, Legislative Federal/State

Health Services Advisory Group (HSAG)

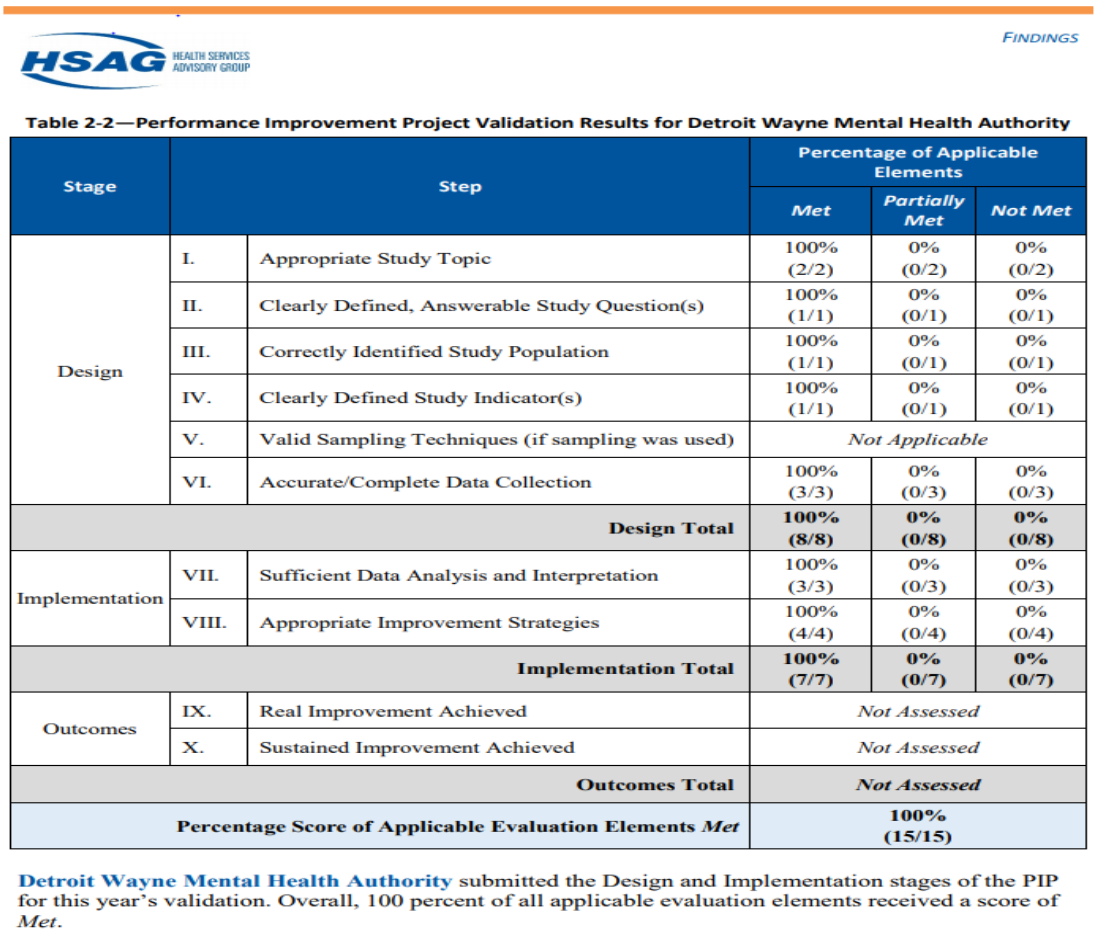
Performance Improvement Project

MDHHS, EQR and NCQA require that the PIHP conducts and submit performance improvement projects (PIP) annually to meet the requirements of the Balanced Budget Act. One of the clinical PIP's selected for this year's validation is *Improving Diabetes Screening for people with Schizophrenia or Bipolar who are using Antipsychotic Medications.*

The goal of the PIP is to ensure that members with schizophrenia or bipolar disorder who are taking an antipsychotic medication are receiving necessary and relevant diabetes screenings (specifically glucose or HbA1c screenings) related to mental health medicines prescribed. This study topic aligns with the HEDIS measure.

Results and Analysis

A benchmark has been established and is based on the data presented in the Michigan Department of Health and Human Services (MDHHS) 2018 Aggregate Report for Michigan Medicaid showing the average for all reporting health plans to be 84.31 %. DWIHN's baseline is reported at 78.6% for FY 2018. The re-measurement 1 period will be calculated in March of 2020, with a goal of 80.0%. The table below illustrates DWIHN's Performance Improvement Project validation results.



HSAG HEALTH SERVICES ADVISORY GROUP

FINDINGS

Table 2-2—Performance Improvement Project Validation Results for Detroit Wayne Mental Health Authority

Stage	Step		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (1/1)	0% (0/1)	0% (0/1)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (3/3)	0% (0/3)	0% (0/3)
	VIII.	Appropriate Improvement Strategies	100% (4/4)	0% (0/4)	0% (0/4)
Implementation Total			**100% (7/7)**	**0% (0/7)**	**0% (0/7)**
Outcomes	IX.	Real Improvement Achieved	*Not Assessed*		
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			***Not Assessed***		
Percentage Score of Applicable Evaluation Elements *Met*			**100% (15/15)**		

Detroit Wayne Mental Health Authority submitted the Design and Implementation stages of the PIP for this year's validation. Overall, 100 percent of all applicable evaluation elements received a score of *Met*.

Performance Measure Validation (PMV)

HSAG PMV is one of three mandatory external quality review (EQR) activities required by the Balanced Budget Act of 1997 (BBA) to ensure that performance measures developed and selected by the state are validated. The Performance Measure Validation (PMV) review was conducted on Monday July 26, 2019 covering data reported to MDHHS (MMBPI) for Quarter 1 FY 2019. The results from the review demonstrated compliance with recommendations for Continuous Quality Improvement.

- ⇒ Indicator 4a and 4b
  - Ensure the dates of rescheduled appointments are documented in MH_WIN.
- ⇒ Indicator 10
  - Ensure readmissions documented accurately at the end of each Fiscal Year. Multiple authorizations were generated by finance that led to inaccurate data being included for measure reporting.

Compliance Review

The HSAG Compliance Review was conducted on September 9th, 2019. The results from the review demonstrated compliance with recommendations for Continuous Quality Improvement as illustrated below.

HSAG HEALTH SERVICES ADVISORY GROUP

3. Summary of Results

Table 3-1 presents for each standard the total number of elements as well as the number of elements that received scores of *Met*, *Not Met*, or *Not Applicable (NA)*. Table 3-1 also presents **Detroit Wayne Integrated Health Network**'s overall compliance score for each standard, the totals across the nine standards reviewed, and the total compliance score across all standards for the 2018–2019 compliance monitoring review. Refer to *Appendix A—2018–2019 Documentation Request and Evaluation Tool* for a detailed description of the findings.

Table 3-1—Summary of 2018–2019 Compliance Monitoring Review Results

Standard	Total # of Applicable Elements	Number of Elements			Total Compliance Score
		Met	*Not Met*	*NA*	
Standard I—QAPIP Plan and Structure	8	8	0	0	100%
Standard II—Quality Measurement and Improvement	8	6	2	0	75%
Standard III—Practice Guidelines	4	3	1	0	75%
Standard IV—Staff Qualifications and Training	3	2	1	0	67%
Standard V—Utilization Management	16	13	3	0	81%
Standard VIII—Members' Rights and Protections	13	12	1	0	92%
Standard XI—Credentialing	9	5	4	0	56%
Standard XIII—Coordination of Care	11	11	0	0	100%
Standard XVI—Confidentiality of Health Information	10	5	5	0	50%
Total	82	65	17	0	79%

Utilization Management

The Annual Utilization Management (UM) Program Executive Summary is under a separate cover for FY 2019. It is the responsibility of DWIHN to ensure that the UM Program meets applicable federal and state laws and contractual requirements and is a part of the QAPIP. DWIHN is required to have a written Utilization Management Program Description which includes procedures to evaluate medical necessity criteria, and the processes used to review and approve the provision of mental health and substance abuse services. DWIHN is also required to have an Annual Utilization Management Program Evaluation report in order to:

- ⇒ Critically evaluate Utilization Management Program goals;
- ⇒ Identify opportunities to improve the quality of Utilization Management processes;
- ⇒ Manage the clinical review process and operational efficiency;
- ⇒ MCG-Indicia medical necessity software
- ⇒ Implementation of clinical protocols
- ⇒ Complex case management

DWIHN is trending in a positive direction towards attainment of our improvement goals and objectives. We are encouraging DWIHN to fully embrace the Continuous Quality Improvement (CQI) philosophy throughout our system utilizing the Board approved Strategic Plan and the goal to obtain full accreditation as a Managed Behavioral Healthcare Organization (MBHO) from the National Committee of Quality Assurance (NCQA).

In FY 2020, the QAPIP Evaluation will be reviewing these areas:

- ⇒ ECHO Survey for member experience
- ⇒ Grievances / Appeals
- ⇒ Culturally and Linguistically
- ⇒ MMBPI/Access
- ⇒ Annual Needs Assessment
- ⇒ Ensure Consistent and standardized model of care
- ⇒ Ensure model fidelity to best practices
- ⇒ Standardized Clinical Guidelines
- ⇒ Medversant - Impaneling/Credentialing
- ⇒ Performance Monitoring
- ⇒ Autism Benefit
- ⇒ Critical/Sentinel Events Reporting
- ⇒ Incident Reporting
- ⇒ Behavior Treatment Plan Oversight
- ⇒ Performance Improvement Projects

- ⇒ HEDIS Measures
- ⇒ Crisis Services
- ⇒ Service Denials
- ⇒ Naloxone, Prescription and Opioid Drug Overdoses
- ⇒ Advocacy

Recommendations

It is recommended the Board of Directors approve the following:

- ⇒ The Annual Quality Assurance Performance Improvement Program (QAPIP) Evaluation Report FY 2019