Detroit Wayne Integrated Health Network

(DWIHN)

Quality Assurance Performance Improvement Plan

Annual Evaluation FY 2020

Submitted by:

April L. Siebert - Director of Quality Improvement

Approved:

Approved by the Quality Improvement Steering Committee (QISC)	2/9/2021
Approved by Program Compliance Committee (PCC)	2/10/2021
Approved by the Full Board of Directors	2/17/2021

Table of Contents

Introduction

The Detroit Wayne Integrated Health Network (DWIHN) is the Pre-Paid Inpatient Health Plan (PIHP) and Community Mental Health Service Provider (CMHSP) for Detroit and Wayne County. DWIHN is the largest community mental health service provider in the State of Michigan. The Quality Assurance Performance Improvement Plan (QAPIP) Evaluation is an annual document that serves to emphasize the accomplishments and effectiveness of DWIHN's Quality Program as well as identify barriers and opportunities for improvement within the process.

Executive Summary

This QAPIP evaluation provides a description of completed and ongoing quality improvement activities that address quality, safety of clinical care and quality of services. The goals and objectives from the 2019 QAPIP Work Plan were evaluated and are included in the QAPIP evaluation for FY20. HEDIS scores were used as one of the measurement tools to identify progress or barriers for the Quality Improvement Projects. The QAPIP evaluation follows a structured format including a description of the activity, quantitative analysis and trending of measures, evaluation of effectiveness, barrier analysis and identified opportunities for improvement. The QAPIP evaluation also includes the six (6) pillars that are identified in DWIHN's Strategic Plan. The Quality Improvement Steering Committee (QISC) is the decision-making body that is responsible for the oversight of DWIHN's QAPIP Description, Evaluation and Work Plan. The Program Compliance Committee (PCC) Board gives the authority for implementation of the plan and all of its components. The QAPIP evaluation was presented to QISC, PCC and the full Board of Directors for review and approval.

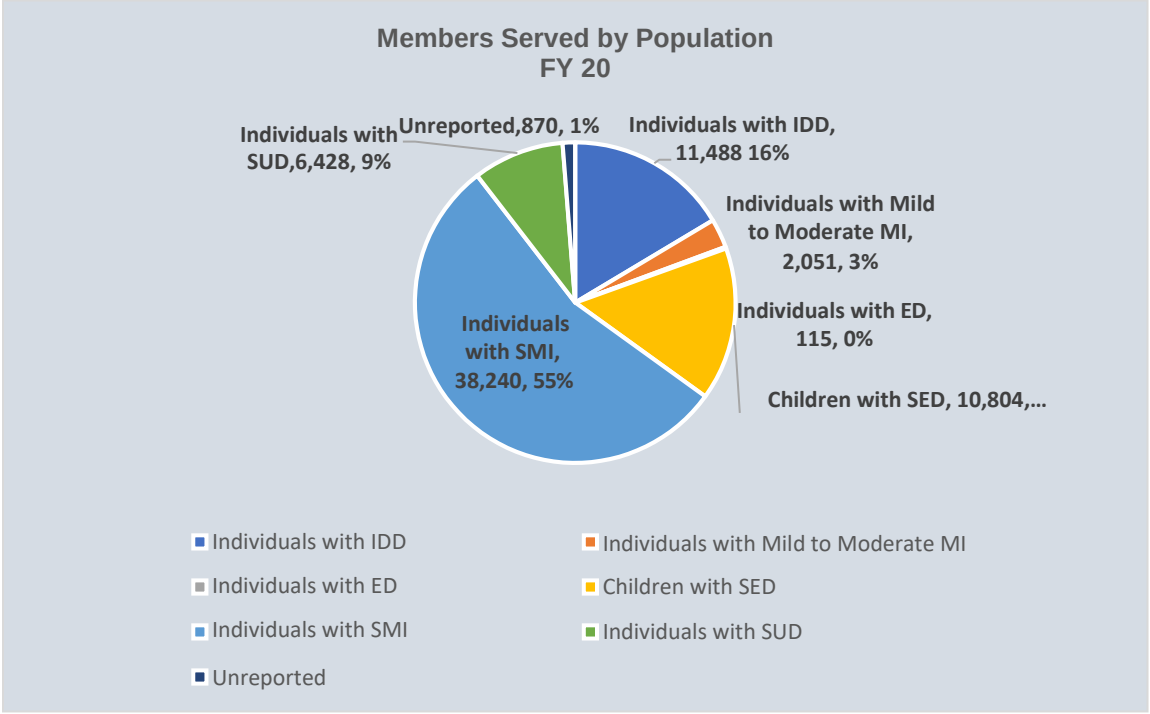
Description of Service Area

Wayne County is the most populous county in the State of Michigan. As of 2020, the United States Census estimated its population as 1.7 million, and ranked 19th in population in the United States. Wayne County is comprised of 34 cities and 9 townships covering roughly 673 miles. The municipality of Detroit had a 2020 estimated population of 670,031, making it the 23rd-most populous city in the United States. Member populations receiving services through DWIHN are commonly referenced throughout this evaluation using the following abbreviations:

- MI Adults—Adults diagnosed with mental illness
- SMI Adults—Adults diagnosed with serious mental illness
- IDD Adults—Adults with intellectual developmental disability
- IDD Children—Children with intellectual developmental disability
- SUD – Adults diagnosed with substance use disorder
- SED Children—Children diagnosed with serious emotional disturbance
- ASD- Autism Spectrum Disorders
- Youth with serious emotional disturbances

Demographics

DWIHN provided services to an unduplicated count of 70,030 members during FY20, which is a decrease of 3,399 *(9.5%)* from FY19 (73,429). Of those served 45,200 *(52.09%)* received services through Medicaid funding, 16,812 *(19.37%)* received services through Healthy Michigan Plan funding, 8,940 *(10.30%)* received services through General Fund, 7,977 *(9.19%)* through SUD Block Grant, 5,267 *(6.07%)* through MI Health Link, 1,671 *(1.92%)* through State Disability Assistance (SDA), 902 *(1.03%)* through Habilitation Supports Waiver. The percent of adults who reported having a SMI in FY20 (38,240), demonstrated a decrease of *(5.48%)* from the previous year (40,460). Followed by 10,804 *(15.43%)* (SED), 11,488 *(16.40%)* (IDD), 6,428 *(9.18%)* (SUD), 2,051 *(2.92%)* (MI), 3,846 (*4.97%)* Co-Occurring, and 870 *(1.24%)* unreported. Of those served 38,612 *(55.15%)* were of African American decent. This reflect a decrease of 2,761 *(6.7%)* from FY19. The Caucasian count was 22,251 *(31.78%).* The remaining *(15%)* were identified as other, two or more races, unreported, Asian, American Indian, Native Hawaiian and Alaskan. The largest group of individuals served are in the age group of 22-50 years-old 30,652 *(43.78%),* demonstrating a decrease of 2,149 *(7.01%)* from FY19. Followed by the age group of 51-64 years-old,15,238 *(21.76%)* and the age group of 0-17 years-old, 15,073 *(21.52%).* The growth of persons served 65 and over increased by *(4.3%)* from the previous year.



Customer Pillar

Experience of Care and Health Outcomes (ECHO) Survey

Activity Description

DWIHN conducted the ECHO survey to receive feedback from members who accessed behavioral health services in the past 12 months. This survey is to obtain information about experience with behavioral health care services and the health plan. As with other member experience data, DWIHN's member experience manager along with a cross-departmental member experience workgroup annually reviews the data and develops improvement activities and interventions to impact ECHO scores. DWIHN combines the ECHO data with other data sources throughout the organization to have a comprehensive view of member satisfaction with DWIHN services. Data sources include appeals and grievances, focus groups, internal member surveys, post-survey and other member feedback received directly from customer service.

Quantitative Analysis and Trending of Measures

ECHO survey results for both the overall rating questions and the composite questions. The overall rating questions assessed overall experience with counseling or treatment, and overall experience with the behavioral health care services for counseling or treatment. Response options range from 0-10, with 0 being lowest and 10 being highest. Ratings of 8, 9 or 10 are considered achievements and the achievement score is presented as the proportion of members whose response was an achievement. In the ECHO survey for adults in 2017, DWIHN members reported scores below the goal in the overall rating for "Rating of counseling or treatment" and the composite scores for "Office wait and access". DWIHN members also reported scores below the goal in the composite score for "Getting treatment quickly". DWIHN provided a randomly selected list of 5,999 members, out of the approximately 77,000 adults receiving services, 966 DWIHN members responded to the survey. 752 members reported receiving services in the past year. In FY20, DWIHN scored well on several of the ECHO reporting measures, notably members reporting receiving information on patient rights *(91%)* and confidence in the privacy of their information *(91%).* There were three measures with scores of lessthan *(50%):* Perceived improvement *(31%);* Office wait *(36%);* and Getting treatment quickly *(43%).* Compared to 2017, more members reported treatment helped "a lot" and more rated their overall treatment a "9" or "10", with10 being the highest rating. The difference between the Global Rating in FY20 *(51%),* compared to 2017 *(46%)* was found to be statistically significant. The chart below illustrates the composite scores for FY20 and FY17, in which the scores were <50% for the 2017 reporting period. The reporting measures listed below were identified in the 2018-2019 Work Plan. There were no ECHO Surveys administered during FY 2018-2019. The domains include: Treatment after benefits are used up, Counseling and Treatment, Getting Treatment Quickly, Office Wait and Perceived Improvement. The identified areas improved with an overall percentage increase of *(10%).*

ECHO Reporting Measures, Comparison AcrossYears

Composite Measures and Global Rating	2020	2017
Treatment after benefits are used up	55%	48%
Global Rating: Treatment (Overall rating of counseling and treatment)	51%	46%
Getting treatment quickly	43%	37%
Office wait	36%	33%
Perceived improvement	31%	29%

The ECHO Survey for Children was administered for the first time by DWIHN during FY20. DWIHN scored well on several measures, notably Parents/Guardians reporting receiving information on Patient Rights *(95%),* Confidence in the privacy of their information *(93%)* and Completely discussing the goals of their child's treatment *(93%).* There were four measures with scores of less than *(50%)*: Perceived Improvement *(25%)*; Getting Treatment Quickly *(42%)*; Overall rating of counseling and treatment *(49%);* and Amount helped *(49%).*

There were statistically significant differences in the responses of those with children whose primary disability designation was IDD and those with SED. Members with IDD were less likely to indicate delays in treatment and there were no identified problems while waiting for approval *37%* of members with a disability designation of IDD, compared to *68%* of members with a disability designation of SED. Parents/Guardians with children with a disability designation of IDD were less likely to indicate they felt they could refuse a specific type of medicine or treatment (*85%* compared to *90%*). Respondents with children with a disability designation of IDD were more likely to report that their children had been helped a lot by the treatment (*54%* compared to *46%*).

Respondents with children receiving autism services were less likely to report delays in treatment were not a problem while waiting for approval (*38%* for those receiving autism services), compared to *61%* for those not receiving autism services); getting needed help was not a problem when calling customer service (*48%*, compared to *65%* for those not receiving autism services); their child always had someone to talk to for counseling or treatment when troubled (*51%* compared to *59%*); and they felt they could refuse a specific type of medicine or treatment (*84%* compared to *89%*). However, respondents with children receiving autism services were more likely to report that their children had been helped a lot by the treatment (*56%* compared to *47%*).

DWIHN randomly selected 7,087 members to receive the survey, out of approximately 17,000 members younger than 18 receiving services. Overall, 1,532 *(21%)* responded to the survey out of the 7,087 selected. Out of the 1,532 responses, 1,123 reported their children had received counseling, treatment, or medicine in the last 12 months. DWIHN scored well on several of measures, notably parents/guardians reporting receiving information on patient rights *(95%),* confidence in the privacy of their information *(93%),* and completely discussing the goals of their child's treatment (*93%*). However, there were four measures with scores of less than *(50%):* Perceived improvement (*25%*); Getting treatment quickly *(42%);* Counseling and treatment *(49%);* and Amount helped *(49%).* The chart below illustrates the composite scores in the ECHO Child reporting measures compared to Adult reporting measures for FY20. There was variation in the overall rating for "Perceived improvement" (*25%* compared to *31%*); How Well Clinicians Communicate" (*72%* compared to *68%*); and rating of counseling and treatment (*49%* compared to *51%*).

ECHO Reportingmeasures, Child Comparisonto Adult Results FY20

Composite Measures and Global Rating	Children	Adult
Getting treatment quickly	42%	43%
How well clinicians communicate	72%	68%
Getting treatment and information from the plan or MBHO	55%	57%
Perceived improvement	25%	31%
rating of counseling and treatment)	49%	51%

DWIHN will continue to address recommendations from appropriate committees regarding treatment and access in relation to behavioral health services. The ECHO survey results are shared across cross functional teams both internally and externally to identify opportunities for improvement and how DWIHN can improve behavioral health care services. As with other member experience data, DWIHN reviews the data and develops improvement activities and interventions to improve member experience.

Evaluation of Effectiveness

DWIHN has worked on strategies to increase response rates to better understand DWIHN population that accesses behavioral health services. DWIHN administered the ECHO Survey using Wayne State Center for Urban Studies (WSCUS) as its vendor. The survey was administered via three modes: The Center mailed the members a paper survey, link to the web version was included with the mailed invitation and one week after the paper survey was sent, staff from the Center's Computer Aided Telephone Interviewing (CATI) lab began calling members and asking them to complete the survey over the phone. The three modes of surveys administered demonstrated that the CATI method was proven to be more effective at (49.6%), Mail (47.1%) and Web (3.3%). Respondents received a $5-dollar CVS gift card and a chance to be randomly selected to receive one of three visa cards ($100, $250 and $500) WSCUS offers a mailed survey as well as an online version. WSCUS also offers improved reporting and dashboards. WSCUS also conducts follow-up calls to members encouraging completion of the survey. This vendor provides detailed reports that allows DWIHN to complete a more thorough analysis of results year over year. The survey response rate did increase from 2017 with DWIHN members, well over the 600 targeted for FY20.

DWIHN will continue to address questions about treatment and access to behavioral health services. DWIHN's behavioral health case management/supports coordination team will work directly with parents/guardians of its minor-aged members with a behavioral health condition and encourages medication adherence. Case managers/supports coordinators will review medications with members and talk about the importance of timely medication refills, provide education about timely follow-up and assist members with scheduling appointments.

Barrier Analysis

DWIHN continues to receive low response rates on getting members to complete the ECHO survey. The data that is gathered is not entirely representative of all DWIHN members that access behavioral health services. The survey is a sample of member scores and is a barrier to representative data for the populations served and who received behavioral health services. Members may not always be aware of how to access behavioral health materials from the service provider and are not aware of behavioral health services offered. There was a statistically significant difference in subgroups. Respondents 18 to 24 had lower scores than the other age groups on several measures. Overall, *(43%)* of the respondents reported always seeing someone as soon as they wanted, 21% of respondents were 18 to 24. A lower percentage of people with guardians *(50%)* reported clinicians always listened carefully to them, compared to 66% overall. Respondents with substance use disorders were more likely to report that they always felt safe with people they went to for counseling or treatment (*96%* compared to *78%* overall).

Another major barrier is understanding available treatment options and services included in their benefits. Also, members may require continued access to behavioral health care services and treatment options before they begin to see improvement. Social factors are another aspect that can affect individuals with a mental health diagnosis. Individuals may experience lack of education or health literacy, economic instability, lack of social connections, poor infrastructure of neighborhoods and communities, and access to health care including mental health services. Social factors and mental health often correlate with health equity. Individuals who have a mental health diagnosis and experience any type of social factor may find it difficult to know and understand types of services they qualify for to address the condition, as well as accessing the appropriate level of care to address their needs.

Opportunities for Improvement

DWIHN will continue to focus on access to care for behavioral health services based on the 2020 Adult ECHO survey results. Intervention strategies that will be implemented include the following:

- Service providers to identify barriers to, and potential improvements that would support, members being seen within 15 minutes of appointment time.
- Service providers and members to identify barriers to members being able to get treatment quickly, particularly as it pertains to getting help over the telephone.
- Service providers to ensure all members, including those with DD or SUD, are confident in the privacy of their information and that those with guardians feel clinicians listen carefully to them.
- Review the provider network for access to behavioral health services, especially in more urban counties and reducing the amount of services that require a prior authorization, increasing behavioral health staff, and expanding to telehealth services.

The ECHO Survey for Children results will be shared both internally and externally to identify opportunities for improvement and how DWIHN can improve behavioral health care services. DWIHN has identified the following as opportunities for improvement.

- Service providers and members to explore the reasons why more families do not perceive improvements in their children, particularly with regard to social situations, and whether their self-assessments reflect clinicians' assessments.
- Service providers and families to identify barriers to members being able to get treatment quickly, particularly as it pertains to getting help over the telephone.
- Service providers to help them to understand the feedback their clients offered via the ECHO survey, particularly for those providers given lower scores on members' experience.

Member Grievances

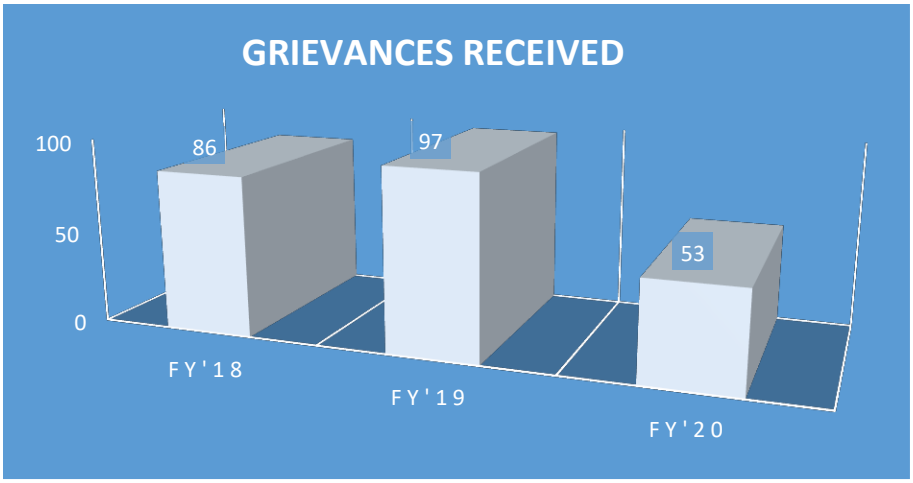
Activity Description

The grievance system is an important element in identifying how providers function in various areas. The grievance data is reviewed daily, monthly, and quarterly. It is also shared quarterly with the Quality Improvement Steering Committee (QISC) and monthly with DWIHN's Constitutes Voice Member Experience Workgroup. The appeals and grievances data are divided into five categories: quality of care, access, attitude and services, billing and financial issues, and quality of practitioner office site. DWIHN's goal is to reduce the number of appeals and grievances relating to access to care. DWIHN focused on improving member experience scores in order to remain above the national average for getting needed care and getting care quickly. DWIHN also worked to improve ECHO scores in order to obtain the threshold for getting treatment quickly and getting treatment and information from the plan.

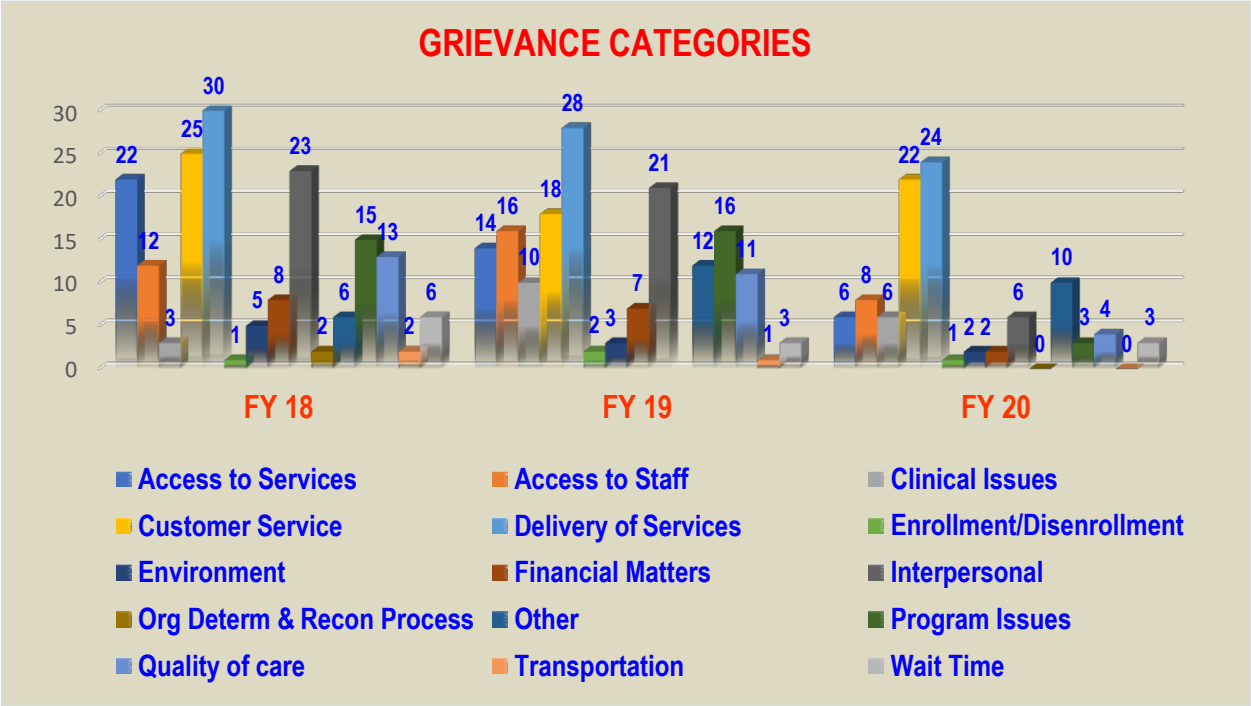
During FY20, DWIHN completed an analysis of member experience trends and occurrences through review of Grievances, Appeals, Recipient Rights and Sentinel Events data. DWIHN uses this data and other initiatives to determine priority actions and improvements to better engage members and stakeholders. Outcomes of the analysis helps to forecast the direction and future of DWIHN's public behavioral health system by enhancing and developing policy, initiating process improvement plans, funding new programs and services to enhance our system of care. It also serves as a source to identify opportunities for improvement in the quality and delivery of behavioral health service within the DWIHN system. It is DWIHN's goal to educate members as well as providers on the importance of promoting expressions of member dissatisfaction as a means of identifying continuous quality improvements in our delivery of behavioral health care services. It promotes members access to medically necessary, high quality, consumer-centered behavioral health services by responding to member concerns in a sensitive and timely manner. This process supports recovery and assures that people are heard. It empowers individuals receiving services to become self-advocates and provides input for making the system better for everyone.

Quantitative Analysis and Trending of Measures

There was a total of 236 grievances reported within the last three fiscal years. Grievances originated with either the Service Provider or DWIHN. As the graph below indicates the most grievances were reported during FY19 and the second highest number being in FY18. There was a significant decline in the number of grievances reported in FY20 compared to FY19. Between April 1st, 2019 and September 30th, 2019, there were 40 grievances received compared to 19 grievances during the same time frame in 2020. The difference in the two years represents a *(52%)* decrease in the number of grievances reported for this period in 2020. It is believed this could be attributed to the COVID-19 pandemic during which time there was a "stay at home order" that was effective as of March 23rd, 2020 and yet to be completely lifted.



A grievance may include more than one category. With that being stated, the number of categories identified within a grievance can be significantly greater than the number of grievances received. However, a grievance is not considered resolved until all the categories within a grievance have been thoroughly investigated and considered appropriate for closure. DWIHN identifies grievance categories in alignment with MDHHS requirements as illustrated in the graph below. During FY18 there were 86 grievances reported in which 173 categories were identified; 162 categories within 97 grievances reported in FY19 and 97 categories within the 53 grievances reported in FY20. Delivery of Service and Customer Services were consistently high over each of the three years. There was a decline in the number of grievances in the following categories in FY '20. 1.) Access to Services; 2.) Interpersonal and 3.) Quality of Care.



The data collection of these grievances, provided no reliable way to determine if any of them consisted of any cultural, racial, ethnic or linguistic concerns. DWIHN recognizes that this information is needed to identify the nature and extent of disparities, to target quality improvement efforts, and to monitor progress. Tracking the racial and ethnic composition and changing health care needs of different populations is vital if our health care system is to fulfill its essential functions. Measurement, reporting, and benchmarking are critical to improving care.

Evaluation of Effectiveness

DWIHN's Customer Service unit completed a total of 28 appeals for FY20. An estimated *(17%)* decrease from the previous FY19 where 34 appeals were completed. There was a total of 10 State Fair Hearings completed, a *(23%)* decrease from FY19. Thirteen (13) State Fair Hearings were completed. There were 53,073 Advance and Adequate Adverse Benefit Determination Letters sent in FY19 and 32,278 Advance and Adequate Adverse Benefit Determination Letters sent for FY20, approximately *(39%)* less than the previous year.

Overall, of the 432 grievance categories reported over the last three fiscal years, 331 or *(77%)* were resolved within the Customer Service unit at either the Service Provider or DWIHN**.** Those grievances were usually coordinated with other departments for resolution. Nineteen (19) or *(4.3%)* of the grievance categories were suspected recipient rights violations and therefore, referred to ORR for further follow-up and investigation. There were 40 *(9%)* grievances received during the same time frames that were determined not to be in DWIHN jurisdiction and therefore referred to outside entities for further assistance and follow-up. Thirteen (13) or *(3%)* of the grievances reported were later withdrawn by the grievant. The remaining *(7%)* of the grievance categories were either not resolved or disposition is unknown. Typically, in such a case as this, the member cannot be reached to determine satisfaction. Medicaid and MI Health Link grievances are required to be resolved within ninety (90) calendar days, whereas Non-Medicaid grievances must be resolved within sixty (60) calendar days. Grievances were resolved within the average number of 38 days during FY18. The average timeframe for resolution of a grievance was 22 days in FY19 and 37 days in FY20.

Barrier Analysis

It is DWIHN's goal to educate members as well as providers on the importance of promoting expressions of member dissatisfaction as a means of identifying continuous quality improvements in our delivery of behavioral health care services. There were 236 grievances reported over the last three fiscal years (FY18, FY19 and FY20). 163 or *(69%)* of those grievances were resolved to the satisfaction of the grievant. Nineteen *(19%)* were not satisfied with the resolution of his/her grievance. Unable to determine the satisfaction disposition for *(8%)* of the members due to inability to speak with the member. The remaining *(5%)* of the member satisfaction fell in the other category as those grievances were not resolved.

Opportunities for Improvement

Overall, DWIHN's 2020 grievance data showed improvement; however, DWIHN is continuously striving to improve the health and safety of members through innovative services and partnerships. DWIHN identified a number of key areas of focus.

- Providing relevant training on cultural competence and cross-cultural issues to health professionals and creating policies that reduce administrative and linguistic barriers to member care.
- 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.
- Review and discuss grievance data with the Member Engagement Division which will allow for an additional avenue for evaluating member experiences.
- Continue to identify continuous quality improvement opportunities through use of patterns and trends of grievances reported.
- Continue to support members by resolving issues of dissatisfaction with DWIHN.

Complex Case Management (CCM)

Activity Description

The overall goal of Complex Case Management (CCM) is to help members move towards optimum health, improved functional capability, and a better quality of life by focusing on their own health goals. The member selects the health goals that they wish to address, and DWIHN coordinator will help facilitate the identification of steps needed and the community support available to meet the member-centered goals. Complex Case Management is available to members who have a variety of co-morbid behavioral health, physical conditions, and needs. Complex Case Management offers DWIHN members the opportunity to talk with a Registered Nurse to assess physical and behavioral health needs; establish member-centered goals to address needs; identify barriers and solutions to help achieve goals and identify additional available community resources. The purpose of Complex Case Management is to help organize and coordinate services for members with complex physical and behavioral health conditions.

Quantitative Analysis and Trending of Measures

Members participating in Complex Case Management (CCM) services demonstrated overall improvement in their PHQ scores, and the improvement increased the longer that the members participated in CCM services. Average PHQ scores improved *(7%)* from baseline at 30 days, *(25%)* at 60 days and *(46%)* at 90 days of receiving CCM services. Members PHQ baseline scores ranged from 5 to 22, with an average score of *(11.8).* Members participating in Complex Case Management services demonstrated overall improvement in their WHO-DAS scores, and the improvement increased the longer that the members participated in CCM services. Average WHO-DAS scores did not show improvement from baseline to 30 days of receiving CCM services. Average WHO-DAS scores improved *(13%)* from baseline at 60 days and *(32%)* at 90 days of participating in CCM services. DWIHN analyzed member Admission, Discharge and Transfer (ADT) alerts and DWIHN claims data to measure utilization of Emergency Department and Hospital Admissions 90 days prior to participating in CCM services and 90 days after starting CCM services.

Members participating in CCM services showed an average *(25%)* reduction in Emergency Department utilization and average *(69%)* reduction in Hospital Admissions from 90 days prior to 90 days after starting CCM services. No members experienced an increase in Hospital Admissions from 90 days prior to receiving CCM services to 90 days after starting CCM services.

Evaluation of Effectiveness

Four out of 35 (11%) members who actively received CCM services signed up to use the myStrength application during FY2020. One-member reports that she uses the application on a daily basis to assist with her symptoms of anxiety. PIHP Care Coordinators reported that additional members did not enroll in the myStrength due to not having access to, or choosing not to access, an electronic device to utilize the myStrength services.

DWIHN analyzed members claims data for out-patient behavioral health service utilization 90 days prior to participating in CCM services and 90 days after starting CCM services. The average number of out-patient behavioral health services during the 90 days prior to CCM services was 7.2 and the average number of out-patient services after starting CCM services was 10.5, which amounts to a *(46%)* increase in out-patient services utilization.

DWHIN also measured the number of members who attended two out-patient behavioral health services within 60 days of starting CCM services. Of the 31 members that were available to participate in 2 out-patient services after starting CCM services, 30 members *(97%)* attended two out-patient behavioral health services within 60 days of starting CCM services. Of the 36 CCM cases opened during FY2020, 25 members had Complex Case Management services closed during FY2020. 12 *(48%)* Satisfaction Surveys were completed and returned.
No members reported responses of 'Less than expected' to the Survey questions. One member provided a response of 'As expected' to one question. All other members provided responses of 'More than expected' and 'Consistently more than expected'. The majority of the responses were 'Consistently more than expected' for an overall satisfaction rate of *(100%)*. Six respondents also included positive comments in the Satisfaction Survey.
In addition to the comments included on the Satisfaction Surveys, a member's parent, and a provider also submitted highly positive comments regarding Complex Case Management services to the DWIHN CEO and to the Director of Integrated Care.

Barrier Analysis

PHQ and WHO-DAS scores were higher than PHQ and WHO-DAS scores at baseline, 30 days and 60 days after starting CCM services in FY2020 compared to the FY2019 and 2018 periodic reviews. This could be an issue of interrater reliability as a result of staff changes that occurred during FY2019. The two staff that provided CCM services during the 2018 and FY2019 timeframes transferred to other positions within the organization during FY2019. Due to the possible interrater reliability concern with the completion of the PHQ and WHO-DAS assessments, current Care Coordinator staff will be re-in serviced on the completion of the assessment tools.

Opportunities of Improvement

An area identified as an opportunity for improvement during FY2019 was Behavioral Health engagement. While the sample size of 11 was low, only *(73%)* of members attended two or more visits with a behavioral health provider within 60 days of starting CCM services. The intervention was for Care Coordinators to work at engaging members in outpatient treatment and identifying potential barriers to attending outpatient appointments. During FY2020, the Care Coordinators emphasized the importance of member attendance and participation at outpatient behavioral health appointments and assisted with addressing barriers of attending appointments, including arranging transportation, rescheduling appointments to accommodate member schedules, and connecting member to service providers of members preference. As a result of these efforts, *(97%)* of members who received CCM services for 60 days or more during FY2020 attended at least two outpatient behavioral health visits within 60 days of starting CCM services.

Two areas that DWIHN will focus on improving during FY2021 are in the areas of self-management tools. During FY2021, DWIHN will offer non-web-based self-management tools to all members, along with the myStrength application. DWIHN PIHP Care Coordinators will encourage members to utilize the self-management tools that are right for them. While responses to the CCM Satisfaction Surveys that were returned were overwhelmingly positive, DWIHN would like to increase the return rate. During FY2021, DWIHN will offer a $5 Visa Gift Card to all members who complete and return a CCM Satisfaction Survey. Lastly, continue to coordinate services for the highest risk members with members with complex conditions and help members access needed resources.

National Core Indicator Survey (NCI)

Activity Description

Another measure of member experience and health outcomes is the Michigan National Core Indicators Survey (NCI), which surveys adults with intellectual developmental disabilities. The NCI are measures used across states to access the outcomes of availability of services provided to individuals and families. The indicators address key concerns including employment, rights, service planning, community inclusion, choice, and health and safety.

Quantitative Analysis and Trending of Measures

In FY19, 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 Quality Improvement Steering Committee (QISC) for development of interventions as needed. Interviews and surveys were not completed during FY19-20 due to the COVID-19 Pandemic. Interviews and surveys will reconvene in FY21.

Barrier Analysis

The survey is only conducted in English, Spanish, Vietnamese, Arabic and Chinese. DWIHN population is a very diverse population and members may not receive the survey in their primary language or do not read in English or their first language making it difficult to complete or answer the NCI questions. In addition, self-reported data is difficult to use as members may not fully understand the questions or the questions are not applicable to diversity and one's culture. 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.

Provider Practitioner Survey

Activity Description

In FY20, DWIHN administered the Provider Practitioner Surveys during the month of September related to service access, service provision, treatment experiences and outcomes.

Quantitative Analysis and Trending of Measures

A Comparison of FY19 and FY20 surveys, indicate that provider participation increased overall by *(25%)*; *(50%)* for provider organizations and *(21%)* for individual practitioners.

Evaluation of Effectiveness

DWIHN experienced a significant increase in the survey response rate from FY19. The response rate increased *(50%)* for provider organizations and *(21%)* for individual practitioners. The total number of actual respondents from provider organizations was 180 out of 354 and 572 respondents out of 1,500 individual practitioners. In total 753 surveys were returned out of approximately 3,000 emailed surveys with an overall percentage response rate of about *(25%).*

Barrier Analysis

DWIHN's targeted response rate of *50%-60%* was below the targeted benchmark of *50% -75%* participation. The length of survey questions (76) may dissuade provider organizations and practitioners to complete survey. "*As it was reported to have taken 30 minutes to complete"*. Based upon number of surveys that bounced back there is further need to clean up our email database to void invalid email addresses.

Opportunities for Improvement

The surveys have identified several opportunities for improvement. The Provider Survey Ad-Hoc Task Force will utilize the findings from FY19 and FY20 surveys, and develop a Corrective Action Plan for implementation. The ad-hoc group will be charged with tailoring the survey to best fit our contracted provider organizations and practitioners to achieve a higher response rate; as well as gain a better understanding of how we can support and maintain a strong provider network that will provide high quality supports and services to our members. Additionally, specific interventions for each of these opportunities for improvement should be developed, implemented and tracked through a collaborative effort. Those areas of focus are:

- To alert provider organization and practitioners of the issuance of the survey and promote the significance of completion via email.
- Post notifications in our MH-WIN System.
- Contract Managers to send reminders to provider organizations as well as encourage provider organizations to promote individual practitioner.
- Correct the email address database to avoid emails from bouncing back.

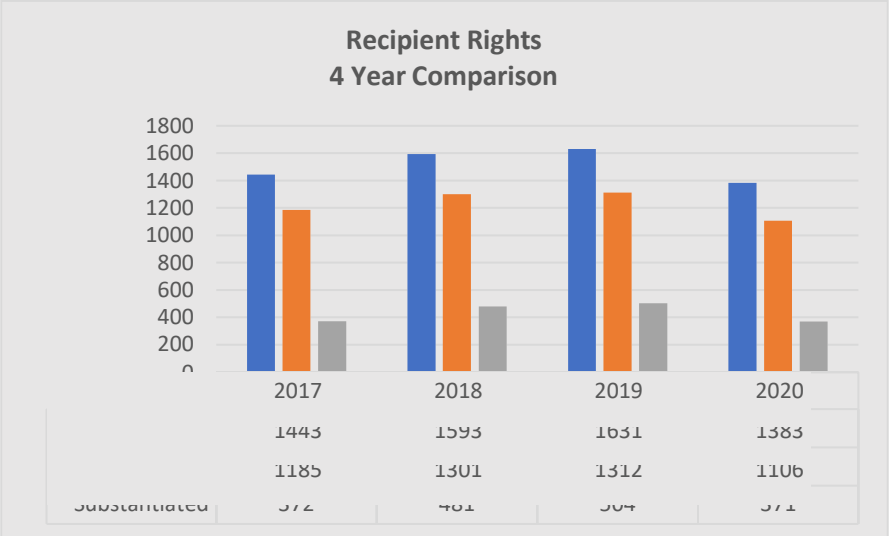
Office of Recipient Rights (ORR)

Activity Description

The Office of Recipient Rights' mission is to ensure that recipients of mental health services throughout the DWIHN system of care receive individualized treatment services suited to their condition as identified in their individualized Plan of Service (IPOS). The IPOS is developed by using the Person-Centered Planning (PCP) process and maps out how to receive service in a safe, sanitary, and humane environment where people are treated with dignity and respect, free from abuse and neglect.

Quantitative Analysis and Trending of Measures

The chart below indicates the most allegations were reported during FY19 and the second highest number being in FY18. There was a significant decline in the number of allegations reported in FY20 1,383 *(17%)* compared to 1,631 reported allegations in FY19. The difference in the four years represents a *(5%)* decrease in complaint allegations since 2017; *(3%)* increase in complaint investigations since 2017; and *(1%)* increase in substantiated complaint allegations since 2017. In addition, ORR received allegations from 474 recipients and 376 employees which represents the highest number of individuals that filed complaints. This is significant and supports the fact that recipients and employees are one of our greater resources in protecting the rights of the ones we serve.



Evaluation of Effectiveness

The role of ORR plays a vital role in the monitoring of member safety through investigations, identification of potential quality of care issues and identification of potential trends in retaliation, harassment or discrimination. This critical component of the rights protection system aims to reduce risk factors for rights violations and increase proactive influences which prevent violations. Complaint Resolution through the recipient review and investigation of suspected or alleged rights violations. If it is determined that violations have occurred DWIHN ORR recommends appropriate remedial action and will assists recipients and /or complaints or to fulfill its monitoring function.

Barrier Analysis

Abuse and Neglect are the most serious violations in the rights system and account for much of the time spent in investigations by rights staff. The data that is gathered is not entirely indicative of all DWIHN members that access behavioral health services, as the violations is a sample of member scores and is a barrier to representative data for the populations served and who received behavioral health services. A review of the data as it relates to access to behavioral care services deserve high priority as the ECHO survey results in 2020 indicated *(36%)* of respondents see it as a critical issue and see transportation or the lack thereof being a critical part of the correlation of access due to prohibitive mobility.

Opportunities for Improvement

DWIHN has identified the following as opportunities for improvement:

- Continue to education and trained the provider network to assist in the Code mandated provision.
- Ensure uniformly high standard of recipient rights protection across all service providers.

Cultural and Linguistic Needs

Activity Description

Racial and ethnic disparities in behavior health care have been well documented. Data analysis has demonstrated that racial and ethnic disparities contribute to lower HEDIS effectiveness of care scores. DWIHN seeks to improve the collection of race, ethnicity, and language data to improve the overall care of members by identifying the racial and ethnic composition of DWIHN members so that potential health care disparities can be identified.

Quantitative Analysis and Trending of Measures

In assessing the language needs of members, DWIHN explored the number of requests for interpreter services at the point of the initial request/screening for eligibility for service. The data was pulled from the screening information gathered by the Access Center at the initial request for service for Medicaid members who received services in FY17. Findings: Less than *(1%)* of the screenings request language interpreters.

Evaluation of Effectiveness

As a proxy, DWIHN reviewed the languages spoken at provider locations. Providers had identified the languages spoken by their staff at their various locations. These are languages (other than English) spoken at 242 provider locations in the DWIHN service network. The most frequently requested languages for interpretation were Arabic and Spanish. The least frequent requested languages for interpretation were Filipino, Chinese, Tagalog, Chaldean and Polish. In addition, DWIHN has adopted the Culturally and Linguistically Appropriate Services (CLAS) standards to advance health equity, improve quality, and help eliminate healthcare disparities. These standards provide a blueprint for individuals and healthcare organizations to implement culturally and linguistically appropriate services.

To support access to cultural and linguistic diversity DWIHN have implemented the following:

- DWIHN have about 10 ethnic/culturally specific providers.
- Member has access to interpreters free of change.
- Member literature is routinely available in Spanish and Arabic.
- Diversity and Cultural competence as a mandatory training.
- Faith-based collaboration and programming is available.
- We have developed an improvement plan pursuant to the result of the CLAS assessment.
- Autism has a quality improve project.

Barrier Analysis

Currently DWIHN does not have data on the languages spoken by individual practitioners. This information is being gathered with the current credentialing/re-credentialing process through Medversant program. Full implementation of Medversant is expected in FY22. Baseline data analysis will be available for reporting in FY22.

Opportunities for Improvement

DWIHN has identified the following as opportunities for improvement:

- Continue to advance health equity, improve quality and help eliminate health care disparities by implementing culturally and linguistically appropriate services.
- Address barriers to accessing interpreters and language services.
- Increase data collection to document cultural linguistic competency need, include cultural linguistic competency in staff evaluations and creating recruitment strategies for bilingual and diverse staff.
- Place greater emphasis on policy change related to sexual orientation and gender identity and expression.
- Continue to utilize the data so the Implementation team and participating agencies and organizations can develop best practices that promote cultural linguistic competency and enrich workforce development on cultural linguistic competency specific needs.
- 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.

Access Pillar

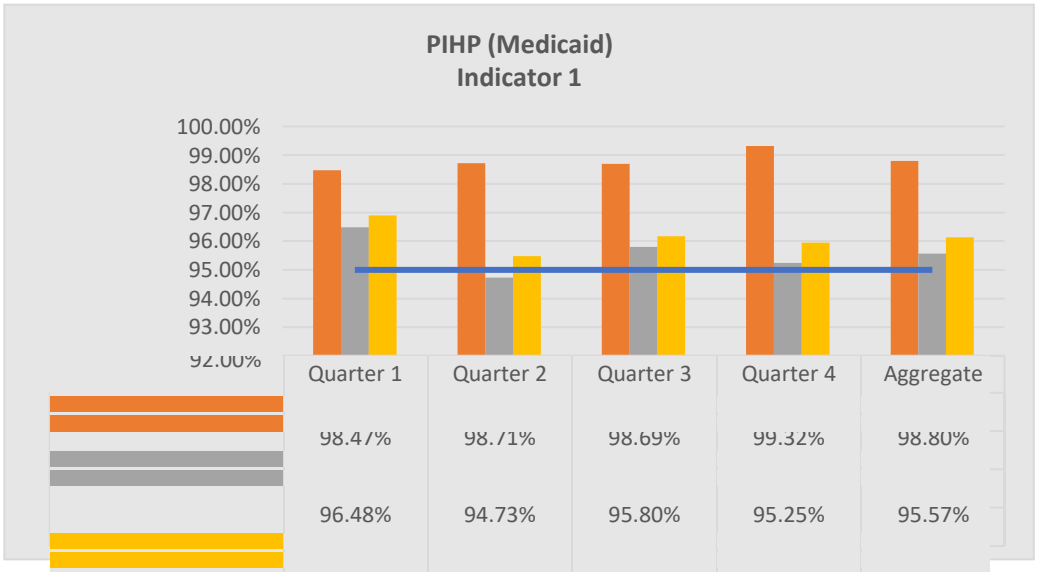
Michigan Mission Based Performance Indicators (MMBPI)

Activity Description

DWIHN monitors access to service using the Michigan Mission Based Performance Indicators (MMBPI). The indicators measure the performance of the PIHP for Medicaid beneficiaries served through the CMSP/SUD affiliates. The performance measure data are aimed at measuring access, quality of service, and to identify barriers to ensure appropriate access to behavioral healthcare and member services.

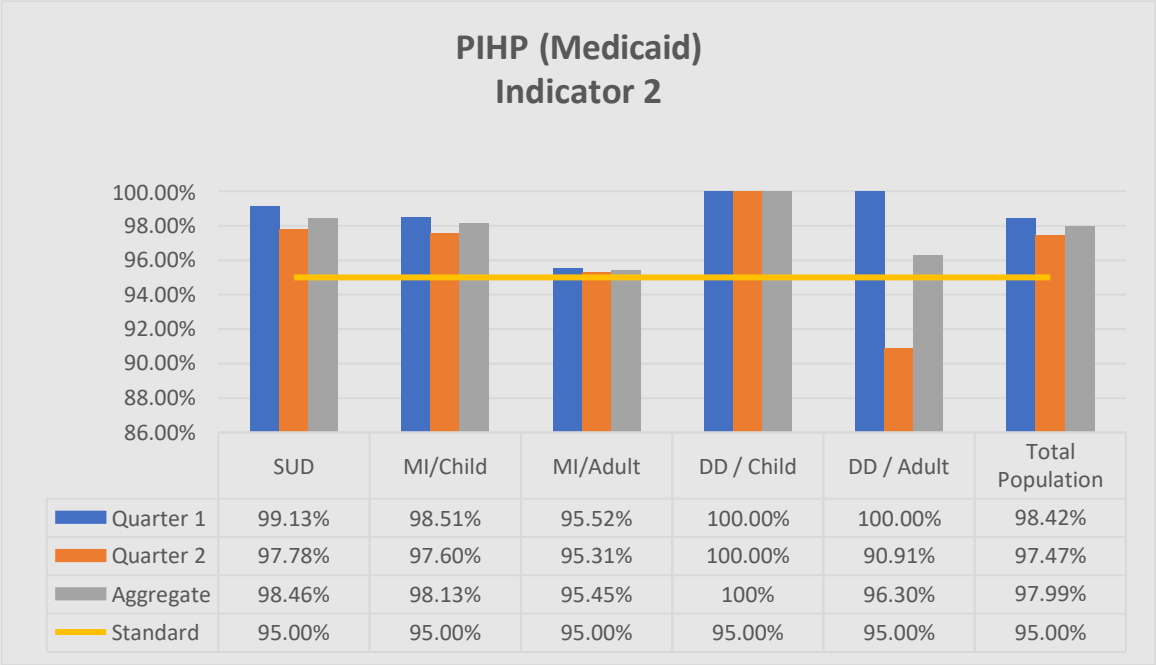
Quantitative Analysis and Trending of Measures

The percentage of persons during 2020 receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. **Target Goals**: To achieve the Michigan Department of Health and Human Services (MDHHS) established benchmark of *(95%)* for (4) quarters during FY 2020. **Results:** FY 2020 standard met for adult and children population for 4 quarters.



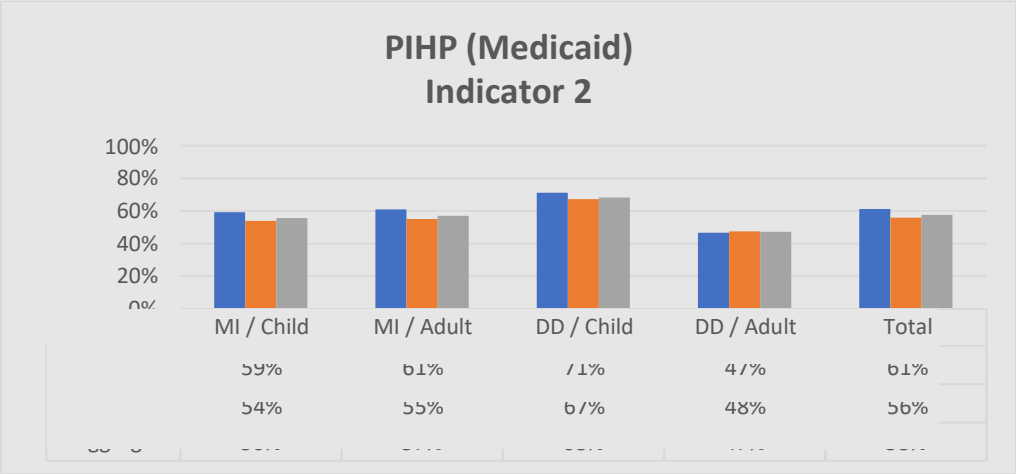
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Aggregate
	98.47%	98.71%	98.69%	99.32%	98.80%
	96.48%	94.73%	95.80%	95.25%	95.57%
	96.90%	95.48%	96.17%	95.95%	96.14%
Standard	95%	95%	95%	95%	95%

The percentage of persons during FY 2020 receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service. **Target Goal**: To achieve MDHHS established benchmark of *(95%)* for (4) quarters during FY 2020. **Results**: FY 2020 standard met for all populations with the exception of Q2 DD/Adult *(90.91%).* DWIHN falls below the threshold for Q2 (DD/Adult). To address this area, DWIHN will continue to evaluate applicable policies and procedures to more effectively support the evaluation and improvement of access and availability to the provider network. The goal will be to streamline data collection and evaluation efforts to enhance quality reporting. This will include exploring additional or new quantitative and qualitative assessment tools and metrics regarding accessibility.

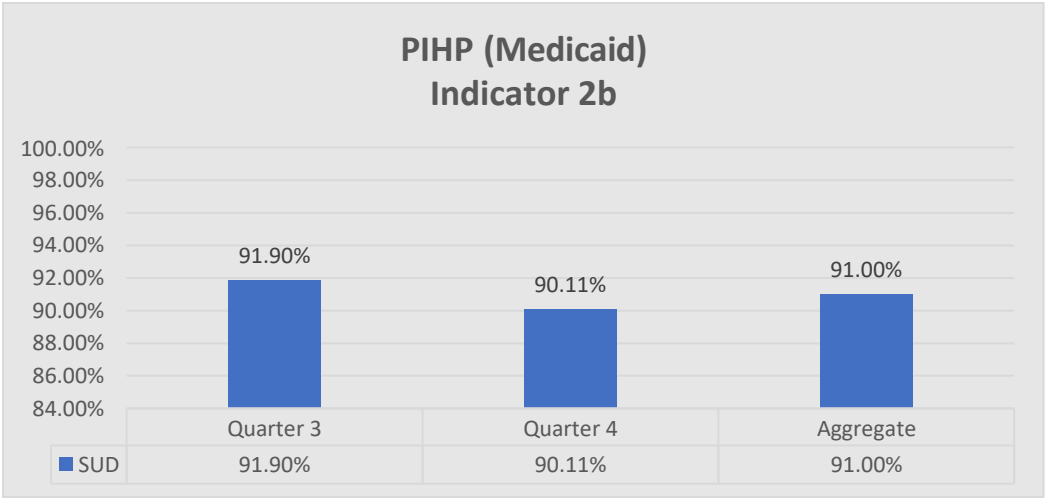


	SUD	MI/Child	MI/Adult	DD / Child	DD / Adult	Total Population
Quarter 1	99.13%	98.51%	95.52%	100.00%	100.00%	98.42%
Quarter 2	97.78%	97.60%	95.31%	100.00%	90.91%	97.47%
Aggregate	98.46%	98.13%	95.45%	100%	96.30%	97.99%
Standard	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%

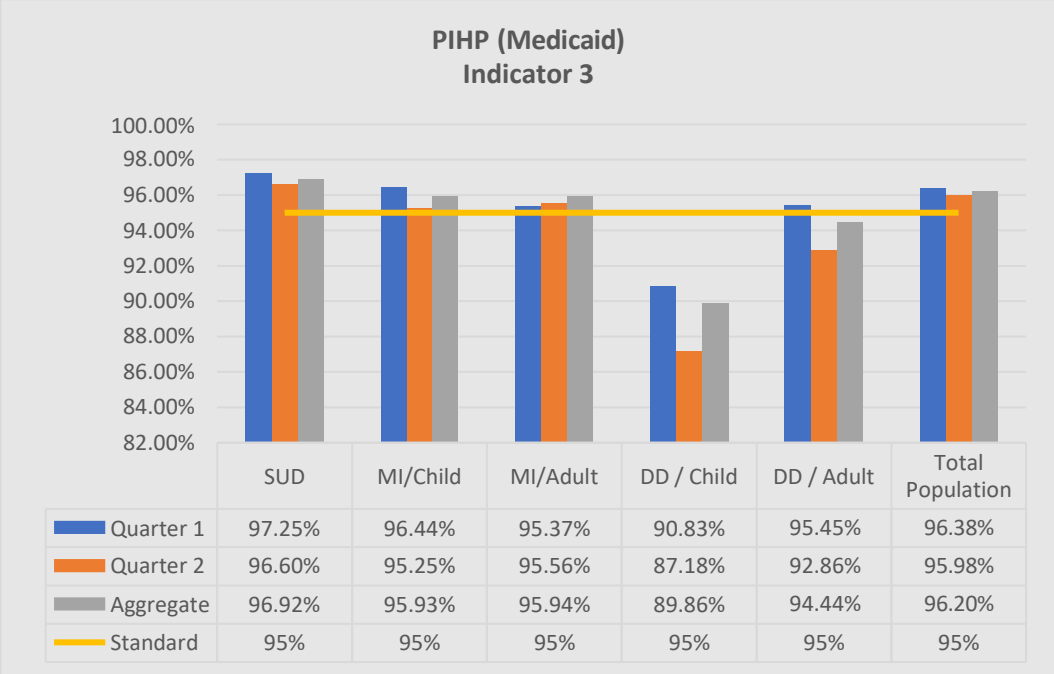
Beginning Q3 of FY 2020, a separate indicator was developed for new persons receiving a completed Biopsychosocial Assessment within 14 calendar days of a non-emergency request for service. There are no exceptions for indicator 2. No standard/benchmark for first year of implementation has been set by MDHHS.



Beginning Q3 of FY 2020, a separate indicator was developed for SUD for persons requesting a service who received treatment or supports within 14 days. There are no exceptions for indicator 2b. No standard/benchmark for first year of implementation has been set by MDHHS.

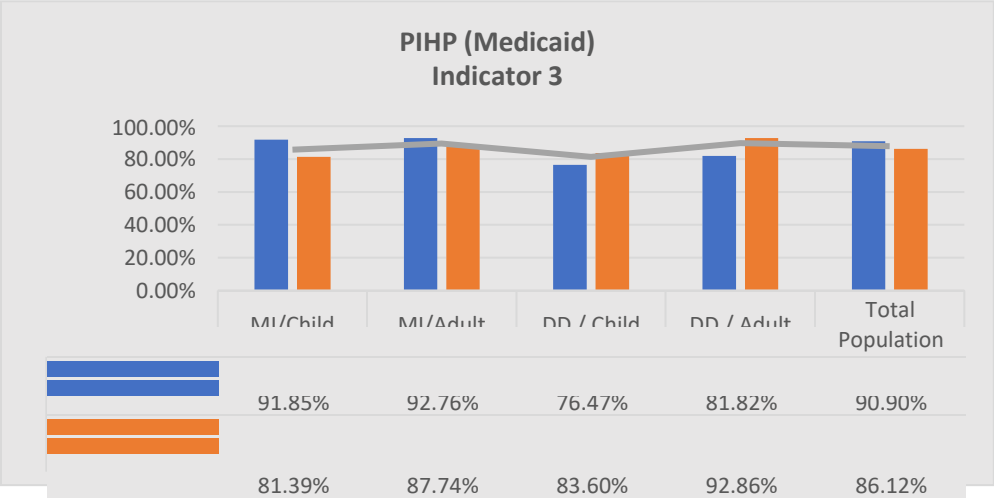


The percentage of persons during FY 2020 needed on-going service within 14 days of a non-emergency request for service. **Target Goal**: To achieve MDHHS established benchmark of *(95%)* for (4) quarters during FY 2020. **Results**: FY 2020 standard met for all populations with the exception of Q1 DD/Child *(90.83%),* Q2 DD/Child *(87.18%)* and Q2 DD/Adult *(92.86%).* DWIHN falls below the threshold for Q1, Q2 and Q3. To address these areas, DWIHN will continue to evaluate applicable policies and procedures to more effectively support the evaluation and improvement of access and availability to the provider network. The goal will be to streamline data collection and evaluation efforts to enhance quality reporting. This will include exploring additional or new quantitative and qualitative assessment tools and metrics regarding accessibility.



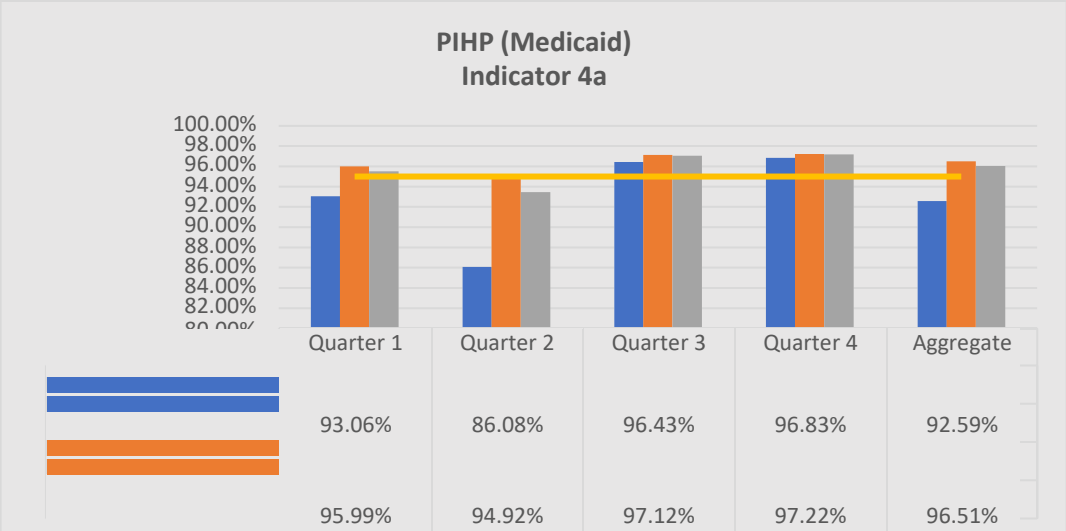
	SUD	MI/Child	MI/Adult	DD / Child	DD / Adult	Total Population
Quarter 1	97.25%	96.44%	95.37%	90.83%	95.45%	96.38%
Quarter 2	96.60%	95.25%	95.56%	87.18%	92.86%	95.98%
Aggregate	96.92%	95.93%	95.94%	89.86%	94.44%	96.20%
Standard	95%	95%	95%	95%	95%	95%

Beginning Q3 of FY 2020, a separate indicator was developed for new persons starting any medically necessary on-going covered service within 14 days of completing a non-emergent Biopsychosocial Assessment. There are no exceptions for indicator 3. No standard/benchmark for first year of implementation has been set by MDHHS.



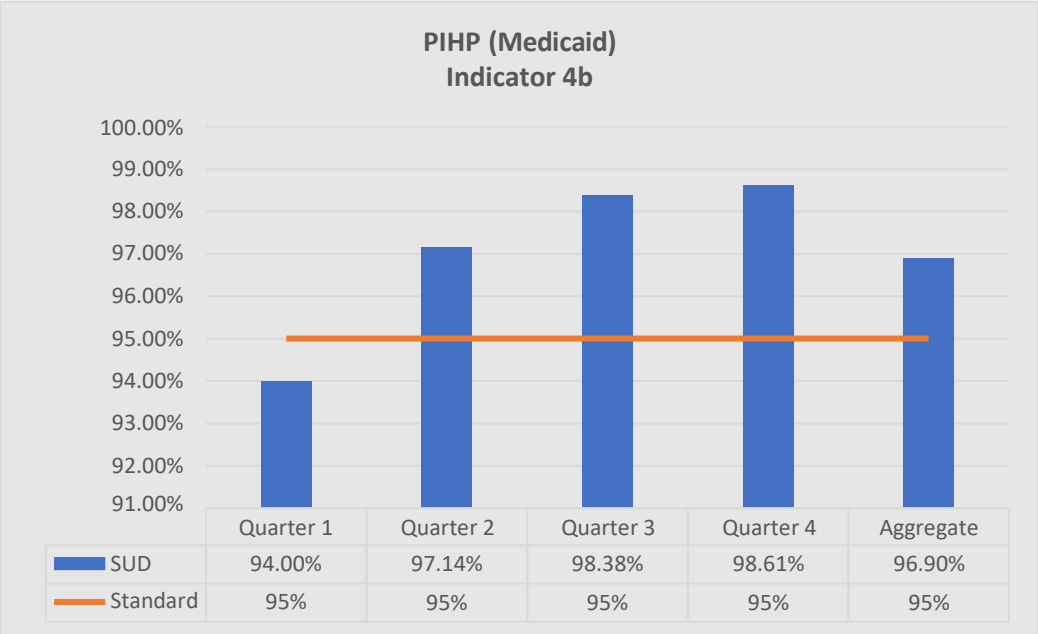
	MI/Child	MI/Adult	DD / Child	DD / Adult	Total Population
	91.85%	92.76%	76.47%	81.82%	90.90%
	81.39%	87.74%	83.60%	92.86%	86.12%
Aggregate	85.82%	89.50%	81.39%	89.74%	87.84%

The percentage of discharges from a psychiatric inpatient unit during FY 2020 who are seen for follow-up care within seven days. **Target Goal**: To achieve MDHHS established benchmark of *(95%)* for (4) quarters during FY 2020. **Results**: FY 2020 standard met for all populations with the exception of Q1 Child *(93.06%)*, Q2 Child *(86.08%)* and Q2 Adult *(94.92%).* DWIHN falls below the threshold for Q1, Q2 (Child) and Q2 (Adult). To address these areas, DWIHN will continue to evaluate applicable policies and procedures to more effectively support the evaluation and improvement of access and availability to the provider network. The goal will be to streamline data collection and evaluation efforts to enhance quality reporting. This will include exploring additional or new quantitative and qualitative assessment tools and metrics regarding accessibility.



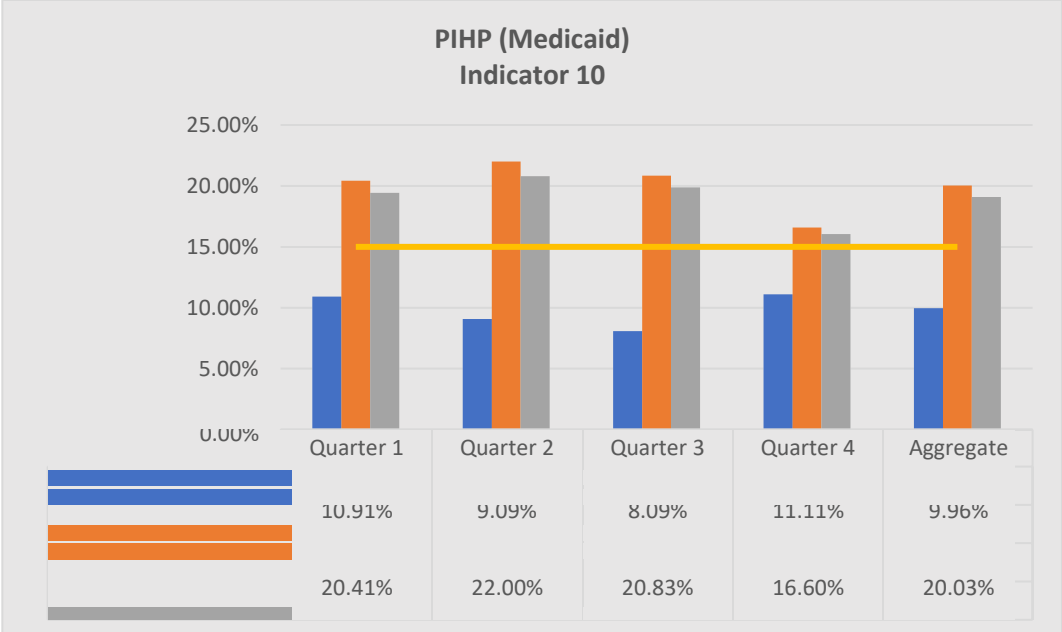
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Aggregate
	93.06%	86.08%	96.43%	96.83%	92.59%
	95.99%	94.92%	97.12%	97.22%	96.51%
	95.52%	93.45%	97.06%	97.19%	96.04%
Standard	95%	95%	95%	95%	95%

The percentage of discharges during FY 2020 from a Substance Abuse Detox Unit who are seen for follow-up care within 7 days. **Target Goal**: To achieve MDHHS established benchmark of *(95%)* for (4) quarters during FY 2020. **Results**: FY 2020 standard met for all populations with the exception of Q1 *(94.0%)*. DWIHN falls below the threshold for Q1. To address this area, DWIHN will continue to evaluate applicable policies and procedures to more effectively support the evaluation and improvement of access and availability to the provider network. The goal will be to streamline data collection and evaluation efforts to enhance quality reporting. This will include exploring additional or new quantitative and qualitative assessment tools and metrics regarding accessibility.



	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Aggregate
SUD	94.00%	97.14%	98.38%	98.61%	96.90%
Standard	95%	95%	95%	95%	95%

The percentage of readmissions of children and adults during FY 2020 to an inpatient psychiatric unit within 30 calendar days of discharge from a psychiatric inpatient unit. **Target Goal**: To achieve MDHHS established benchmark of *(15%)* or less for (4) quarters during FY 2020. **Results:** FY 2020 standard met for the children population. The standard was not met for the adult population for all quarters. DWIHN falls below the threshold for adult population. To address this area, DWIHN will continue to evaluate applicable policies and procedures to more effectively support the evaluation and improvement of access and availability to the provider network. The goal will be to streamline data collection and evaluation efforts to enhance quality reporting. This will include exploring additional or new quantitative and qualitative assessment tools and metrics regarding accessibility.



Evaluation of Effectiveness

During FY 2020, The state's overall benchmark of *(95%)* was met for each indicator for Quarters 1-2 with the exception of Indicators 4b (Q1) and 4a (Q2). During Q1, the score for indicator 4b was at *(94.0%).* On the contrary, during Q2, Indicator #4b increased 3.14 percentage points and was able to meet the state standard for the first time of FY 2020. During Q2, the score for Indicator #4a decreased by 2.07 percentage points and fell below the state standard to *(93.45%).* While our department does not want to ever see our numbers decrease, Q2 includes the timeframe when workplaces in the United States were transformed due to the COVID-19 Pandemic. Providers have reported some interruptions/delays with appointments in the middle/end of March 2020 due to closing of agencies and adjusting to telehealth services. Nonetheless, the performance improvements 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.

Barrier Analysis

DWIHN has failed to meet the threshold of *(15%)* or less for Indicator # 10 (Adult Recidivism) during the last four (4) quarters. Quarter 4 data has demonstrated an overall decrease in adult readmissions *(16.50%),* which is an average of *(4.6%)* less than the prior three quarters *(Q1 20.4%), (Q2 22%),* and *(Q3 21%).* This decrease is noted to ongoing efforts which include review of members that are recidivist. Indicator #10 increased by *(1.38)* percentage points in Q2 for adults readmitted within 30 days to *(22.0%),* the state standard is *(15%)* or less. There are several departments within DWIHN that continue to meet and complete work in an attempt to reduce the adult recidivism rates. This group continues to meet regularly and discuss action items. Network providers will be asked to complete a Plan of Correction again to ensure steps are taken to prevent numbers from increasing during Quarter 3. Efforts to decrease hospital admissions and readmissions continue to be a challenge for DWIHN. DWIHN Quality Improvement unit has established an internal workgroup to examine admission and readmission trends, conduct root cause analysis, identify opportunities for improvement and determine next steps.

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. Overall, when two or more indicators are missed, DWIHN implements a higher level of scrutiny, which requires the providers to submit monthly (and sometimes weekly) reports on their progress. DWIHN providers are required to submit the MMBPI tracking template monthly to ensure accuracy and outliers are being followed-up with on a timely basis. Quarterly data is compiled and sent to MDHHS on the last day of the 3rd month in each quarter.

Opportunities for Improvement

DWIHN has identified the following interventions and improvement efforts:

- Identification of members that are readmitted more than once during each quarter.
- Development of a Recidivism Workgroup which is a collaboration effort with Quality Improvement, Integrated Health, Access/Crisis and Clinical Practice Improvement 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), ACT or assigned to a Clinical Responsible Service Provider (CRSP).
- Engagement of the CRSP's to conduct Interdisciplinary meetings for members that have multiple readmissions.
- Monitoring of the Quality Improvement Project (PIP) data for improving the attendance at Follow-up Appointments with a Mental Health Professional after a Psychiatric Inpatient Admission.
- Providing technical assistance and training to our provider network as required.
- Review and monitoring of the correlation between Indictor 4a (follow-up care within 7 days) and Indicator 10 (Recidivism).
- DWIHN has also increased the frequency of analysis data during the Quality Operations Technical Workgroup and Performance Indicator meetings and sharing best practices across the network. This process has helped identify trends early on. DWIHN has also developed dashboards in the MHWIN system, that allow providers to access and review their own cases that are approaching the end of the follow-up period.
- Continue to ensure providers are meeting regulatory and DWIHN standards.

Improving Access to Substance Use Disorder

Activity Description

DWIHN SUD continuum of care consists of prevention, treatment and recovery services. DWIHN prevention programs address reducing childhood and underage drinking, reducing prescription and over the counter drug abuse/misuse, reducing youth access to tobacco, and reducing illicit drug use.

Quantitative Analysis and Trending of Measures

There were 7,355 individuals that received SUD services for FY20. This is a *(18%)* decrease from FY 19 with 8,943 individuals served. Consistent with the decrease in individuals served, there were 14,885 admissions, a decrease of *(19%)* from FY18 with 17,724 admissions. This decrease can be attributed to COVID-19 which greatly reduced the capacity of many providers to serve members in both residential and outpatient settings. The age distribution metric has remained relatively constant over the last several years. During FY20, *(68%)* percent of individuals admitted were between 25-54 years of age. Twenty-eight *(28%)* of individuals admitted were for 55+ years of age. Four *(4%)* were for individuals age 18-24, and less than *(1%)* were admissions individuals between 0-17.

DWIHN saw a reduction in three performance indicators (PI) in two fiscal years including the first quarter in 2020 that did not meet the threshold of *(95%)* compliance. Those indicators are # 2 Access 1st Request Timeliness, #3 Access/1st Services Timeliness and 4b SUD-Detox Discharges Follow -up. These PIs are being closely monitored by SUD and information technology staff. Previously DWIHN was looking only for residential admit within 7 days from detox discharge for compliance. Now DWIHN is looking for paid service units also in residential admits with service date within 7 days from detox discharge.

Evaluation of Effectiveness

DWIHN received a new indicator 3rd quarter of fiscal year 2020. The Percentage of Indicator #2e is always *(0.00%).* This is about the number of clients who were approved by DWIHNs access center for SUD Treatment but never received an admittance by any SUD Providers. The Michigan Department of Health and Human Services (MDHHS) asked the Pre-paid Inpatient Health Plans (PIHP) to give this number from 3rd quarter of FY2020.

Barrier Analysis

Withdrawal management services (WMS) previously detoxification, accounts for *(22%)* of admissions. If all levels of residential services are combined, it accounts for *(32%)* of admissions. Outpatient admits account for *(13%)* of admissions. Intensive Outpatient, IOP Level 1 through Level 4 account for *(8%)* of admissions. Admissions for Medication Assisted Treatment including methadone account for *(16%)* of admissions, followed by Recovery Services at *(9%).* (Note: some categories that are less than *(1%)* of whole, reflect *(0%)* even though there are admissions reflected in those categories). The percentage served in each category remains relatively consistent, and is correlated with the available capacity of the provider network. Even though number of members admitted was reduced overall, the level of care service mix remains consistent. Another barrier is that providers have neglected to input claims in residential admits after detox discharge. As a result, providers cannot enter service units in MHWIN without authorization approval. They are unable to mark this as an exception.

Opportunities for Improvement

DWIHN will continue to educate and improve understanding about substance use disorder, increase access to effective treatment and support recovery. Through working across the criminal justice systems, hospital settings, and other systems within Wayne County, DWIHN believes prevention works, treatment is effective and recovery is real! Our actions will continue to improve health and achieve excellence in operations.

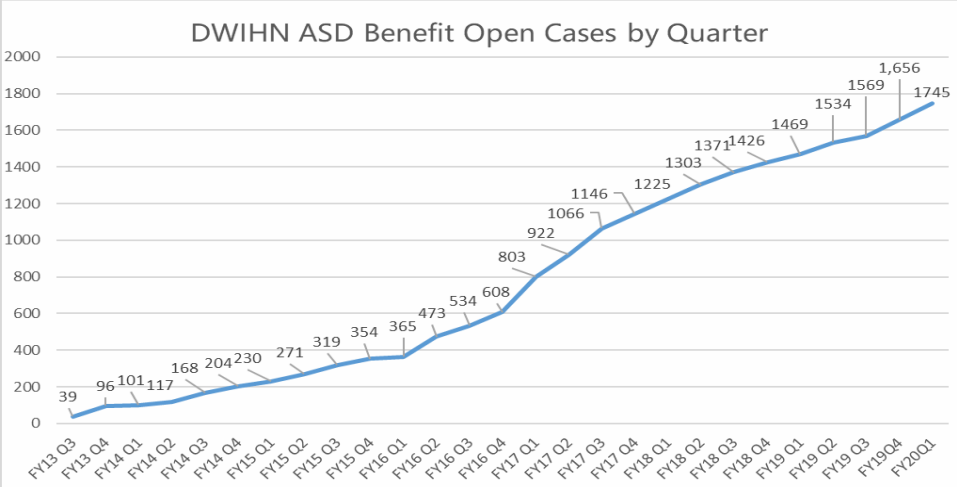
Improving Access to Autism

Activity Description

Another significant area in which DWIHN strive to improve is to increase the number of members who receive Applied Behavior Analysis (ABA) services from an ABA Behavior Technician within 90 days of the Michigan Department of Health and Human Services (MDHHS) approval.

Quantitative Analysis and Trending of Measures

FY20, there are currently 1,710 open cases of members receiving ABA services with the largest concentration of enrollees between the ages of two and seven compared to 1,659 in FY19. In FY20, referrals reduced by *(20%)* due to COVID-19. Timeliness of authorizations reached *(98%)* in FY 20. Overall, as illustrated below the numbers served over the past 8 years have increased substantially.



Evaluation of Effectiveness

DWIHN's ABA Benefit continues to grow each quarter for members enrolled in the ABA Benefit. DWIHN receives approximately 100 new referrals each month for the Benefit. DWIHN's ABA Provider Network continues to have an 8:1 or less ratio of staff to member. DWIHN added 2 new ABA providers during FY 20 for a total of 15 ABA providers throughout Wayne County. In addition, DWIHN hosted (2) two virtual trainings for the provider network on interpreting ABA Assessments, and Building Foundational Livings Skills. Each training highlighted a different focus area as well as provide the right tools and resources that providers can leverage to improve outcomes. The ABA providers are completing Authorization Approval documents in DWIHN's MHWIN system. This form details important information the Support Coordinators need in order to request authorizations in MHWIN for the ABA Benefit. This has increased communication between ABA Providers and Support Coordinators and decreased the return rate authorizations with errors. The ADOS-2 Worksheets and Behavior Assessment Worksheets have been added to MHWIN. Over the last fiscal year DWIHN has focused on improving data collection and analysis to enhance overall quality of care. Working in conjunction with the information technology department, authorizations are now automatically approved in accordance with the service utilization guidelines and providers are now capable of entering assessment data electronically.

Barrier Analysis

One of the major barriers is that DWIHN continues to struggle to provide services within 90 days of MDHHS approval (15:1 is the requirement set forth by the national guidelines of the Behavior Analysis Certification Board). Another barrier is that Behavior Technicians are unable to provide ABA Direct Services until IPOS and Authorization is input timely and BCBAs are expending time and energy into getting Support Coordinators to update IPOSs and input authorizations timely. DWIHN has a *(38)* percent denial rate and *(62)* percent approval rate for meeting ASD benefit enrollment criteria and Medical Necessity criteria for FY20.

Opportunities of Improvement

DWIHN is continuously striving to improve ABA services through focus areas and interventions. DWIHN identified a number of key areas of focus:

- Implemented systems process changes including: ASD Benefit Request Form, ADOS-2 Worksheet, Behavior Assessment Worksheet in MHWIN, and Auto-Authorization Approval Process.
- Added 2 additional ABA Providers to network.
- Provided 4 ASD specific trainings.
- Contracted with 2 Independent Evaluator Organizations to conduct initial ASD evaluations.
- Increase provider meetings to monthly to increase communication, education, and support for providers from DWIHN.
- Continue to meet with and contract with prospective providers to build provider network capacity.
- Encourage providers to increase number of consumers per BCBA to reach 15:1 ratio.
- Begin tracking number of Behavior Technicians in DWIHN's network.
- Continued training and technical assistance for supports coordinators submitting authorizations.
- Hosted Supports Coordinator Roundtable.
- Implemented Authorization Request for Form.

Habilitation Supports Waiver (HSW)

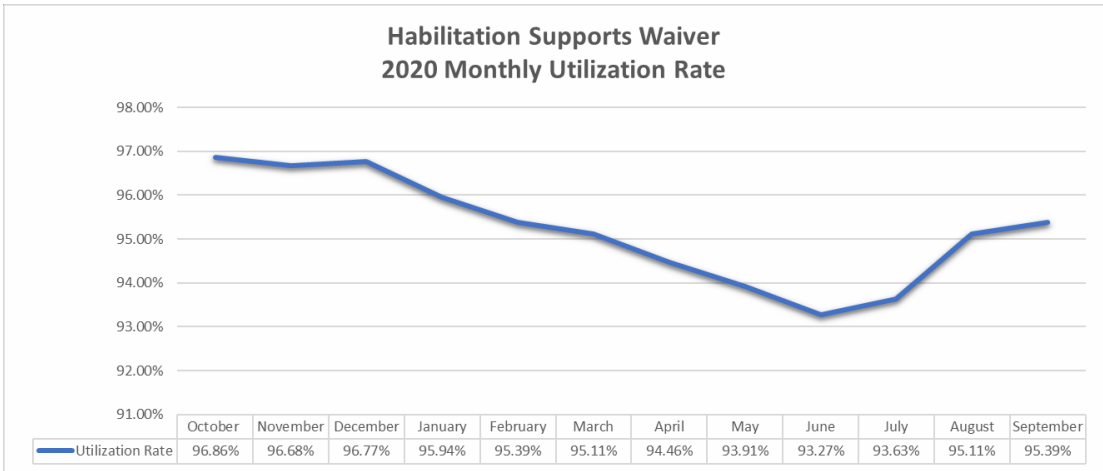
Activity Description

To improve service access to the Habilitation Supports Waiver (HSW) program, DWIHN took steps to modify the program's rate structure. In July of FY2020, an incentive program that provided a one-time payment of $1,000 per member was made available to contracted supports coordinator agencies. Additionally, these agencies began to receive an increased payment rate of *(7%)* for HSW billed services. Lastly, the HSW Program Coordinator performed Supports Coordinator Meetings and Technical Assistance Meetings throughout 2020. As a result of the incentives and meetings, DWIHN was able to change the HSW program membership downward trend that has been occurring over the last two years.

Quantitative Analysis and Trending of Measures

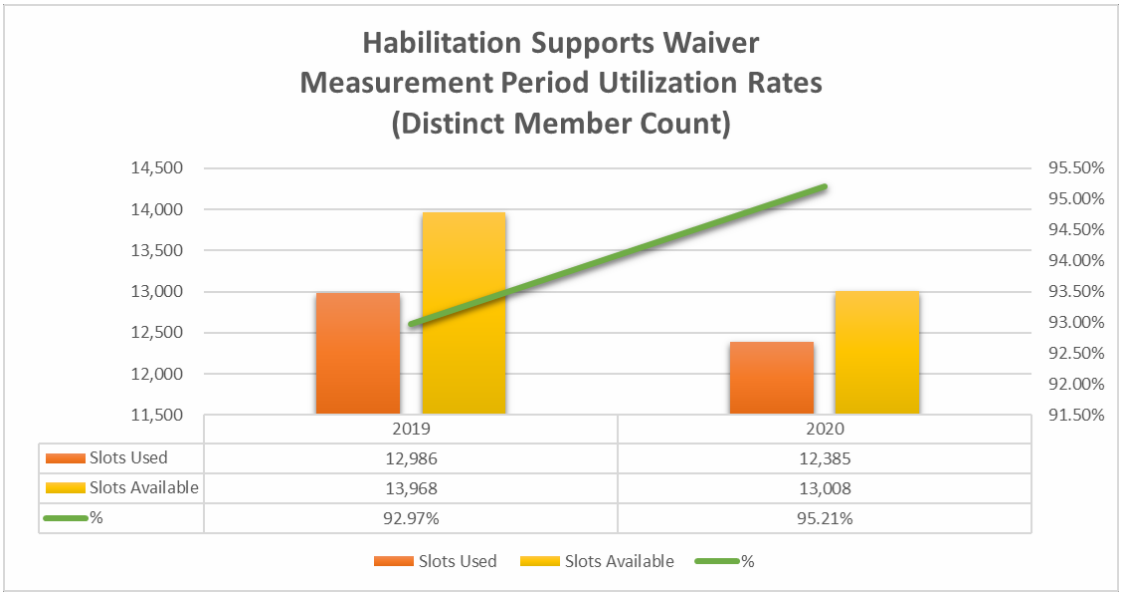
DWIHN's HSW program utilization rate and enrollment numbers have been decreasing the last three years. This struggle has led MDHHS to reducing DWIHN's number of allocated program slots in 2018 and 2020. At the beginning of the FY20, this reduction gave the illusion that the HSW program was running more successfully than it actually was. Table 1 shows the continuous decline in program enrollment from the months of October 2020 to June 2020. Key interventions (financial incentive and technical assistance meetings) were implemented in June 2020 and July 2020 and helped shift the downward trend. Table 2 shows how the overall utilization rate increased during FY2020 compared to FY19.

Table 1



	October	November	December	January	February	March	April	May	June	July	August	September
Utilization Rate	96.86%	96.68%	96.77%	95.94%	95.39%	95.11%	94.46%	93.91%	93.27%	93.63%	95.11%	95.39%

Table 2



	2019	2020
Slots Used	12,986	12,385
Slots Available	13,968	13,008
%	92.97%	95.21%

Evaluation of Effectiveness

During FY20, the Michigan Department of Health and Human Services (MDHHS) required a utilization rate goal of *(95%)* for all of its Prepaid Inpatient Health Plans' HSW Programs. DWIHN's HSW program utilization rate and enrollment numbers have been decreasing the last three years. This struggle has led MDHHS to reducing DWIHN's number of allocated program slots in 2018 and 2020.

DWIHN has been working on interventions to halt the declining HSW program members. The first half of FY20 continued the downward program membership trend. Key interventions, including the financial incentive program and technical assistance meetings that were discussed in the Activity Description section, were implemented in the second half of the year and changed the downward trajectory. They assisted DWIHN in finishing the year at a *(95.21%)* utilization rate for FY20. While FY20 had fewer slots available, DWIHN found it encouraging that the number of enrollees began to increase in the second half of the year. DWIHN will work to continue this trend in FY21.

Barrier Analysis

At the beginning of FY20, DWIHN had a number of barriers preventing the HSW program from meeting its *(95%)* goal. The first identified barriers included provider delays in application submissions; difficulties in completion of applications due to poor provider documentation; and low application numbers. DWIHN addressed this barrier by sending monthly reports to providers as well as implementing a Corrective Action Plan process.

A second set of barriers included lack of awareness among supports coordinators of the HSW program and its benefits; lack of knowledge and understanding of qualification criteria for the program; and lack of knowledge of the process for certification and recertification. Interventions to address these barriers included Supports Coordinators Trainings for providers as well as Technical Assistance Meetings at two providers who make up *(87.5%)* of DWIHN's HSW members.

The last set of barriers were providers' concerns regarding the additional cost associated with enrolling participants in the HSW program; supports coordinators vocalizing not having capacity to enroll members due to other duties; and HSW participants having more complex support and service needs. The intervention that was created to address these barriers was a financial incentive program.

Opportunities of Improvement

DWIHN has identified the following interventions and improvement efforts:

- Present this Quality Improvement Project to DWIHN's Improving Practices Leadership Team for any barrier ideas as well as for the project's approval.
- Explore pre-post tests and sign-in sheets at meetings with providers to ensure accurate attendance and learning.
- Send Corrective Action Plans to providers who are failing to meet deadlines or program requirements.
- Continue to facilitate trainings for new staff members as well as refresher trainings for experienced ones.
- Continue financial incentive program to assist providers with the additional costs of program enrollment and the complexity of members' service needs.

Children's Waiver Program

Activity Description

The Children's Waiver Program (CWP) makes it possible for Medicaid to fund home and community-based services for children with IDD who are under the age of 18 when they otherwise wouldn't qualify for Medicaid funded services.

Quantitative Analysis and Trending of Measures

During FY20, DWIHN had 36 children, youth and their families served by the different agencies on this waiver. On October 1, 2020, the Michigan Department of Health and Human Services (MDHHS) took steps to expand this waiver to an additional 50 children throughout the state increasing the available slots from 469 to 519, with an ultimate goal of 569 slots for the State of Michigan by the end of 2021.

Evaluation of Effectiveness

The School Success Initiative is offered by 11 Community Mental Health agencies in Wayne County and utilizes a three-tier universal health screening. Students that score in Tier 1 are eligible for stigma reduction services. Tier 2 students receive evidence based behavioral health supports and Tier 3 participants are linked to community mental health or private insurance for additional services. During FY20, 8,182 students received services at all 3 Tier Levels. A total of 16,792 services were delivered which included: case management, classroom observation, consultation, crisis intervention, family therapy, individual therapy, group therapy, psychoeducation, and others.

Additionally, funding for this project was given to Detroit Public Schools Community District (DPSCD) and the Goal Line. DPSCD provided services through social workers and nurses to students online or phone to general education students at Mason, Pershing, Dixon, Cody, Ronald Brown, and East English Village. They served 3,025 students in this project. Goal Line provided services to students in 14 schools and served 1,356 students with after school and busing activities. Ronald Brown, and East English Village. They served 3,025 students in this project. Goal Line provided services to students in 14 schools and served 1,356 students with after school and busing activities

Barrier Analysis

During FY20, four risk factors were identified to increase accessibility to children, youth and families. DWIHN staff collaborated with the Children's Community Mental Health (CMH) providers to enhance services to address the following identifiable risks:

- Depression and Anxiety*: 62%* of students experience symptoms of depression and *56%* experience anxiety.
- Bullying: *65%* have heard students called mean names and *71%* have heard rumors or lies being spread about others.
- Dating Violence: *33%* reported witnessing community or domestic violence*, 61%* have seen classmates get pushed, hit, or punched, *51%* heard others being threatened.
- Suicide: *31%* reported having thoughts of suicide or self-harm; *23%* reported having seriously thought about attempting suicide; one-third in grades 8-12 have considered suicide.

Children's Serious Emotional Disturbance Waiver (SEDW)

Activity Description

DWIHN is currently responsible for the assessment of potential SED waiver candidates. Wayne County currently has 5 SEDW providers providing this service; Black Family Development Inc., Development Centers, Southwest Counseling Solutions, The Children's Center and The Guidance Center. DWIHN is required to serve at a minimum 65 children and youth in this program. DWIHN exceed that number by providing services to 81 children, compared to 56 in FY19.

Evaluation of Effectiveness

In FY19, the waiver moved from a fee-for-service program to managed care payment. Additionally, the SEDW will be offered state wide, allowing young people to receive waiver services regardless of proximity within the State of Michigan. Two (2) new SEDW services will also be added to the array; Choice Voucher and Overnight Health and Safety Support. SEDW trainings were held throughout FY20 to both Department of Health and Human Services district offices as well as Wraparound providers within Wayne County. DWIHN trained 500 DHHS Specialist on the SEDW.

Crisis Services

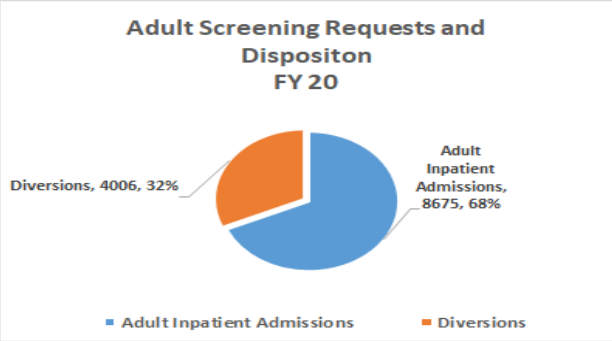
Activity Description

Access and Crisis Services works to ensure access to DWIHN's full array of services which includes the Crisis Continuum Service System. The department began working remotely in early March due to the COVID-19 pandemic. Access and crisis services across all programs decreased during the early months of the pandemic, however, volume began to consistently increase near the end of the 3rd quarter.

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.

Quantitative Analysis and Trending of Measures

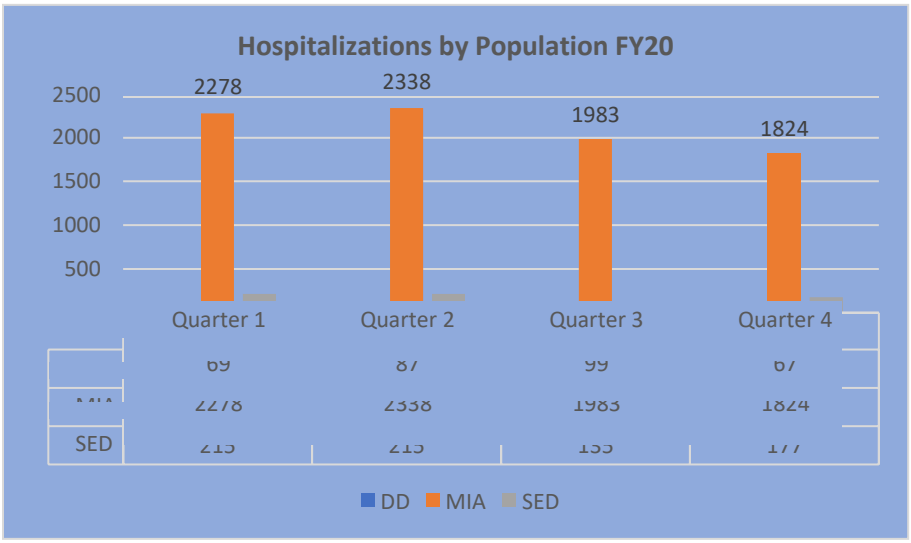
The following pie charts indicate the volume of requests for service received by COPE and the Children's Screening Entities. The screeners for children and adolescents are The Children's Center, The Guidance Center, and New Oakland Family Services. A preadmission review is conducted to determine need for hospitalization. Hospitalization is the most restrictive and expensive level of care. Diversions are not only cost effective but provide a less restrictive environment for consumers.



Evaluation of Effectiveness

The above chart shows that COPE screened 12,681 members. *(68%)* were hospitalized and the other *(32%)* diverted to the other levels of care which include outpatient, crisis residential, partial hospital, SUD residential, withdrawal management and other. The other referral categories may include home, health plan or other community resource. COPE also reported that 1277 (*10%* of members screened) had to wait more than 23 hours from time of request to time of placement. Additionally, 132 clients were admitted due lack of a crisis residential bed. This is reduced significantly from the previous year where 286 were admitted due to lack of a crisis residential bed in FY19. The data for Inpatient Hospitalizations indicates a decrease in number of admissions and unique members hospitalized during FY20 compared to FY19. This is consistent with decrease in overall members served this FY. When reviewing the percentage of Admissions per the number of members served for the past 3 fiscal years, the following emerges:

- FY18 DWIHN served 74,932 members and had 7860 members hospitalized for a percentage of *(10%).*
- FY19 DWIHN served 73,307 members and had 8757 members hospitalized for a percentage of *(12%).*
- FY20 DWIHN served 69,333 members and had 8149 members hospitalized for a percentage of *(8.5%).*



DWIHN continues to move forward in the planning and development of the Crisis Assessment Center. Plans for completion are scheduled for October 2022. DWIHN has worked with the Detroit Police Department (DPD) since FY19 to engage *(65%)* of the individuals in behavioral health services. Approximately of those individuals *(15%)* received long-term housing. COPE Leadership is a key contributor and has developed additional partnerships with the following law enforcement agencies: Canton, Grosse Pointe and Plymouth. Conversations are occurring with Romulus and Livonia to expand COPE services into those communities. In addition, documentation will assist in providing and Established "Crisis Alerts" in Member Records for identified recidivistic cases. The alerts assist crisis providers in coordinating services with the Clinically Responsible Service Provider (CRSP) for individuals experiencing crisis.

Barrier Analysis

Hospitalization is the most restrictive and expensive level of care. Diversions are not only cost effective but provide a less restrictive environment for member. As indicted above, Adults with Mental Illness account for *(89%)* of the 9487 hospital admissions. Children with Serious Emotional Disturbance account for *(8%)* of the hospital admissions, and individuals with developmental disabilities account for *(3%)* of the hospital admissions.

Opportunities of Improvement

DWIHN has identified the following interventions and improvement efforts:

- 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.
- Continue the Med Drop program which provides education about specific medications and assists in identifying and implementing organizational strategies for members to take their prescribed medications. Members that participate have a 90% or better medication adherence rate, a reduction in psychiatric hospitalization usage and in crisis home usage.
- Identify members who are recidivist in MH-WIN with a banner alert, allowing the assigned CRSP the ability to review and update member crisis plans as needed.

Quality Pillar

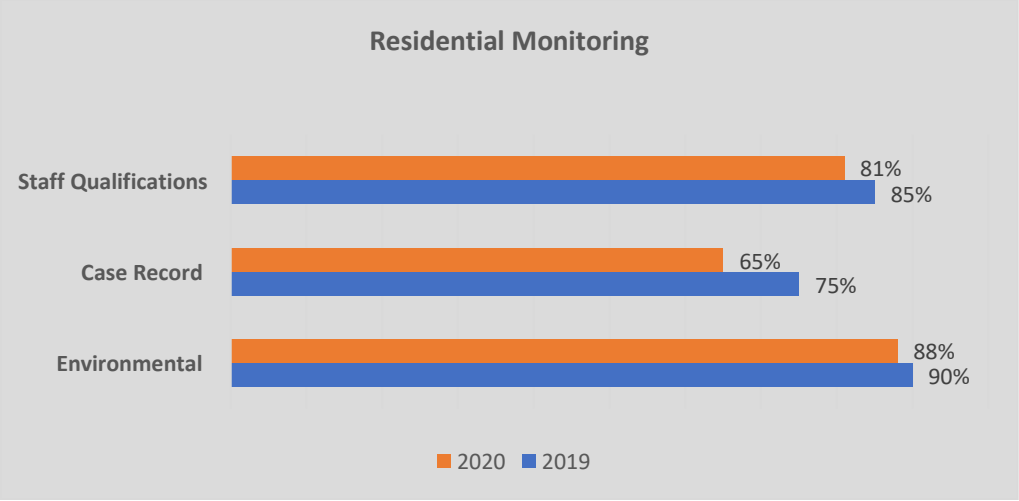
Monitoring and Oversight

Activity Description

Providers are monitored monthly, quarterly and as needed through the complaint threshold reporting for trends. The analysis allows DWIHN to determine if members have adequate access to care while ensuring compliance with state and federal statutes, the Michigan Department of Human and Health Services (MDHHS) contract, the Medicard Provider Manual, and NCQA requirements. DWIHN annually measures the provider network access across all programs against the established access standards. DWIHN collects and analyzes information using a sound data collection methodology that produces valid and reliable results.

Quantitative Analysis and Trending of Measures

During FY20, DWIHN staff conducted approximately *(65%)* of required reviews through virtual monitoring. Monitoring included SUD, CRSP and Residential providers. This is a substantial decrease from the previous fiscal year by *(15%)*. Scores for Residential Environmental Compliance ranged from (*77%-96%)*; with an average score of *(88%)*. Scores for Case Record reviews ranged from *9%* to *100%*; averaging *(65%).* Scores for Residential staff qualifications reviews ranged from (*39%-100%)*, with an average score of *(81%).* The chart below is an aggregate display of each area reviewed with a slight decrease from FY19.



Evaluation of Effectiveness

DWIHN continues to present trends of quality concerns to the Quality Improvement Steering Committee quarterly. The collaborative effort continues to identify that education is an important factor to informing providers, members, and community stakeholders about compliance. DWIHN has several forums to educate providers on performance measures, as well as provide the right tools and resources that providers can leverage. DWIHN maintains an adequate network of providers available to meet the needs of persons serve. DWIHN contract with all available providers in our service area if they meet our credentialing standards, are in good legal standing, and provide additional value to our network. DWIHN geographic adequacy analysis helped identify that DWIHN currently meets adequacy in the network. DWIHN also have been pioneering Telehealth services as ways to further expand accessibility for members.

Barrier Analysis

Each year the performance monitoring staff conducts reviews of provider services and programs. However due to the COVID-19 pandemic, all on-site Performance Monitoring reviews were suspended on March 11, 2020. Performance Monitoring Reviews resumed remotely on July 6, 2020. Since this time the performance monitoring staff has conducted approximately *(65%)* of required reviews through virtual monitoring. Areas that require improvement for Residential reviews for environmental, case record and staff qualification include the following:

- Ensuring that member's food choices are honored as evidenced by documenting chosen substitutions on posted menus.
- Ensuring that members have full access to their home as evidenced by no signs restricting their access; ensuring that members can safely exit the home in the event of a fire, as evidenced by correctly documented Evacuation Scores.
- Posting of emergency contact information on the dashboard of vehicles used to transport members; working Carbon Monoxide detectors in the bedroom hallways.
- Heat detectors in the kitchen; single motion door handles and current Material Data sheets for chemical products in the home.
- Making certain the records contain guardianship papers.
- Signed consent forms; a copy of the current signed IPOS.
- Evidence that staff were trained on the member's IPOS.
- Completion of I-9 verification forms at date of hire to verify staff's eligibility to work in the state of MI.
- Monthly Office of Inspector General (OIG) checks to ensure staff's ongoing eligibility to be paid using Medicaid dollars.
- Ensuring that staff have an emergency contact listed in their Human Resources file.

Opportunities of Improvement

DWIHN will continue to monitor the network to determine if additional contracts need to be executed to provide more access to services. DWIHN will also engage with providers to expand the behavioral health providers including diverse ethnic and cultural service. Further identification of these providers will provide a more personalized member experience. DWIHN will continue to evaluate applicable policies and procedures to more effectively support the evaluation and improvement of access and availability to the provider network. The goal will be to streamline data collection and evaluation efforts to enhance quality reporting. This will include exploring additional or new quantitative and qualitative assessment tools and metrics regarding accessibility. This will include continuing quarterly forums with member-facing staff to discuss the barriers and challenges members are experiencing while accessing care across our service provider network, especially ancillary providers. DWIHN's QI staff will continue to provide technical assistance during site reviews and make themselves available to help throughout the year as requested. Providers have access to DWIHN's Provider Notification Form to assist them with obtaining documentation from the Clinically Responsible Service Provider (CRSP).

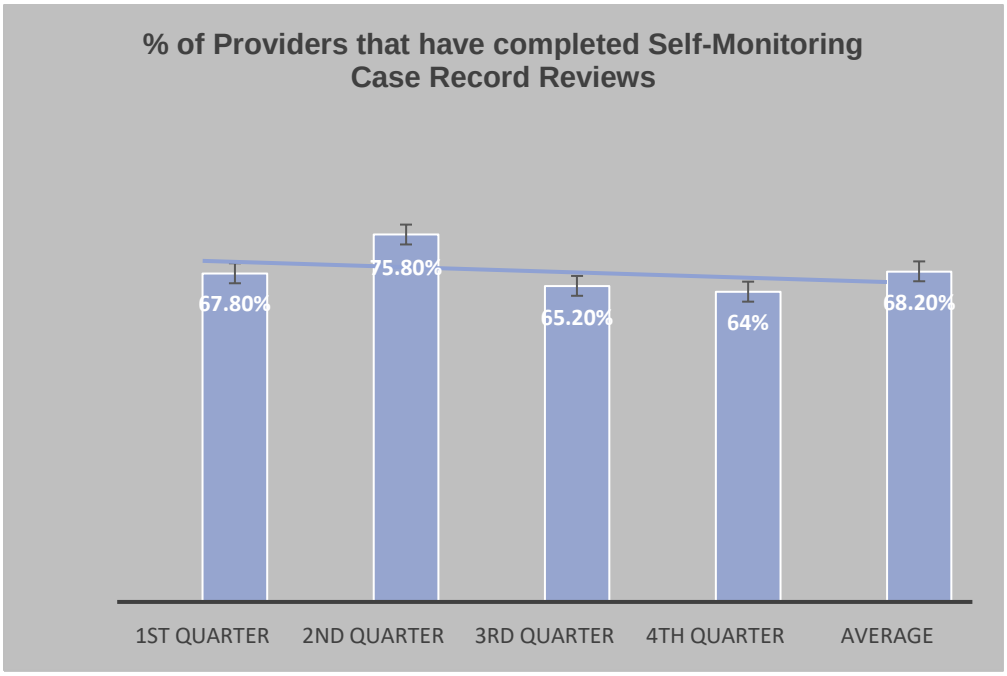
Performance Measurement Validation

Activity Description

As a component of the Continuous Quality Improvement (CQI) process, DWIHN implemented a provider self-monitoring plan. DWIHN developed and trained on a standardized monitoring tool 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 unit and other departments as needed.

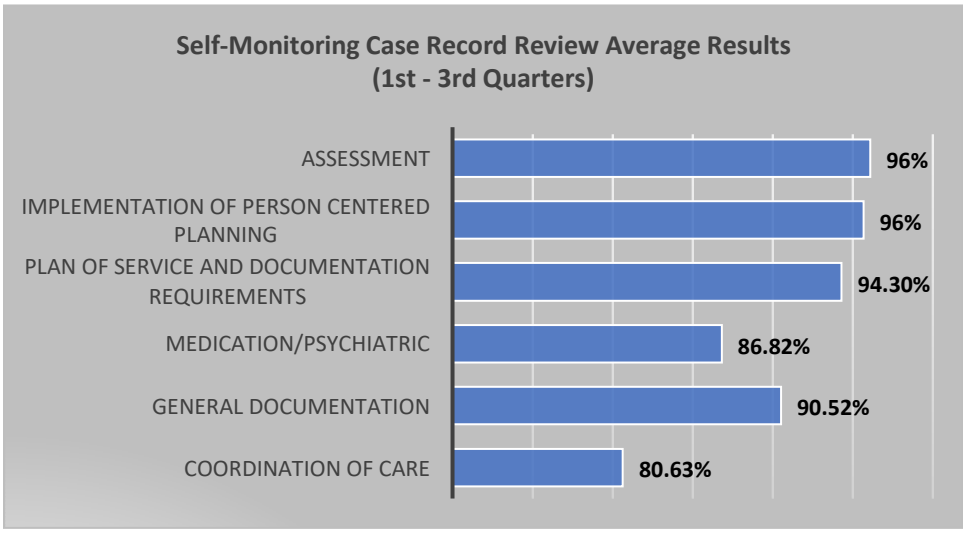
Quantitative Analysis and Trending of Measures

The chart below represents the percentage of providers that completed the quarterly case record reviews self-monitoring as required for FY20. The results demonstrate an increase in provider participation in Quarters 2 *(75.8%),* Q3 *(65.2%)* and Q4 *(64%)* The overall average increased from *(61.6%)* to *(68.2%).* This is a significant increase over previous years.



Evaluation of Effectiveness

The chart below represents the average compliance score for the selected areas for FY20, and received less than *(95%)* overall on Case Record Reviews. During FY20, compliance scores ranged from *(82%)* to *(100%),* which is a slight decrease from FY19. There was an increase in the Behavior Treatment Plan Score from previous year FY19, however the sample size is too small to draw an overarching conclusion. There was significant improvement in the areas of Wraparound and General Documentation while there was a decrease in Medication/Psychiatric and Coordination of Care. For FY20 the annual review findings focused on provider performance in the following areas; Person Centered Planning, Plan of Service Documentation, Medication/psychiatric, General Documentation and Coordination of Care.



Barrier Analysis

All providers were not completing the 35 case record reviews quarterly as required pursuant to the contract. In FY19, *(62%)* participated in the self-monitoring, compared to *(68%)* in FY20. QI will increase monitoring of provider's participation in the self-monitoring as part of the continuous quality improvement process (CQI).

Opportunities of Improvement

Quality Improvement staff will increase monitoring of provider's participation in the self-monitoring as part of the continuous quality improvement process (CQI). Quality Improvement staff will:

- Review a *(10%) sample* of the providers self-monitoring on a quarterly basis.
- Validate the self/monitoring activity submitted by the providers and identify patterns, trends and outcomes.
- Review the results with the provider, offer any needed technical assistance.
- Monitor for improved compliance as needed.
- Where there is ongoing inconsistencies and lack of improvements QI staff will collaborate between internal units to assist with improving outcomes.
- 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.

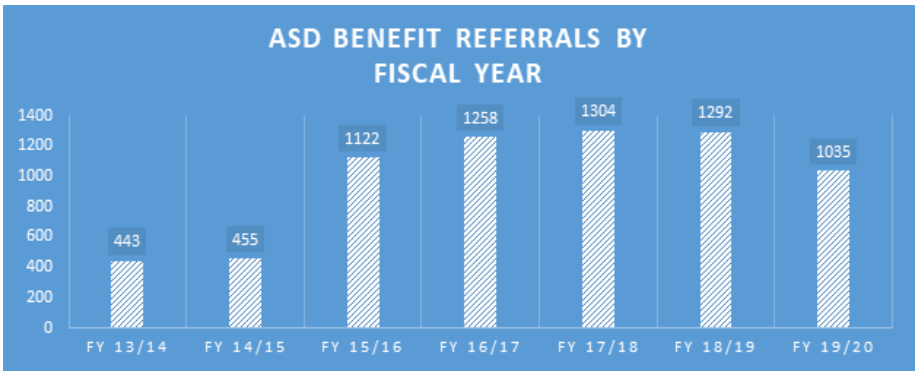
Autism Benefit

Activity Description

In FY20, DWIHN brought in review of medical necessity denials for Applied Behavior Analysis (ABA) services in order to achieve greater efficiency in processing denials and appeals. Reducing the number of delegated functions is not only cost effective, but positions DWIHN as a leader in integrated care.

Quantitative Analysis and Trending of Measures

The graph below indicates the number of referrals that DWIHN has in its provider network. There are currently 1,710 cases open in the ASD benefit. During FY20, *(98.4%)* of authorization reviews were completed in 14 days or less exceeding the NCQA standard timeliness disposition of *(90%).*



All referrals to the ASD benefit result in a member receiving direct services. A service of the benefit is completing evaluations to determine if a member meets criteria for the benefit. Members may be evaluated and found not eligible for the benefit or may meet criteria but decline services. As part of this system, electronic worksheets were developed to capture data from the evaluations and behavior assessments. Implementation of the electronic worksheets, has allowed DWIHN to resume responsibility in determining if a consumer meets medical necessity criteria for the ASD Benefit. Previously, DWIHN had delegated this responsibility to the service providers.

DWIHN QI 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 *(85%)* to *(100%),* compared to *(56%)* to *(82%)* for FY19. This is a substantial increase from the previous fiscal year.

Barrier Analysis

As is the case with many service areas, the ASD Benefit has been impacted by COVID-19. Historically, many of the service providers have only offered center-based treatment. At the onset of the pandemic in March 2020, many of the ASD Benefit services were initially not allowed to be provided via telehealth per MDHHS. After the onset of the pandemic, MDHHS quickly adjusted allowing nearly all ABA services to be administered via telehealth when clinically appropriate while also being more flexible on evaluation date requirements. While these changes were a tremendous help to the providers and consumers, some consumers opted to temporarily discontinue services until they felt they could safely receive services at the centers. Some consumers also chose to wait to pursue referrals into the ASD Benefit out of similar concerns. COVID-19 is likely a leading factor for the *(19.89%)* decrease in referrals from last year to this year.

Additionally, challenges remain in the following areas which had a combined score below the threshold of *(95%).*

- The annual consent for treatment is current, signed and dated.
- There is evidence the members Medicaid was active at the time of service delivery.
- The average hours of ABA services during a quarter were within the suggested range of service intensity *(+/-25%)*.
- 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.
- 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.

Opportunities of Improvement

To improve access availability 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.

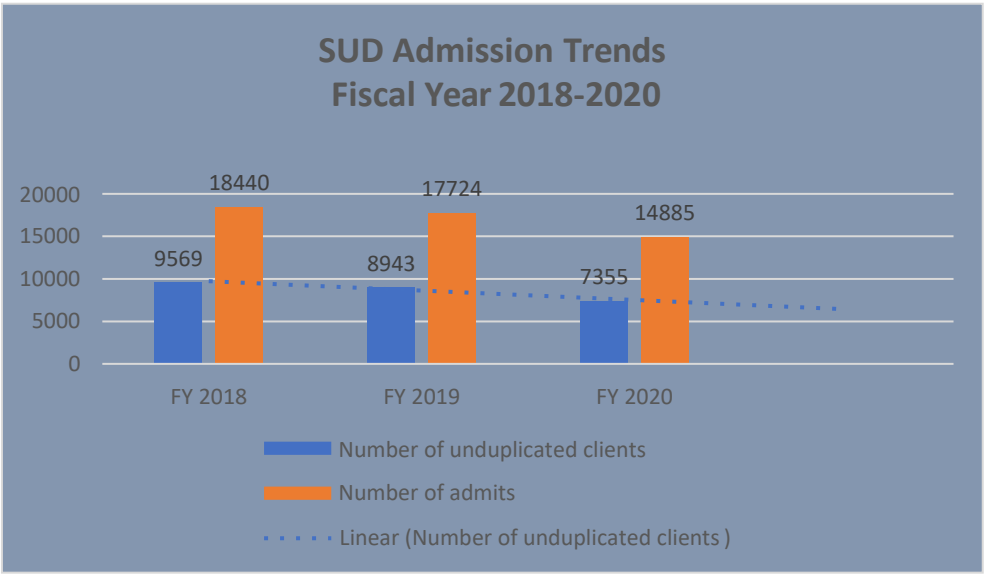
Substance Use Disorder (SUD)

Quantitative Analysis and Trending of Measures

In FY20, there were 7,355 members that received SUD services. This is a *(18%)* decrease from FY19 with 8,943 members served. Consistent with the decrease in members served, there were 14,885 admissions, a decrease of *(19%)* from FY18 with 17,724 admissions. This decrease can be attributed to COVID-19 which greatly reduced the capacity of many providers to serve consumers in both residential and outpatient settings. DWIHN QI staff completed annual reviews for *(100%)* of the SUD Treatment and Prevention providers for FY19 and FY20. The compliance scores range from *(86.0%)* to *(100%)* for FY20, compared to *(85%)* to *(100%)* for FY19 and *(90%)* to *(100%)* in FY18, which demonstrates a slight decrease from previous years. Each individual provider, obtain an overall aggregate score of *(96%)* for FY20, compared to *(97%)* for FY19, which met MDHHS established benchmark of *(95%).* Providers that have compliance scores of < *95%* are placed on Plans of Corrections (POC) in addition to requesting supporting documentation to support compliance. No CAPs were issued this year, due to no serious findings.

Evaluation of Effectiveness

The bar graph below shows the trend of admissions and the number of members served for the past 3 fiscal years. From FY18 to FY20, there has been a decrease in the number of individuals served. A large portion of the reduction in FY20 can be attributed to COVID. Each change in level of care is considered an admission. Some members receive more than one level of care, such as withdrawal management, followed by residential services and outpatient and/or recovery services.



The age distribution metric has remained relatively constant over the last several years. During FY 20, *(68%)* percent of individuals admitted were between 25-54 years of age. Twenty-eight *(28%)* of individuals admitted were for 55+ years of age. Four *(4%)* were for individuals age 18-24, and less than *(1%)* were admissions individuals between 0-17.

Barrier Analysis

No barriers have been identified at this time.

Opportunities of Improvement

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

Critical/Sentinel Events Reporting

Activity Description

The processing of Critical/Sentinel Events is one element for identifying member safety and risks.

Quantitative Analysis and Trending of Measures

DWIHN processed a total 4,731 Critical/Sentinel Events in FY20, which is a decrease of *(49%)* in FY18. The change from FY19 reflected a *(19%)* decrease. With the highest category being Serious Challenging Behavior (815); the next top category is Physical Illness Requiring Emergency Room (634); and the lowest number of critical incidents is Medication Error (27).

Evaluation of Effectiveness

The reduced number of critical/sentinel events reporting can be attributed to member-specific, provider-specific and trend analysis and network trainings, which is required for access to utilize DWIHN's Critical Sentinel Event module. DWIHN has provided ongoing trainings and technical assistance to our provider network on reporting requirements as outlined in Critical/Sentinel Event Policy/Procedures.

The Critical/Sentinel Event training was provided for DWIHN's Clinically Responsible Provider (CRSP) Staff and Specialized Residential Providers. A total of 364 staff throughout the provider network participated in the training. Between October 1, 2019 through March 10, 2020 all trainings were held face-to-face; and beginning May 14, 2020 through September 30, 2020 trainings were conducted via the webinar platform.

The Training Manual was updated providing comprehensive instructions to the provider staff and guidance in the entry of critical/sentinel events. Technical assistance has been increased to ensure that all required reporting is complete, timely, and correct. Together the Quality Improvement unit has assisted in ensuring the updating/upgrading of all aspects of training and review in order to capture trends and patterns which ultimately impact the quality of services to our members.

Barrier Analysis

Per a recent Health Service Advisory Group (HSAG) External Quality Audit, it was determined that risk event analysis needs to be conducted on a more frequent basis. Also, Critical incidents are being reported to MDHHS for Emergency Medical Treatment outside of the 60 days window time frame required. A process has been established to begin collecting this information during FY 2021.

Opportunities of Improvement

To improve contractual compliance issues related to reporting requirements that DWIHN did not adhere to the following interventions and strategies have been established:

- DWIHN has designated an assigned staff to monitor and review the five (5) reportable MDHHS required events on a daily basis to ensure the reporting is completed within the required timeframe.
- Conduct an in-depth review of providers who consistently report minimal or no critical incidents, sentinel events, or risk events.
- Review events related to substance use disorder (SUD) providers and members receiving SUD services.
- The Medical Director will review case findings and determine if a same and similar specialty review is required. (Consult an external expert in the specialty of medicine needed for the review).
- The Medical Director will also review case findings and determine if actions/review is needed.

Behavior Treatment Advisory Committee (BTAC)

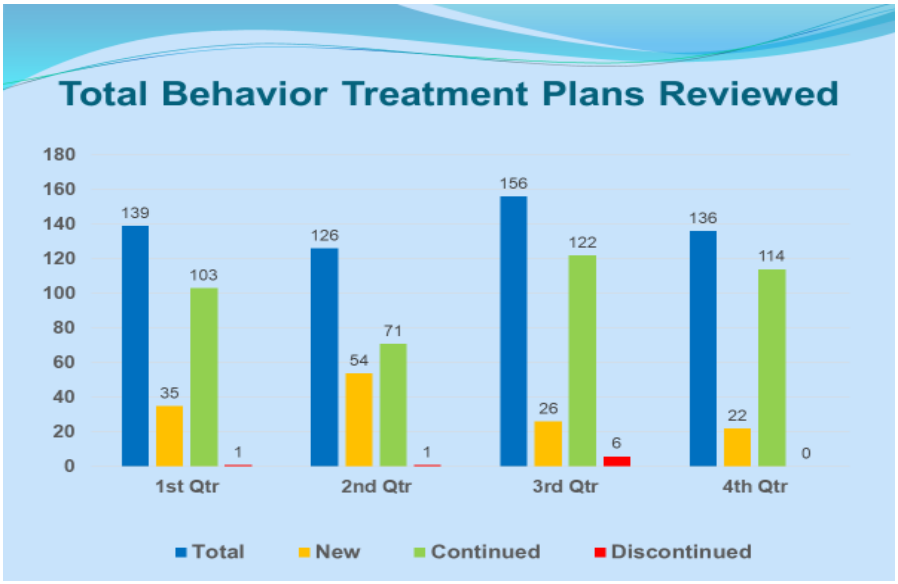
Activity Description

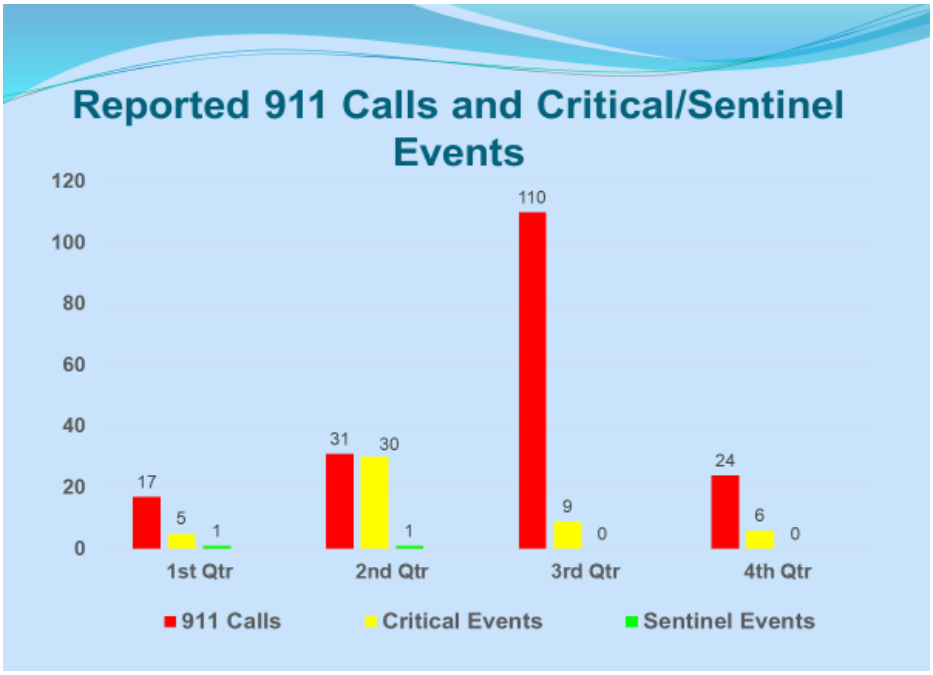
The QAPIP quarterly reviews analyses of data from the Behavior Treatment Review Committee (BTRC) where intrusive or restrictive techniques have been approved for use with members and where physical management has been used in an emergency. The data track and analyze the length of time of each intervention. The Committee also reviews the implementation of the BTRC 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.

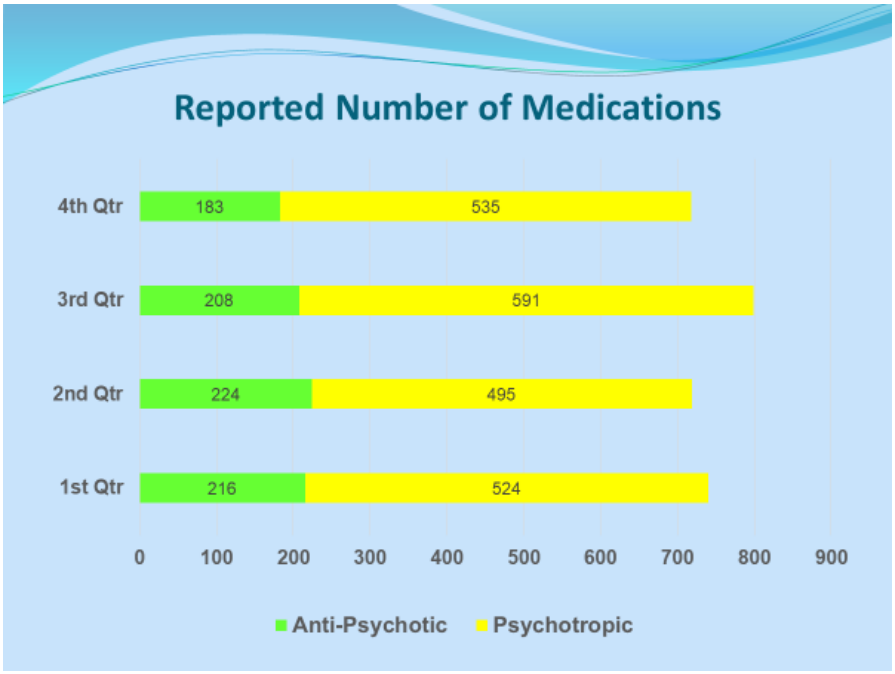
Quantitative Analysis and Trending of Measures

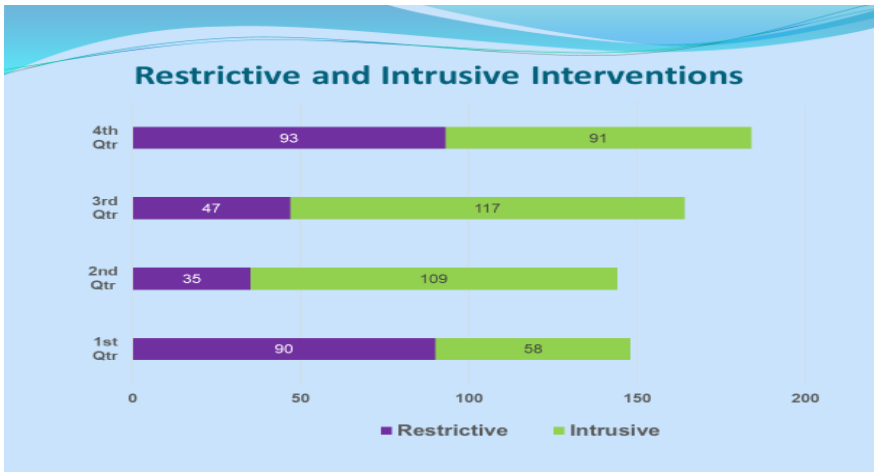
During FY20, DWIHN hosted the largest in-house Behavior Treatment training with MDHHS attended by 112 participants. As a step towards improving the monitoring of case records, a notification banner for each member on a Behavior Treatment Plan has been added to DWIHN's Mental Health Wellness Information Network (MH-WIN). During the pandemic of COVID 19, DWIHN issued HIPPA safe remote review and approval guidelines to network BTPRCs to ensure the continuation of the Behavior Treatment Review process.

In FY20, DWIHN BTPRC reviewed 557 members on Behavior Treatment Plans which is an increase of 24 *(4.3%)* 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 charts below illustrate the BTAC Summary of Data Analysis FY20.




Reported 911 Calls and Critical/Sentinel Events
120
100
80
60
40
20
0
17
5
1
31
30
1
110
9
0
24
6
0
1st Qtr
2nd Qtr
3rd Qtr
4th Qtr
911 Calls
Critical Events
Sentinel Events


Reported Number of Medications
4th Qtr
183
535
3rd Qtr
208
591
2nd Qtr
224
495
1st Qtr
216
524
0
100
200
300
400
500
600
700
800
900
Anti-Psychotic
Psychotropic



Evaluation of Effectiveness

DWIHN's Behavior Treatment Advisory Committee (BTAC) ensures that each Mental Health Clinically Responsible Service Provider (CRSP) submit BTRC data via the BTPRC Data Spreadsheet quarterly. This information is reviewed quarterly during BTAC meetings, and selected cases on the appropriateness of interventions are selected for BTAC review. As a step towards the continuous improvement of Behavior Treatment Review services, DWIHN issued a HIPPA compliant remote review and approval guidelines to the network BTPRC to ensure the continuation of the Behavior Treatment review services. As a step towards improving the monitoring of case records, a notification banner for each member on the Behavior Treatment Plan has been added to DWIHN's Mental Health Wellness Information Network (MH-WIN) to reflect any paid authorization of H2000 services within past 365 days. The Behavior Treatment Category is now available in MH-WIN Critical and Sentinel Reporting Module to improve the systemic under-reporting of 911 Calls, Deaths, Emergency Treatment, and Use of Physical Management, for the members on Behavior Treatment Plans.

Barrier Analysis

There is a lack of formal transition planning at the system level for the members enrolled in Michigan Autism Benefits as they reach 21 years of age, and the Autism Benefit is discontinued. There is clinical evidence that when the ABA benefit ends, the behavior escalates. The data indicates that these individuals are high utilizers of emergency hospitalizations as MI Adults. Some of these individuals may benefit from the Home Help program of MDHHS, Habilitation Supports Waiver program, and some of them may have a better transition with the help of BTP. Another barrier is that in-service for direct care staff is not always provided by the appropriately licensed Clinically Responsible Service Provider staff on implementing the Behavior Treatment Plan. Lastly, per a recent Michigan Department Health and Human Services (MDHHS) Audit, it was determined that the Behavior Treatment Plan and Review Committee (BTPRC) process failed to include all of the elements as required by the Technical Requirement for Behavior Treatment Plan Review Committees. A process has been established to begin collecting this information from the Clinically Responsible Service Providers (CRSP) during FY 2021.

Opportunities for Improvement

DWIHN has identified the following interventions and improvement efforts:

- Ensures the Supports Coordinator or Case Manager provide the Individual's IPOS and ancillary plans, before delivery of service at the service site.
- Ensures IPOS and Behavior Treatment Plans are specific, measurable, and are updated and revised per the policy/procedural guidelines.
- Conduct a training for network providers on the Technical Requirements of Behavior Treatment Plans.
- To implement a system-wide process for Behavior Treatment reviews.

- To improve the under-reporting of the required data of Behavior Treatment beneficiaries that includes 911 Calls, Deaths, Emergency Treatment, and Use of Physical Management.
- Case Validation Reviews of randomly selected cases as a step towards continuous quality improvement at PIHP level.
- To ensure the BTPRC requirements are included in the CRSP written contract for FY21

Workforce Pillar

Activity Description

To ensure a network of qualified practitioners, DWIHN utilizes Detroit Wayne Connect (DWC) for ongoing training requirements. 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).

Quantitative Analysis and Trending of Measures

In FY20, 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 2019. In the fiscal year of 2020, a total of 1,980 calls were made/received between October 1, 2019 and September 30, 2020. Call volumes decreased from the previous fiscal year. As a result of COVID-19, the monthly call volume decreased significantly beginning in March 2020. The March call volume (167 total calls) decreased by 165 calls compared to February 2020 (332 total calls). Beginning March 13, 2020, DWIHN ordered all employees to work from home. Many organizations utilizing Detroit Wayne Connect temporarily closed as well, decreasing the number of inquiries received by the helpdesk. The DWC helpdesk remained functional, and efficiently worked to resolve user issues.

Evaluation of Effectiveness

DWIHN's Naloxone Imitative program has saved 660 lives since its inception, which demonstrates additional 183 lives saved in FY20. DWIHN only reports those saves that we have documentation to support this initiative. Core Competency trainings continued to be held at the provider level throughout the year with the help of certified trainers who provide training to all Community Mental Health (CMH) children's clinical staff. This year 179 staff received training on 7 foundational components: CAFAS and PECFAS, Crisis and Safety Plans, Family Service Plans, Measurable Goals/Objectives, Strength-Based Assessment, Supervision and Systems of Care 101.

DWIHN's partnering provider network are working very closely with law enforcement to ensure individuals are assessed and reengaged with community behavioral treatment services. There has been much discussion around court-diversion services, thus, connecting the MHJN with Mental Health Court Dockets ensuring in-reach and out-reach continues for those with behavioral health challenges. Treatment outcomes have been successful, at least *(60%)* remain connected with their community behavioral health provider, and have not returned to the Wayne County Jail during the period of October 2019 – September 2020.

Last fiscal year the division supported over 89 events that had a cumulative number of 4,470 attendees. Pre-COVID, from October 1, 2019 through beginning March 9, 2020, prior to the shutdown, we impacted 1,351 individuals via training. After going virtual via BlueJeans, we impacted nearly 3 quarters more through September 30, 2020, with a cumulative number of over 3,119 attendees at events for this period. This number excludes internal events such as board meetings, HR trainings, etc.

In FY20, the use of the BlueJeans teleconference application has increased substantially. DWIHN began transitioning its in-person activities to remote/virtual activities. The Bluejeans platform has been an invaluable component in helping the department achieve its goal to maintain a high level of productivity in this new work environment. It has become the primary means for hosting DWIHN Board & committee meetings and public-facing meetings. For example, in the 5 months prior to COVID19, fewer than 50 meetings/trainings were conducted using Bluejeans. In the 8 months since, 20,606 individuals have participated in 2,411 meetings/training from 20,400 different endpoints. This accounts for nearly 1,018,000 minutes spent in those meetings. Further, 355 meetings have been recorded and viewed 611 times and 12 shared throughout the network. Over 8,000 individuals were reached through the social media Adolescent Engagement sessions. The activities and webinars aim to get adolescents engaged during the COVID-19 pandemic. As a result, a weekly web series was created to get adolescents engaged.

DWIHN established a Racial Equality Committee of DWIHN employees to discuss racial equality in the workplace. Staff Developed and implemented first adult focused Transgender affirmative care conference. Delivery of affirming care for individuals that identify as transgender, lesbian, gay, bisexual, queer, intersex, asexual, two-spirited, plus additional identities not included in current discourse. An emphasis on clinical care with transgender identified individuals was provided to practitioners to ensure that services are delivered in a respectful and safe manner within our system of care.

Barrier Analysis

Fentanyl remains the driving force in the drug overdose deaths. COVID 19 impacted the outcomes of our data. The DWIHN Naloxone Initiative program has saved 660 lives since its inception, this number is based on documentation up to September 30, 2020.

Opportunities for Improvement

DWIHN has identified the following as opportunities for improvement:

- Conduct training of Network Staff on how the practice will use social needs data to improve member health.
- Deliver Stage Wise Treatment Education.
- Expand the NAMI relationship to provider community-based education and training.
- Increase Integrated Care Competencies of the network practitioners.
- Increase Quality Improvement competencies of the network practitioners.
- Increase self-care for Caregivers / MyStrength implementation.
- Increase the competencies around Self-Determination, Shared Decision Making and Person-Centered Planning.
- Revamp training portal to cover the holistic care for the member.

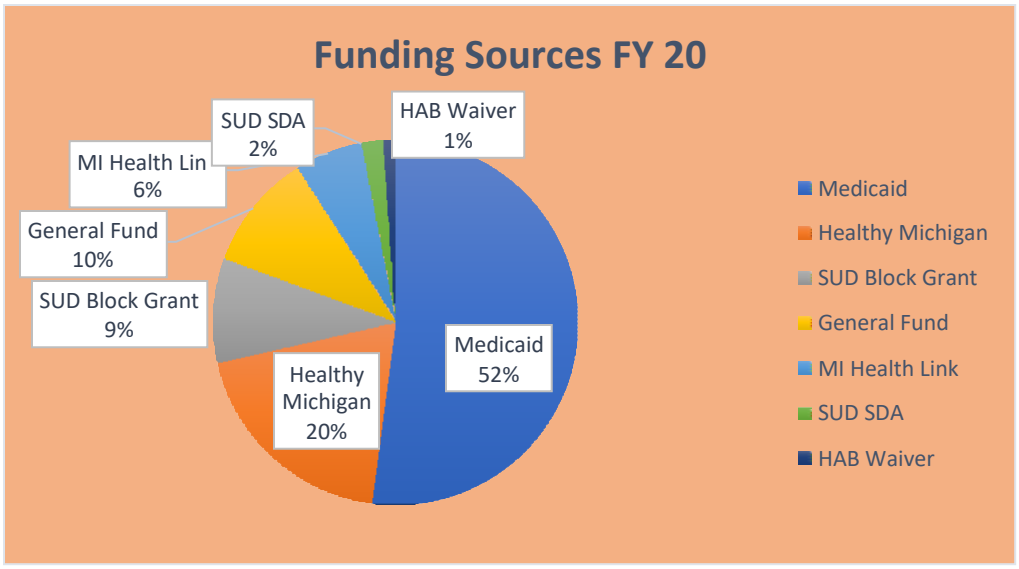
Finance Pillar

Activity Description

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.

Quantitative Analysis and Trending of Measures

The chart below indicates funding sources utilized to pay for an individual's service in FY 20. It combines general Medicaid, Healthy Michigan, Habilitation Waiver and other waiver programs which are all Medicaid, accounting for *(73%)* of the funding source utilized. Block Grant and State Disability Assistance (SDA) which is used to pay for SUD and Room and Board with Substance Use Disorders is reflected as funding sources totaling *(11%);* decreased from *(18%)* last fiscal year. General Fund is reflected at *(10%)* (changed from *9%*) and MI Health Link is at *(6%)* (a change from *5%*). The funding source mix is very similar to last year. Further analysis is required to determine if funding source impacts overall utilization.



During FY20, DWIHN Quality Improvement staff completed 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. It is also the department's goal to share the over and under-utilization of codes and services within the next fiscal year.

During FY20, the UM department approved 4,014 General Fund Exception authorization requests for a range of outpatient services for SMI, SED and IDD consumers. There was an additional unknown number of requests that were *not* approved because of eligibility or inadequate information or over usage issues. An additional unknown number of automated General Fund Exception approvals were generated through HIE at the time of the IPOS, beginning in August 2020.

The General Fund requests approved during FY20 represents a *(71%)* increase from the 2,346 approvals during FY19. That number was a marked increase from FY18, when 827 approvals were processed. Each of these increases are a result of the introduction of General Fund authorization requests that are submitted via MH-WIN, beginning October 2018.

Opportunities of Improvement

- 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 identified and forwarded to Quality for investigation.

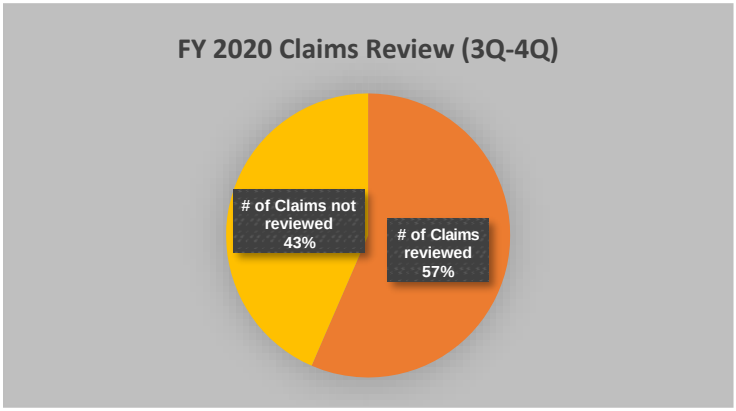
Medicaid Claims Service Verification

Activity Description

DWIHN is required to perform annual Medicaid Claims Service Verification audit to access the validity of claims and encounters submitted by Network Providers. Rat-Stat Variable Sample Size Determination, and Unrestricted Probe Sample module is used to determine the sample size.

Quantitative Analysis and Trending of Measures

In FY20, DWIHN conducted two (2) separate Medicaid Claims Verification audits. DWIHN reviewed a total of 923 claims through the Medicaid Claims Verification Review process, compared to 1,204 for FY19, which demonstrates a significant decline from the previous year. Of those159 were not validated due to the lack of evidence to support the claim, compared to 253 in FY19. For Quarters 3-4, it was decided that the focus of the reviews would include providers that had not been reviewed during the 1st and 2nd Quarters of FY20. This left a total number of 92 claims for review, of which 40 *(43%)* were not validated as illustrated below.



Evaluation of Effectiveness

As part of the audit, DWIHN staff pulled from the claim sample those providers who were on plans of correction from 2018/2019 fiscal year to assess current performance. There was a total of 38 providers and 159 claims in this group. There was six (6) providers of the 38 still on plans of correction during FY20. A further quantitative analysis for FY 2020, for Quarter 1-2, of the randomly selected providers, *(89%)* scored *(95%)* or better, *(10%)* were non-compliant scoring less than *(95%),* and *(1%)* failed to submit required documentation which will result in full recoupment of funds related to the claim. As for Quarters 3-4, 21% of the providers reviewed were non-compliant or failed to submit required documentation to support claim.

Barrier Analysis

The Medicaid Claims review process was impacted by the COVID 19 pandemic. DWIHN staff had to alter the site review process to virtual reviews and desk audits from home. Providers were responsible for displaying documentation virtually, by secured mail or electronic submission in MHWIN. Due to the pandemic there were providers that were closed for an extended period of time, and some providers for the entire duration of the review period.

Performance Improvement Projects

Activity Description

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 measurable) 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.

Quantitative Analysis and Trending of Measures

DWIHN has seen a decrease of the HEDIS measurement from the previous FY18 of *(35.78%)* with a goal of *(45%)* 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 chart below illustrates the quantitative analysis of the HEDIS measurements and the interventions used to achieve improvement in quality of care.

Time Period	Measurement	Numerator*	Denominator*	Rate	Goal	Comparison to goal
1/1/2018-12/31/2018	Measurement 7 day	3348	9357	35.78%	45%	Below 2.33 percentage point decrease
1/1/2018-12/31/2018	Measurement 30 day	5886	9357	62.90%	75%	Below 10.11 percentage decrease
1/1/2019-12/31/2019	Re-Measurement 7 days	2144	8353	25.67%	45%	Below 10.11 percentage point decrease
1/1/2019-12/31/2019	Re-measurement 30 days	4207	8353	50.37%	75%	Below 12.53 percentage point decrease

Evaluation of Effectiveness

Despite the decrease, the interventions initiated that are felt to be strong interventions and had significant outcomes and will continue are the following:

- November 2017 and ongoing: Process developed to have contracted hospitals contact DWIHN Access Center to schedule a 7-day follow-up appointment prior to member discharge. The DWIHN Access Center has access to open appointments for follow up appointments via MHWIN calendar. Hospital case managers encouraged to involve member/caregiver in discharge planning date and time preferences for appointments. In 2018 12,005 7-day follow-up appointments were scheduled through the Access Center and in 2019 10,330 appointments were scheduled.
- In the first and second quarter of 2020 a total of 7207 7-day follow-up appointments were scheduled through the Access Center and 7207 30-day follow-up appointments were scheduled through the Access Center.
- Texting clients to remind them of their upcoming FUH appointment: In 2018 10,160 members agreed to being sent a text reminder. Of those 10,160 members, *(82.21%)* acknowledged the text and of those members *(45.27%)* kept their appointment. In 2019 8040 members were texted appointment reminders and of those *(77.73%)* of the members kept their appointment. For the first two quarters of 2020, 3877 members were texted reminders and *(62.22%)* kept their appointments. This is a definite improvement from 2017 when *(40%)* of the members who had scheduled appointments kept them.
- Starting in 2019, DWIHN staff began making calls to members at least forty-eight hours prior to their appointment that were not in the texting program to remind them of their appointments and to discuss any barriers to them keeping the appointment. In 2019, 336 members were contacted and of those *(47%)* kept their scheduled appointment. In 2020, 525 members were contacted and of those *(58%)* kept their appointment.

In FY20, telemedicine behavioral health appointments were made available to members that had transportation issues or other issues for in-person visits due to COVID 19. For the first two quarters of 2020, 531 telemedicine visits with a behavioral health practitioner were provided. For the last two quarters of 2020, 532 telemedicine visits with a behavioral health practitioner were completed.

Barrier Analysis

- Members having difficulty getting an appointment within timeframes required. (Referral access)
- Members choosing not to schedule and/or keeping appointment. (Member Knowledge)
- Members forgetting to schedule appointments and/or forgetting a scheduled appointment. (Member knowledge)
- Member not understanding process to notify provider if unable to keep appointment. (Member knowledge)
- Member lacks information regarding whom to follow-up with and where they are located and how to contact which can result in non-adherence to attending appointment. (Member knowledge)
- Transportation issues with either member not being able to schedule their own transportation with Medicaid vendor or Medicaid transportation vendor not showing up to pick up member for their appointment. (Referral access and member knowledge)
- Members cannot afford gas or to pay for gas if they use their car or someone else provides the transportation. (Referral access and member knowledge).
- Members have barriers of not having things like childcare issues that interfere with keeping appointments. (Access)
- Member following up with their primary care provider instead of a behavioral health provider due to not understanding importance of following up with a behavioral health provider after an inpatient behavioral health admission. (Member knowledge)

- Appointment time conflicts by members with other responsibilities such as childcare, work, school. (Referral access)
- Members not aware that compliance with aftercare can improve their treatment outcomes. (Member knowledge)
- Lack of coordination and continuity of care between inpatient and outpatient follow up services. (Provider/practitioner knowledge)
- Member not fully involved in discharge planning, as a result they are not engaged in follow-up. (Member knowledge)
- Practitioners and Providers do not understand the importance to seeing a member in follow-up within 7 days of discharge. (Provider/practitioner knowledge.
- Low health literacy. (Member knowledge and provider/practitioner knowledge)

Feedback was also elicited from contracted facilities and these barriers were identified from them; When facility called for seven-day follow-up appointment for member often no appointment available within timeframe needed at member's preferred provider. (Referral access). They suggested a written educational material be developed for member regarding follow-up appointment importance as discussing orally with members did not address those members who learn better via written information or members who require both oral and written education. (Member knowledge and low health literacy.

From the barriers above the following opportunities for improvement were identified:

- Improve ability for member to get appointments within timeframes required.
- Improve access to appointments with contracted behavioral health providers/practitioners within timeframes required.
- Improve process of who and how follow-up appointments are scheduled.
- Identification of ways that member can be reminded of appointments.
- Identify a process to address transportation issues when member is not able to schedule their own transportation with Medicaid vendor or not scheduling at least 5 days in advance of appointment and reminding transportation vendor to pick up member.
- Improve members knowledge regarding availability of gas reimbursement available if they use their own transportation and availability of transportation vendor.
- Improve members knowledge regarding importance of follow up with a behavioral health practitioner.
- Improve appointment time conflicts with other activities member has by addressing appointment availability times and exploring virtual technology(telehealth).
- Improve Member involvement in discharge planning and follow-up.
- Improve Practitioners and Providers knowledge regarding the importance to seeing a member in follow-up within 7 days of discharge.
- Providing information to members both verbally and written using simple language that is focused and using teach back method.

Opportunities for Improvement

- 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

Activity Description

This measure analyzes the 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.

Quantitative Analysis and Trending of Measures

Comparing the 2017 baseline data for Improving Adherence to Antipsychotic Medications for Individuals with Schizophrenia in the first re-measurement period of 2018, showed an increase in this measure from baseline from *(40.42%)* to *(69%)*. This is a *(28.58)* percentage point increase. The *(45%)* goal was achieved. Comparing 2018 to 2019 for Improving Adherence to Antipsychotic Medications for Individuals with Schizophrenia showed a decrease in this measure as the 2019 result was *(53%).* The chart below represents the baseline and results of the HEDIS measurements rates over a six-year period.

Time Period	Measurement	Numerator	Denominator	Rate	Goal	Comparison to goal
1/1/2017-12/31/2017	Baseline	2958	7319	40.42%	40%	Above
1/1/2018—12/31/2018	Remeasurement 1	3306	4762	69%	45%	Above Increase 28.58 percentage points
1/1/2019-12/31/2019	Remeasurement 2	2398	4510	53%	70%	Below Decrease 16 percentage points

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. Barriers to achieving objectives:

- 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.

Evaluation of Effectiveness

Despite the decrease, the interventions that are felt to be strong interventions are the following:

- FY18, educational information posted on DWIHN website on customers site. Educational material that address the importance of medication adherence.
- FY19, several of Detroit Wayne Integrated Health Network providers started providing text messages, to members that agree, medication reminders and refill reminders.
- FY19, DWIHN posted on their website under members, educational material, tools for medication adherence. DWIHN has listed several pharmacies that offer email and text reminders for refills of prescriptions.

Barrier Analysis

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

Opportunities for Improvement

- Improve the relationships with physician by providing member with key pre-appointment questions.
- Improve treatment approach by physician's by memo's sent to physicians quarterly regarding review of member's medication.
- Improve patient compliance with medication adherence.
- Improve patient adherence to medication refill.
- Improve patient follow up.

Improving Diabetes Monitoring for People with Schizophrenia and Bipolar Disorder

Activity Description

This measure analyzes 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.

Quantitative Analysis and Trending of Measures

DWIHN saw a decrease in its HEDIS measure of Diabetes Screening for Schizophrenia and Bipolar Disorder members from *(81.4%)* in 2018 to *(76.9%)* in 2019 (the first remeasurement period. This is a *(4.5)* percentage point decrease. The table below illustrates the baseline and results of the HEDIS measurements rates over a six-year period.

Time period	**Measurement**	Numerator	Denominator	**Rate**	**Goal**	**Comparison to Goal and Statistical Significance**
1/1-12/31 2017#	Baseline	4,076*	5,277*	77.24%	80.10%	Below Increase 0.66 percentage points
1/1/-12/31/ 2018	Re-measurement 1	2589	3179	81.44%	85.0%	Above Increase 4.2 percentage points
1/1/2019-12/31/2019	Re-measurement 2	2380	3094	76.92%	85.0%	Below Decrease 4.52 percentage points

Evaluation of Effectiveness

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.

Barrier Analysis

- Lack of consistent practice among behavioral health (BH) and medical providers of the prevalence of diabetes in this population and the need for screening.
- Physician belief that diabetes prevalence is low in their practice.
- Lack of knowledge among behavioral health and medical providers of recommendations for screening for diabetes in members with schizophrenia and bipolar disorder.

- Lack of knowledge among behavioral health providers of which members have not been screened for diabetes.
- Lack of knowledge among provider support staff of HEDIS measure or DWIHN's HEDIS measure results.
- Behavioral Health and medical providers/practitioners not collaborating to address in an organized, consistent manner.
- Lack of knowledge by enrollee/members that they are at risk for diabetes if on atypical antipsychotic medication.
- Lack of follow-through by enrollee/members to have labs drawn when ordered.
- Lack of knowledge by enrollee/members on importance of healthy eating and exercise to help control any weight gain associated with antipsychotic medication.

Opportunities for Improvement

- Continue to educate providers annually and post clinical practice guidelines on the DWHN website for Improving Diabetes Monitoring for People with Schizophrenia and Bipolar Disorder.
- 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. Providers that have compliance scores of < 95% are placed on Plans of Correction (POC) for monitoring.
- DWIHN has entered into a contract with Vital Data. This will allow us the ability to provide a very detailed drill data in order to develop additional interventions. Providers will also have access to the data to identify their members requiring Diabetic Screening.

DWIHN monitors and continues to analyze the results of NCQA HEDIS measure requirements which include the following:

- Follow-up After Hospitalization for Mental Illness.
- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment.
- Follow-up Care for Children Prescribed ADHD Medication. (Continuation and Maintenance)
- Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults. (MHWIN Data)
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia.
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are using Antipsychotic Medications.
- Plan All-Cause Readmissions.

DWIHN also annually identifies opportunities to improve coordination across the continuum of behavioral healthcare services by collecting data and conducting quantitative and causal analysis of data to identify improvement opportunities.

Care Coordination

Activity Description

Coordination of Care is the cornerstone of many healthcare redesign efforts, including primary and behavioral healthcare integration. DWIHN's goal of care coordination is to meet member needs and preferences in the delivery of high-quality, high-value care. It involves bringing together various providers (physical health, SUD, community supports, etc.) to help achieve the goals of treatment. Data shows that care coordination increases efficiency and improves clinical outcomes and member satisfaction with care.

Quantitative Analysis and Trending of Measures

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 scored *(84%*), which is a slight increase from the previous FY in which scores ranged from (*95%) and (83%*). This slight increase is attributed to the improve efforts of the Behavioral Health Providers receiving evidence of requested documentation from the PCP, Natural and other Community Supports. Also, the results demonstrated a slight increase in the percentage of provider's participation from the previous year of 70%, compared to 71%, which is still considerably below the State Performance Measure goal of 95% set by the state of Michigan for the PIHP's for Continuity and Coordination of Care.

Evaluation of Effectiveness

Care coordination is a core function of the MI Health Link program. MI Health Link requires coordination of services for all individuals to ensure effective integration and coordination between providers of medical services and supplies, behavioral health, substance use disorder (SUD) and intellectual/developmental disabilities (I/DD), pharmacy, and long term supports and services (LTSS). This requires coordination between the Integrated Care Organization (ICO) and the Pre-paid Inpatient Health Plan (PIHP) or the LTSS entities, where applicable.

DWIHN worked with the following health plans in FY20: AmeriHealth, Aetna, Michigan Complete, Molina and HAP Midwest. The Agency Profile within I-Dashboards indicates 5,271 MI Health Link members were enrolled with DWIHN in FY20, compared to the 5,010 members reported as enrolled last fiscal year. MI Health Link enrollees are a significantly small subset of DWIHN members *(6%)*. There were 616 MI Health Link (MHL) members hospitalized during FY20. During FY19, DWIHN managed 560 community hospital admissions of MI-Health Link members. 92 MHL members were readmitted in FY19 and in FY20, there were 58 members who were readmitted within 30 days of discharge. The number of readmissions decreased by (*45%)* in FY20. Molina saw the highest number of admissions during FY20 at 251, *(40%)* of the DWIHN MHL admissions for FY20. AmeriHealth had the lowest number with 60 members admitted, followed by MI Complete, with 62 admissions.

Opportunities for Improvement

DWIHN has identified the following as opportunities for improvement:

- Continue to monitor and take action as necessary to improve continuity and coordination of care within DWIHN health care network.
- Continue to collaborate with behavioral healthcare practitioners to monitor and improve coordination between medical care and behavioral healthcare.
- Require providers to continue to document request and follow - up more than one time per year with the Primary Care Physician 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.

Advocacy Pillar

Home Community-Based Services (HCBS)

Activity Description

The HCBS provide opportunities for Medicaid Beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. DWIHN is committed to working with the provider network toward full compliance with Home and Community Based Services by March, 2023. Activities include, but are not limited to, completing survey process, review of data collected from survey, notifying providers of corrective action, collecting corrective action, approving corrective action and resurveying to assure both initial and ongoing compliance. DWIHN will allow providers a reasonable length of time to remediate identified issues as specified in their corrective action plan as long as the provider is making progress and provides regular updates to DWIHN's Quality Improvement unit. These programs serve a variety of targeted populations, such as people with intellectual or development disability, physical disabilities, and /or mental illnesses. Additionally, the rule is designed to ensure that Medicaid's HCBS programs provide full access to the benefits of community living and offer services in the most integrated settings.

Quantitative Analysis and Trending of Measures

Currently, 65 out of 118 non-residential sites and 133 out of 471 residential sites in the region have been assessed by DWIHN's Quality Improvement (QI) unit as compliant with the HCBS final rule requirements. DWIHN will continue to provide providers a reasonable length of time to remediate identified issues as specified in their CAP as long as the provider is making progress to come into full compliance with the HCBS rule.

Evaluation of Effectiveness

The compliance reviews regarding the HCBS Rules under Medicaid are ongoing. DWIHN has created a residential provider report card that offers an overall view of performance and tracks compliance with standards, policies and procedures regarding the final rule. In addition, DWIHN's Quality Improvement unit maintains a directory of all contracted service providers that are HCBS compliant within the network. This information can be found on DWIHN's website under the Providers/Provider Resources tab. DWIHN has developed a Home and Community Based Services policy for our provider network that will be implement before the next contracting period. DWIHN will continue its efforts towards compliance in all services that fall under HCBS.

Barrier Analysis

To address the HCBS barriers:

- DWIHN plans to provide on-site technical assistance on educating individuals, providers, and communities to better understand and come into compliance with the final rule.
- 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.
- Identify providers who have made the cultural shift to meet the HCBS standards to share best practices.
- Post HCBS resource materials on DWIHN website including direct linked resources from MDHHS.
- Work with other PIHP Leads in the regions through on-going training and sharing of best practices.

Opportunities for Improvement

DWIHN remains steadfast in its commitment to continue to provide technical assistance to the providers to identify implementation approaches that ensure provision of Medicaid Services in a manner consistent with program requirements through the following initiatives:

- 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.

Community Outreach

Most activities were canceled due to COVID but there were several new opportunities to get the word out about DWIHN and its resources. The DWIHN Access to Care 30-minute special aired on Fox 2 in September. DWIHN sponsored a “Community Day of Hope” and a back-to-school supply giveaway. DWIHN was also involved in creating a Wayne County "Walk a Mile in My Shoes Rally" that was shown during the virtual walk in September.

DWIHN Website

During FY20, the DWIHN website was revamped with a new look, better accessibility and more streamlined functionality. In addition, one of the newest features is a searchable Provider directory. A new page designated just to COVID updates was also created.

CALL OUR 24-HOUR HELPLINE
1-800-241-4949
Crisis Info

Find a Provider

https://www.dwihn.org

- About Us
- Access Our Services
- For Members
- For Providers
- Contact Us

Sharing of Information

DWIHN produces and distributes quarterly Member and Provider Newsletters. The Newsletter's primary focus is to keep members updated with the latest information regarding programs and services, and providers updated with the latest information on regulations, reports, and contractual requirements that affect our Network. Types of information the Quality Improvement unit shares on a routine basis include:

- Quality Improvement Steering Committee (QISC)
  - QISC Agenda
  - QISC Minutes
- Quality Assessment Performance Improvement Program (QAPIP)
  - QAPIP Description Plan FY 2019-2021
  - QAPIP Description Plan FY 2021-2023
- Annual Evaluations
  - QAPIP Annual Evaluation FY 2017
  - QAPIP Annual Evaluation FY 2018
  - QAPIP Annual Evaluation FY 2019
  - QAPIP Annual Evaluation FY 2020

Compliance with Applicable Accreditation, Legislative Federal/State

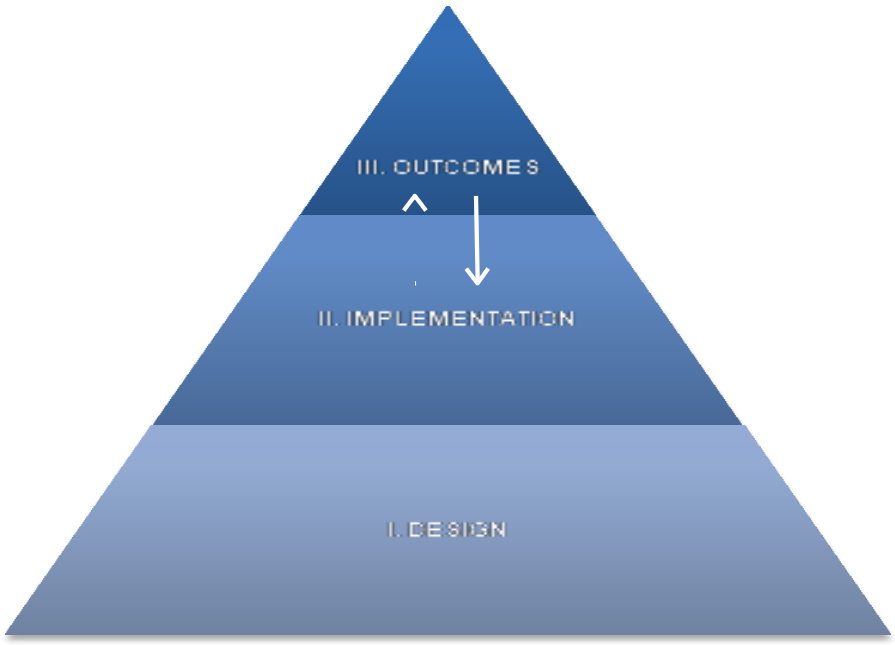
Health Services Advisory Group (HSAG)

Activity Description

HSAG completes three separate reviews as required by MDHHS: Performance Improvement Project (PIP), Performance Measure Validation (PMV) and the Compliance Monitoring review.

Quantitative Analysis and Trending of Measures

The goal of this PIP is to increase Diabetes Screening for members with Schizophrenia or Bipolar Disorder who are dispensed Atypical Antipsychotic Medications. Individuals with a mental health illness are at increased risk for developing diabetes. Diabetes left untreated can result in serious health complications such as blindness, kidney disease, and amputations. This PIP topic represents a key area of focus for improvement by DWIHN. This PIP also aligns with the HEDIS measure. To implement successful improvement strategies, a methodologically sound study design is necessary as illustrated below.



Evaluation of Effectiveness

The table below displays the validation results for DWIHN's PIP evaluated during 2019–2020. The table illustrates the DWIHN's overall application of the PIP process and success in implementing the PIP. Each step is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in the table show the percentage of applicable evaluation elements that received each score by step. Additionally, HSAG calculated a score for each stage and an overall score across all step.

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)	0% (0/1)	100% (1/1)	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			**88% (7/8)**	**13% (1/8)**	**0% (0/8)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (3/3)	0% (0/3)	0% (0/3)
	VIII.	Appropriate Improvement Strategies	100% (6/6)	0% (0/6)	0% (0/6)
Implementation Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Outcomes	IX.	Real Improvement Achieved	33% (1/3)	0% (0/3)	67% (2/3)
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			**33% (1/3)**	**0% (0/3)**	**67% (2/3)**
Percentage Score of Applicable Evaluation Elements *Met*			**85% (17/20)**		

Barrier Analysis

Overall, *(85)* percent of all applicable evaluation elements received a score of *Met*. However, The identification and prioritization of barriers through causal/barrier analysis and the selection of appropriate active interventions to address these barriers are necessary steps to improve outcomes. DWIHN's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the DWIHN's overall success in achieving the desired outcomes for the PIP. The three areas in which DWIHN received a Partially Met and/or Not Met include the following:

- DWIHN failed to describe the eligible population in the denominator description rather than listing the exclusion criteria *(Partially Met).*
- DWIHN failed to demonstrated improvement in the study indicator result *(Not Met).*
- The study indicator did not achieve statistically significant improvement over the baseline *(Not Met)*.

DWIHN's causal/barrier analysis process involved the use of an Ishikawa Fishbone diagram in collaboration with providers and conducted data and literature reviews. DWIHN will use the Plan-Do-Study-Act (PDSA) to assess the identified barriers and determine appropriate interventions. DWIHN's Improving Practice Leadership Team (IPLT) used team discussions to assign priority rankings for each identified barrier. From these tools, DWIHN determined the following barriers:

- Lack of knowledge among providers to recommend diabetes screening for members with schizophrenia and bipolar disorder.
- Physicians' belief that diabetes prevalence is low in their practice.
- Lack of follow through by enrollees/members to have labs drawn when ordered.

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 2019. The re-measurement 1 period will be calculated in March of 2020, with a goal of *(80.0%).*

Opportunities for Improvement

To address these barriers, DWIHN initiated the following interventions:

- DWIHN will monitor compliance with diabetes screening through clinical treatment chart audits. Findings from the chart audits will be provided to providers through the Quality Operations Workgroup meetings and the Quality Improvement Steering Committee.
- DWIHN will measure and monitor compliance with having labs ordered and drawn no less than quarterly through review of the HEDIS-like data in Relias ProAct. Findings will be provided to providers through the Quality Operations Workgroup meetings and the Quality Improvement Steering Committee.
- Enrollees/members will be educated on the importance of having labs completed through community outreach initiatives and training and reinforced in a pilot program through face-to-face medication delivery and monitoring with members transitioning from an Aggressive Community Treatment program.
- DWIHN will provide education on the Clinical Guidelines Procedures to service providers, practitioners, and DWIHN staff members through the Quality Operations Workgroup, Quality Improvement Steering Committee, and Improvement Practices Leadership meetings.

- DWIHN will educate the provider network through community outreach initiatives and training onthe importance of diabetes screening.
- DWIHN will conduct monthly care coordination meetings with Medicaid health plans to develop care plans for members, including those diagnosed with diabetes who have been prescribed atypical antipsychotic mediations. The focus is on effective planning and communication for the care coordination of physical health conditions and behavioral health.

Performance Measure Validation (PMV)

Activity Description

HSAG validated a set of performance indicators that were developed and selected by MDHHS for validation. The reporting cycle and measurement period was for the first quarter of SFY 2020 (October 1, 2019 through December 31, 2019).

Quantitative Analysis and Trending of Measures

The previous year's data was used along with the current reports to assess trending patterns and rate. The measurement period for Indicators #1, #4a, #4b, #5, #6 and 10 is Quarter 1 FY 2020 (October 1, 2019-December 31, 2019). The measurement period for Indicators #8, #9, #13 and 14 is FY 2019 (October 1, 2018-September 30, 2019).

Effective of Evaluation

DWIHN met all required reportable areas during the HSAG Performance Measure Validation (PMV) review for FY20, with the exception of BH-TEDS Data Elements (*Disability Designation) during the HSAG Annual Review Validating that DWIHN's systems and processes successfully captured critical data elements needed to calculate performance indicators in alignment with MDHHS' expectations and codebook. In FY19, DWIHN implemented several quality improvement initiatives to address challenges and improve indicator rates. In June 2019, DWIHN initiated a Performance Indicator Provider and Internal Workgroup to review past performance, address challenges to improving rates, and define quality improvement initiatives. This workgroup meets quarterly and includes both DWIHN staff members and members of its provider network. Additionally, we worked with PCE to enhance the reporting module within MH-WIN that allows the provider to review the performance indicator data prior to submission to the PIHP. This system and process change was designed to address data quality issues and address the completeness and accuracy of information impacting performance. Finally, DWIHN develop a Recidivism Workgroup to review and implement interventions targeted at addressing non-compliance with Indicator #10.

Opportunities for Improvement

Overall, during the HSAG review, DWIHN systems and processes successfully captured critical data elements needed to calculate performance indicators in alignment with MDHHS' expectations and codebook. However, although no material bias was identified during the audit, to further improve the accuracy and completeness of its performance indicator data, DWIHN identified the following improvement efforts:

- Continue with existing provider and internal workgroups to regularly review progress on improving performance measure rates and data collection processes.
- Continue to monitor performance trends and targeting low performing areas, including an assessment of performance at the individual provider level, as well as within core member demographics, to identify systemic patterns of performance.
- Continue to use existing workgroups to identify root causes for low performance and disseminate best practices.
- Review the BH-TEDS to ensure that all required elements are not only collected and reported, but that the logical relationships between fields are correct. Although only one discrepancy was noted in the BH-TEDS data reviewed by HSAG, DWIHN will evaluate the cause for the discrepancy to determine whether data entry systems or validation procedures should be updated to prevent inaccuracy in its submissions.

Compliance Review

Activity Description

To improve performance in the quality and timeliness of and access to care, the Michigan Department of Health and Human Services (MDHHS) has contracted with Health Services Advisory Group, Inc. (HSAG) to comprehensively assess the performance of PIHPs in providing quality, timely, and accessible healthcare services to members.

Quantitative Analysis and Trending of Measures

For FY 2020, the reporting period was the second year of the three-year compliance review cycle. HSAG reviewed approximately *(50)* percent of federally mandated standards and their associated State-specific requirements, when applicable.

Effective of Evaluation

DWIHN received a total compliance score of *(79)* percent across all standards reviewed during the 2018–2019 compliance monitoring review, which was equal to the statewide average. DWIHN scored above *(90%)* indicating strong performance in the following areas: QAPIP Plan and Structure, Members' Rights and Protections, and Coordination of Care standards. DWIHN scored *(75)* percent, *(75)* percent, *(67)* percent, *(81)* percent, *(56)* percent, and *(50)* percent respectively in the Quality Measurement and Improvement, Practice Guidelines, Staff Qualifications and Training, Utilization Management, Credentialing, and Confidentiality of Health Information standards, indicating that additional focus is needed in these areas. DWIHN's performance measure rates were above the MDHHS established MPS for one of the two reportable indicators, indicating strengths in this area. DWIHN's MPS related to timely preadmission screening for psychiatric inpatient care for new Medicaid members for children was not met, indicating opportunities for improvement in this area.

Additionally, Detroit Wayne Integrated Health Network's rates were deemed Not Reported for 17 of the 19 measure indicators related to timely assessment for new Medicaid members, starting ongoing services for new Medicaid members timely, timely follow-up care after discharge from a psychiatric inpatient unit, timely follow-up after discharge from a substance abuse detox unit, and readmissions to an inpatient psychiatric unit, indicating opportunities for improvement in most measures.

Opportunities for Improvement

To address the areas requiring improvement, DWIHN will prioritize areas of low performance. The strategy will include data trends and root cause analyses with actionable and measurable goals, benchmarks, and interventions, addressing development and implementation of mechanisms for sustaining and spreading improvement in health outcomes, member satisfaction, and other focus areas. DWIHN will also develop a comprehensive and effective plan of action to mitigate any deficiencies identified during the 2018–2019 compliance monitoring review. In addition, DWIHN will take proactive steps to ensure a successful PIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers timely.

Utilization Management

The Annual Utilization Management (UM) Program Executive Summary is under a separate cover for FY 2020. 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.

Adequacy of Quality Improvement Resources

The Quality Improvement (QI) Unit is staffed with a Director of Quality Improvement which oversees the Quality Improvement Unit (including two full-time Quality Administrators). The QI Director collaborates on many of the QI goals and objectives with the DWIHN Senior Leadership team and the QISC. The QI unit works in conjunction with DWIHN's Information Technology (IT) Unit. The IT unit plays a pivotal role in the QAPIP, providing internal and external data analysis, management for analyzing organizational performance, business modeling, strategic planning, quality initiatives, and general business operations, including developing and maintaining databases, consultation, and technical assistance. In guiding the QAPIP projects, the IT Unit performs complex analyses of data. The data analyses include statistical analyses of outcomes data to test for statistical significance of changes, mining large data sets, and conducting analyses to determine causes or contributing factors for outcomes or performance outliers; correlates analyses to assess relationships between variables. Based on the data, the IT unit will develop reports, summaries, recommendations, and visual representations to Quality Improvement Activities.

The following chart is an estimated summary of the internal staff included in the Quality Improvement Steering Committee (QISC), their title and the percentage of time allocated to the quality improvement activities.

Title	Department	Percent of time per week devoted to QI
Medical Director	Administration	50%
Director of Quality Improvement	Quality Improvement	100%
Quality Improvement Administrator	Quality Improvement	100%
Director of Utilization Management	Utilization Management	50%
Clinical Officer	Clinical Practice Improvement	20%
Director of Customer Service	Customer Service	70%
Director of Integrated Health Care	Integrated Health Care	50%
Director of Managed Care Operations	Managed Care Operations	20%
Strategic Planning Manager	Compliance	80%
Information Technology	Information Technology	20%
Practitioner Participation	Provider Network	100%

Overall Effectiveness

The 2019-2020 QI Work Plan was implemented in accordance with the plan. The performance indicators measured cover a broad spectrum, including quality of clinical care, quality of service and safe clinical practices. The QI initiatives are relevant to the needs of the residents of Wayne County and in alignment with DWIHN's mission, vision and values. Overall, most activities planned in the 2019-2020 Work Plan were Partially Met *(50%).* Activities and outcomes that scored Partially Met may be attributed to the ongoing Covid-19 pandemic. The activities that were Partially Met and or Not Met will be considered for continuation in 2021. Planned activities for review on the QAPIP 2019-2020 Work Plan are attached to the FY20 QAPIP Evaluation. (Attachment A). The quality resource needs are determined based on the percentage of key activities completed and associated goals attained. After evaluating the performance of the Quality Program, DWIHN has determined there are adequate staffing resources to meet the current program goals and include highly educated and trained staff. DWIHN evaluated data, staff, resources, and software to ensure our health information system that collects, analyzes and integrates the data necessary to implement the QI program is adequate. DWIHN will move to use Vital Data in 2021 to run our HEDIS data. This move will allow us to have more detailed reporting which will allow us to drill down to the member level as well as the ability to share data with our providers.

The DWIHN Medical Director chairs the QISC with the Quality Improvement Administrator. The Medical Director also is the designated senior official and is responsible for the QAPIP implementation. DWIHN supports the use of evidence-based practices and nationally recognized standards of care. The clinical practice guidelines are reviewed every two years and approved by the Medical Director. The Medical Director is also a member of the following committees:

- Improving Practices Leadership Team. (IPLT)
- Critical Sentinel Event Committee.
- Death Review Committee.
- Peer Review Committee.
- Behavior Treatment Advisory Committee. (BTAC)
- Credentialing Committee.
- Cost Utilization Steering Committee.
- Compliance Committee.
- Research Advisory Committee. (RAC)

DWIHN believes there are adequate practitioner involvement and consultation to meet the objectives of the Quality Program. No changes are anticipated for FY 2021.

Committee Structure

After evaluating the QI program committee structure, DWIHN committee involvement is adequate and all committee members regularly attend and actively participate in QISC committee meetings. DWIHN's commitment to quality is strong and shared across all levels of the organization. DWIHN believes the structure supports effective governance and align key strategic initiatives to ensure adequate guidance to help DWIHN reach goals and objective, changes are anticipated for FY 2021 which include the implementation of the Research Advisory Committee (RSC).

Practitioner Participation

DWIHN's partnership with the service provider network encourages practitioner participation and leadership involvement in the QI program. The practitioners actively participate in DWIHN's QISC committee which involves process improvement, program planning, implementation and program evaluation, through data collection and analysis. In addition to serving on the QISC committee, DWIHN enlists practitioner input regarding key initiatives. After evaluating the practitioner participation, DWIHN believes there are adequate practitioner involvement and consultation to meet the objectives of the Quality Program. No changes are anticipated for FY 2021.

QI Program Effectiveness

An evaluation of DWIHN's QI program has been conducted. This evaluation included review of trended results for QI measures over time, comparison against performance objectives, quantitative and qualitative analyses for completed and ongoing QI activities. Overall, improvements were achieved in planned QI initiatives, both clinical and service. In addition, programs that address member safety were implemented. The QI program resources, QI Committee Structure, practitioner participation and leadership involvement has determined the current QI Program structure effective. No changes to the QI Program structure are needed at this time with the exception of adding the Research Advisory Committee (RSC).

DWIHN's commitment to continuous improvement is integral to achieving excellent health outcomes and an excellent overall member experience. In 2021, DWIHN will continue to address identified opportunities for improvement to ensure optimal member experience.

2021 Work Plan Goals and Objectives

The Quality Improvement Unit will continue to monitor the 2020 goals and quality initiatives. Additional priorities identified for 2021 that will be added to the goals include the following:

- Maintain and Achieve NCQA accreditation.
- Improve Member Engagement and Satisfaction of Services.
- Continue focus on maintaining and improving member behavioral health outcomes through Performance Improvement Projects.
- Continuously improve the quality, appropriateness, availability, accessibility, coordination and continuity of health care services to members across the continuum of care.
- Identify and implement strategies to address social factors and health disparities to improve overall health and health outcomes of our members.
- Define, demonstrate and communicate the organization-wide commitment to improving the quality of patient safety.
- Ensure a high-quality network through credentialing, peer review and contracting processes.
- Collaborate with providers to share ideas and implement strategies to improve care coordination and quality.
- Ensure compliance with MDHHS standards as well as state and federal regulatory requirements and accreditation standards.

Attachment A

QAPIP Work Plan
FY 2019-2020

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Responsible Department	Timeframe for Each Activity's Completion	Monitoring of Previously Identified Issues	Evaluation	Outcomes	Oversight of QI Activities by Committee
	Customer Pillar						
Goal I	**Enhance the quality of services based on member feedback**						
I.1	ECHO Adult Satisfaction Survey	Customer Service	FY 2019-2020	Increase response rates and improve member access to behavioral health services for the 5 reporting measures scoring < 50% which include:1) Treatment after benefits are used up; 2)Counseling and Treatment; 3). Getting Treatment Quickly; 4). Office Wait and Access; 5). Perceived Improvement.	The identified areas improved with an overall percentage increase of (10%) from the previous surveys administered in FY2018.	**Partially Met**; Goal will be continued in FY2020-2021.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
I.2	National Core Indicator Survey (NCI)	Customer Service	FY 2019-2020	Identify areas for system enhancement to improve access to service and quality of care. DWIHN will use the results of the NCI Survey to identify and investigate areas of dissatisfaction and implement interventions for improvement.	Interviews and surveys were not completed during FY19-20 due to the COVID-19 Pandemic. Interviews and surveys will reconvene in FY21.	**Not Met**; Goal will be continued in FY2020-2021.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
I.3	Provider Survey	Customer Service	FY 2019-2020	Increase response rates and improve service access, service provision, treatment experiences and outcomes in the network.	A Comparison of FY19 and FY20 surveys, indicate that provider participation increased overall by (25%); (50%) for provider organizations and (21%) for individual practitioners. DWIHN's targeted response rate of 50%-60% was below the targeted benchmark of 50% -75% participation. The length of survey questions (76) may dissuade provider organizations and practitioners to complete survey. "As it was reported to have taken 30 minutes to complete". Based upon number of surveys that bounced back there is further need to clean up our email database to void invalid email	**Partially Met; Goal will be continued in FY2020-2021.**	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
I.4	Grievance/Appeals	Customer Service	FY 2019-2020	Improve outcomes and member experience for the top five (5) grievances identified for FY 18/19. (1). Delivery of Service, (2). Interpersonal, (3) Program Issues, (4) Access to Staff, (5) Customer Service.	During FY18 there were 86 grievances reported in which 173 categories were identified; 162 categories within 97 grievances reported in FY19 and 97 categories within the 53 grievances reported in FY20. Delivery of Service and Customer Services were consistently high over each of the three years. There was a decline in the number of grievances in the following categories in FY '20. 1.) Access to Services; 2.) Interpersonal and 3.) Quality of Care.	**Partially Met**; Goal will be continued in FY2020-2021.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
I.5	Timeliness of Denials & Appeals	Customer Service, Utilization Management	FY 2019-2020	Meet performance set by the state for timely UM decisions making, timeframes and notification. Threshold 90% .	All of the delegated entities met the 90% threshold for timeliness of urgent preservice UM decision making during FY 20. The urgent concurrent category improved from 85% in FY 19 to 91.1% in FY 20. This improvement has led to SUD meeting the 90% threshold for the urgent concurrent category.	**Met**; Goal will be continued and monitored to improve outcomes during FY2020-2021.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.

Attachment A

QAPIP Work Plan
FY 2019-2020

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Responsible Department	Timeframe for Each Activity's Completion	Monitoring of Previously Identified Issues	Evaluation	Outcomes	Oversight of QI Activities by Committee
I.6	Cultural and Linguistic Needs	Customer Service, Managed Care Operations, Quality Improvement and Information Technology	FY 2019-2020	To advance health equity, improve quality, and help eliminate health care disparities by implementing culturally and linguistically appropriate services.	In assessing the language needs of members, DWIHN explored the number of requests for interpreter services at the point of the initial request/screening for eligibility for service. The data was pulled from the screening information gathered by the Access Center at the initial request for service for Medicaid members who received services in FY17. Findings: Less than *(1%)* of the screenings request language interpreters. Currently DWIHN does not have data on the languages spoken by individual practitioners. This information is being gathered with the current credentialing/re credentialing process	**Partially Met**; Goal will be continued in FY2020-2021.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
	Access Pillar						
Goal II.	**Assess Needs and Manage Demand, Implement Holistic Care Model**						
	Michigan Mission Based Performance Indicators (MMBPI)						
II.1	Indicator 1(a) and 1(b) - Percentage of pre-admission screenings for psychiatric inpatient care (Children and Adults) for whom disposition was completed within three hours	Quality Improvement	FY 2019-2020	Meet performance on required state performance indicators. Outcome: FY 18/19 standard met for all populations for all quarters. Threshold 95% for each quarter.	FY 2020 standard met for adult and children population for 4 quarters.	**Met;** Goal will be continued in FY2020-2021.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
II.2	Indicator 2(a) and 2(b) - Percentage of persons (Children and Adults) receiving a face to face meeting with a professional within 14 calendar days of a non-emergency request for service.	Quality Improvement	FY 2019-2020	Meet performance on required state performance indicators. Outcome: FY 18/19 standard met for all populations for all quarters. Threshold 95% for each quarter.	FY 2020 standard met for all populations with the exception of Q2 DD/Adult (90.91%). DWIHN falls below the threshold for Q2 (DD/Adult).	**Partially Met**; To address this area, DWIHN will continue to evaluate applicable policies and procedures to more effectively support the evaluation and improvement of access and availability to the provider network. The goal will be to streamline data collection and evaluation efforts to enhance quality reporting. This will include exploring additional or new quantitative and qualitative assessment tools and metrics regarding accessibility Goal will be continued in FY2020-2021.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
II.3	Indicator 3(a) and 3(b) - Percentage of persons (Children and Adults) needed on-going service within 14 days of a non-emergent assessment with a professional.	Quality Improvement	FY 2019-2020	Meet performance on required state performance indicators. Outcome: FY 18/19 standard met for all populations for all Quarters except for Quarter 3 (88%). Threshold 95% for each quarter.	FY 2020 standard met for all populations with the exception of Q1 DD/Child (90.83%), Q2 DD/Child (87.18%) and Q2 DD/Adult (92.86%). DWIHN falls below the threshold for Q1, Q2 and Q3.	**Partially Met**; To address this area, DWIHN will continue to evaluate applicable policies and procedures to more effectively support the evaluation and improvement of access and availability to the provider network. The goal will be to streamline data collection and evaluation efforts to enhance quality reporting. This will include exploring additional or new quantitative and qualitative assessment tools and metrics regarding accessibility Goal will be continued in FY2020-2021.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.

Attachment A

QAPIP Work Plan
FY 2019-2020

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Responsible Department	Timeframe for Each Activity's Completion	Monitoring of Previously Identified Issues	Evaluation	Outcomes	Oversight of QI Activities by Committee
II.4	Indicator 4a(1) and 4a(2) - Percentage of discharges from a psychiatric inpatient unit (Children and Adults) who are seen for follow up care within 7 days.	Quality Improvement	FY 2019-2020	Meet performance on required state performance indicators. Outcome: FY 18/19 Quarter 1 (57%), Quarter 2 (88%) did not meet the standard; Standard met for Quarter 3 (96%) and Quarter 4 (95%). Threshold 95% for each quarter.	FY 2020 standard met for all populations with the exception of Q1 Child *(93.06%)* , Q2 Child *(86.08%)* and Q2 Adult *(94.92%).* DWIHN falls below the threshold for Q1, Q2 (Child) and Q2 (Adult).	**Partially Met**; To address this area, DWIHN will continue to evaluate applicable policies and procedures to more effectively support the evaluation and improvement of access and availability to the provider network. The goal will be to streamline data collection and evaluation efforts to enhance quality reporting. This will include exploring additional or new quantitative and qualitative assessment tools and metrics regarding accessibility Goal will be continued in the FY2020-2021 Workplan.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
II.5	Indicator 4b - Percentage of discharges from a Substance Abuse Detox Unit who are seen for follow-up care within 7 days.	Quality Improvement	FY 2019-2020	Meet performance on required state performance indicators. Outcome: FY 18/19 Quarter 1 (57%), Quarter 2 (88%) did not meet the standard; Standard met for Quarter 3 (96%) and Quarter 4 (95%). Threshold 95% for each quarter.	FY 2020 standard met for all populations with the exception of Q1 (94.0%). DWIHN falls below the threshold for Q1.	**Partially Met**; To address this area, DWIHN will continue to evaluate applicable policies and procedures to more effectively support the evaluation and improvement of access and availability to the provider network. The goal will be to streamline data collection and evaluation efforts to enhance quality reporting. This will include exploring additional or new quantitative and qualitative assessment tools and metrics regarding accessibility Goal will be continued in FY2020-2021.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
II.6	Indicator 10 (a) and 10 (b) - Percentage of readmissions (Children and Adults) to inpatient psychiatric unit within 30 days of discharge.	Quality Improvement	FY 2019-2020	Meet performance on required state performance indicators. Outcome: FY 18/19 Standard not met for Adults for Quarter 2 (17%), Quarter 3 (17%) and Quarter 4 (20%). Outcome: FY 18/19 Standard met for Children for all quarters with the exception of Quarter 4 (16%). Aggregate score for Children and Adults for FY 18/19 (17%). Threshold 15% for each quarter.	FY 2020 standard met for the children population with the exception of Q4. The standard was not met for the adult population for all quarters.	**Not Met**; To address this area, DWIHN will continue to evaluate applicable policies and procedures to more effectively support the evaluation and improvement of access and availability to the provider network. The goal will be to streamline data collection and evaluation efforts to enhance quality reporting. This will include exploring additional or new quantitative and qualitative assessment tools and metrics regarding accessibility Goal will be continued in FY2020-2021.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
II.7	Complex Case Management	Integrated Health Care	FY 2019-2020	Ensure members are move towards optimum health, improved functional capability, and a better quality of life by focusing on their own health goals. CCM will be measured against the following benchmark for participating members.	Members participating in Complex Case Management (CCM) services demonstrated overall improvement in their PHQ scores, and the improvement increased the longer that the members participated in CCM services. Average PHQ scores improved *(7%)* from baseline at 30 days, *(25%)* at 60 days and *(46%)* at 90 days of receiving CCM services. Members PHQ baseline scores ranged from 5 to 22, with an average score of *(11.8).*	**Met**; Goal will be continued in FY2020-2021 .	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.

Attachment A

QAPIP Work Plan
FY 2019-2020

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Responsible Department	Timeframe for Each Activity's Completion	Monitoring of Previously Identified Issues	Evaluation	Outcomes	Oversight of QI Activities by Committee
II.8	Crisis Intervention	Utilization Management	FY 2019-2020	Decrease number of re-hospitalization within 30 days of discharge to 15% or lower. Baseline FY 18/19 (17%).	The state benchmark of 15% or less was not met for adults during FY 20. Quarters 1, 2 and 3 for FY 20, resulted in rates of recidivism over 20%, while quarter 4 decreased to 16.6%, notably lower but still higher than the 15% state requirement for adults. The number of children admitted within 30 days of discharge, remained below the 15% threshold for the entire fiscal year. The first quarter of FY 19 resulted in 15.70% and 8.12% rates of recidivism for adults and children compared to 20.41% and 10.91% for the first quarter of FY 20. The rates for the fourth quarter of FY 19 were 19.27% and 16.33% and 16.60% and 11.11% for FY 20 for adults and children, respectively. *Recidivism data for FY 20 is inclusive of the MI Health Link population. *	**Not Met**: Goal will be continued in FY2020-2021.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
	Workforce Pillar						
Goal III.	**Development of maintain a Competent Workforce**						
III.1	Maintain Competent Workforce	Workforce Development, Quality Improvement, Clinical Practices Improvement and Managed Care Operations	FY 2019-2020	Increase the capacity of staff and providers to work effectively with diverse cultural and linguistic populations (expand cultural competency trainings as well as develop additional practice policies).	In FY20, 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 2019. In the fiscal year of 2020, a total of 1,980 calls were made/received between October 1, 2019 and September 30, 2020. Call volumes decreased from the previous fiscal year. As a result of COVID-19, the monthly call volume decreased significantly beginning in March 2020. The March call volume (167 total calls) decreased by 165 calls compared to February 2020 (332 total calls). Beginning March 13, 2020, DWIHN ordered all employees to work from home. Many organizations utilizing Detroit Wayne Connect temporarily closed as well, decreasing the number of inquiries received by the helpdesk. The DWC helpdesk remained functional, and efficiently worked to resolve user issues.	**Met**: Goal will be continued in FY2020-2021.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
	Finance Pillar						
Goal IV	**Maximize Efficiencies and Control Costs**						

Attachment A

QAPIP Work Plan
FY 2019-2020

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Responsible Department	Timeframe for Each Activity's Completion	Monitoring of Previously Identified Issues	Evaluation	Outcomes	Oversight of QI Activities by Committee
IV.1	Claims and Compliance Monitoring	Quality Improvement, Compliance and Finance	FY 2019-2020	Eliminate Fraud, Waste and Abuse in the network by identifying patterns and trends of behavioral health service utilization by funding source and by monitoring over and underutilization of services.	Incorporated several processes to match the utilization with Standardized IPOS travelling over Health Information exchange in a electronic real time format and create trends to ensure there is balance in what is medically necessity vs claims payment. Detecting fraud and abuse several measures have been implemented in partnership with Quality and Compliance teams: Quarterly checks in the system have been implemented to look for scenarios that would point to such activities. Standardized IPOS implementation will ensure nothing authorized is outside of Plan HIE implementation of IPOS will ensure all plans/addendums and authorizations reside in MHWIN which will ensure all services are authorized can only be billed Over and under utilization rules was developed in conjunction with DWIHN UM team to ensure such activities can be monitored and followed through.	**Met**: Goal will be continued in FY2020-2021.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
	Quality Pillar						
Goal V.	**Improve Quality Performance, Member Safety and Member Rights system-wide**						
V.1	Performance Monitoring - Clinically Responsible Service Provider (CRSP)	Quality Improvement	FY 2019-2020	Ensure providers are meeting regulatory and DWIHN's access standards and adequate to meet members needs. Measurement will include the number of providers reviewed during FY19 with reported outcomes.	During FY20, DWIHN staff conducted approximately (65%) of required reviews through virtual monitoring. Monitoring included SUD, CRSP and Residential providers. This is a substantial decrease from the previous fiscal year by (15%). Scores for Residential Environmental Compliance ranged from (77%-96%); with an average score of (88%). Scores for Case Record reviews ranged from 9% to 100%; averaging (65%). Scores for Residential staff qualifications reviews ranged from (39%-100%), with an average score of (81%). The chart below is an aggregate display of each area reviewed with a slight decrease from FY19.	**Partially Met**: Goal will be continued in FY2020-2021.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
V.2	Specialized Residential Settings	Quality Improvement	FY 2019-2020	Targeted goal is to review 60% of the Specialized Residential Providers to ensure regulatory requirements are met and adequate to meet members needs.	During FY20, DWIHN staff conducted approximately *(65%)* of required reviews through virtual monitoring. Monitoring included SUD, CRSP and Residential providers. This is a substantial decrease from the previous fiscal year by *(15%)* . Scores for Residential Environmental Compliance ranged from (*77% -96%)* ; with an average score of *(88%)* . Scores for Case Record reviews ranged from *9%* to *100%* ; averaging *(65%).* Scores for Residential staff qualifications reviews ranged from (*39% -100%)* , with an average score of *(81%).* The chart below is an aggregate display of each area reviewed with a slight decrease from FY19.	**Partially Met**: Goal will be continued in FY2020-2021.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.

Attachment A

QAPIP Work Plan
FY 2019-2020

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Responsible Department	Timeframe for Each Activity's Completion	Monitoring of Previously Identified Issues	Evaluation	Outcomes	Oversight of QI Activities by Committee
V.3	Provider Self Monitoring (Inter-Rater Reliability)	Quality Improvement	FY 2019-2020	Increase Provider's participation in Self Monitoring from the previous year by 10%.	The results demonstrated a slight increase in the percentage of provider's participation from the previous year of 70%, compared to 73%, which is still considerably below the State Performance Measure goal of 95% set by the state of Michigan for the PIHP's for Continuity and Coordination of Care.	**Partially Met**: Goal will be continued and monitored to improve outcomes in FY2020-2021.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
V.4	Autism Services	Quality Improvement and Children's Initiatives	FY 2019-2020	Achieve greater efficiency in processing denials and appeals.	During FY20, (98.4%) of authorization reviews were completed in 14 days or less exceeding the NCQA standard timeliness disposition of (90%).	**Met**: Goal will be continued in FY2020-2021.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
V.5	Enhancement of Critical/Sentinel Event Modules (MH_WIN) and Reporting	Quality Improvement and Information Technology	FY 2019-2020	Improve and update the Critical Sentinel Event Modules for better reporting.	Several enhancements were made to the module to consolidate the various functions required to streamline Critical and Sentinel events.	**Met**: Goal will be continued in FY2020-2021.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
V.6	Behavior Treatment Plan Oversight	Quality Improvement and Medical Director	FY 2019-2020	Meet performance on required BTPRCs requirements set by MDHHS. Threshold 95%.	During MDHHS audit, DWIHN lack evidence of functioning BTPRC for all CMHSP's under DWIHN.	**Partially Met**: Goal will be continued and monitored in FY2020-2021.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
	Quality Improvement Projects (QIP's)						

Attachment A

QAPIP Work Plan
FY 2019-2020

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Responsible Department	Timeframe for Each Activity's Completion	Monitoring of Previously Identified Issues	Evaluation	Outcomes	Oversight of QI Activities by Committee
V.7a	Improving the availability of a follow up appointment with a Mental Health Professional with-in 7 days after Hospitalization for Mental Illness.	Integrated Health Care and Quality Improvement	FY 2019-2020	DWIHN has focused on follow up after hospitalization within 7 or 30 days. This measure has the potential to improve the health of members with mental illness and reduce readmissions through increasing appropriate follow up care.	In 2017 which is DWIHN's baseline year, 38.11% of clients followed up after hospitalization within seven days and 66.02% within thirty days. According to the NCQA 2016 State of Health Care Quality which was the version available in January 2018, 45.5 % of the HMO Medicaid health plans members had completed a follow-up appointment at 7 days post-discharge and 63.8% had completed a follow-up appointment at 30 days post discharge. DWIHN was not only below the national health plan averages as published by NCQA for the seven-day measure, but we were only performing in the HEDIS 25th percentile for the 7 day follow-up and in the HEDIS 50th percentile for the 30 day follow-up rates. DWIHN's ultimate long-term goal is to be in the HEDIS 90th percentile for both	**Not Met**: Goal will be continued in FY2020-2021.	Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.
V.7b	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Integrated Health Care and Quality Improvement	FY 2019-2020	Improve members with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.	For FY20, DWIHN performed below both the Medicaid health plan NCQA average and the Michigan health plan average for the HEDIS measures as well as below their goal.	**Not Met**: Goal will be continued in FY2020-2021.	Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.
V.7c	Antidepressant Medication Management for People with a New Episode of Major Depression	Integrated Health Care and Quality Improvement	FY 2019-2020	Improve measurement-medication Compliance for Members 18 years or Older with a Diagnosis of Major Depression on Antidepressant Medication for at least 84 Days (12 weeks).	For FY20, DWIHN performed below both the Medicaid health plan NCQA average and the Michigan health plan average for the HEDIS measures as well as below their goal.	**Not Met**: Goal will be continued in FY2020-2021.	Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.
V.7d	Improving Diabetes Monitoring for People with Schizophrenia and Bipolar Disorder	Integrated Health Care and Quality Improvement	FY 2019-2020	Increase Diabetes Screening for people with Schizophrenia and/or Bipolar Disorder measures for percentage of patients 18-64 years of age.	For FY20, DWIHN performed below both the Medicaid health plan NCQA average and the Michigan health plan average for the HEDIS measures as well as below their goal.	**Not Met**: Goal will be continued in FY2020-2021.	Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.
V.7e	Coordination of Care	Integrated Health Care, Utilization Management and Quality Improvement	FY 2019-2020	Collect and analyze data to identify opportunities for improvement of coordination between behavioral healthcare in the following areas: Exchange of information; Appropriate diagnosis, treatment and referral of behavioral disorders commonly seen in Primary Care.	Enhance the care management and incorporating effective Targeted Case Management , Complex Case management and delivery of best clinical practices , we are presently evaluating a population management solution as part of HEDIS measures and will roll that out to entire CRSP network to ensure effective outcome based clinical strategies are implemented in both operationalizing the care as well as clinical protocols Implementing a pilot implementation with a Health Plan to provide a care coordination platform with our Integrated care team and health plan partners. The goal is to take this pilot live 1/1/2021. HIE implementation of IPOS ensured all plans/addendums and authorizations reside in MHWIN which ensured all services are	**Partially Met:** Goal will be continued in the FY2020-2021 Work Plan.	Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.
V.7f	Case Finding for Opiate Treatment	Substance Use Disorder	FY 2019-2020	Increase the Number of Persons Revived with provided Naloxone Kits in Wayne County MI (Naloxone Project). Distribution of Naloxone kits to promote the use of overdose-reversing drugs.	DWIHN HEDIS measures outcomes declined. DWIHN implemented several programs and strategies to address the identified barriers.	**Partially Met:** Goal will be continued and monitored to improve outcomes during FY2020-2021.	Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.

Attachment A

QAPIP Work Plan
FY 2019-2020

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Responsible Department	Timeframe for Each Activity's Completion	Monitoring of Previously Identified Issues	Evaluation	Outcomes	Oversight of QI Activities by Committee
V.7g	Increasing Hepatitis A Vaccination	Integrated Health Care	FY 2019-2020	DWIHN was asked in June 2018 by the State of Michigan Department of Health and Human Services (MDHHS) to make available a prevention initiative for opioid treatment programs (OTP) that would help the State of Michigan reach the goal of 80% of the population vaccinated for Hep A.	There were opportunity's for improvement with this activity. DWIHN found it difficult scheduling vaccination clinics at the provider sites. Some DWIHN providers were not able to determine how many clients would be at their agency in a given day. DWIHN developed the strategy of attending the clients group therapy educational session to education clients regarding Hep A and offered the vaccine on the same day.	**Not Met**: Goal will be continued and monitored to improve outcomes during FY2020-2021.	Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.
V.7h	PHQ-9 Implementation	Clinical Practice Improvement	FY 2019-2020	DWIHN's goal to reduce the suicide rate for enrolled members which includes determining if the PHQ-9 could be a value added screener for its service population, DWIHN reviewed its population data/Agency Profile to determine the prevalence of depression among the enrolled members within the service delivery system	There have been some slight improvements in the number of members receiving an initial PHQ9 screening at intake as indicated by the 2018 baseline data query as compared to FY2020 data.	**Met**: Goal will be continued in FY2020-2021.	Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.
V.7i	PHQ-A Implementation	Children's Imitative	FY 2019-2020	To improve the health of the pediatric community through a grant to implement the Integrated Care for Kids Model. The Model outlined a child-centered local service delivery and state payment model that aims to improve the quality of care for children under 21 years of age covered by Medicaid through prevention, early identification, and treatment of behavioral and physical health needs. DWIHN in collaboration with providers and practitioners within the contracted provider network determined that youth members ages 11-17 will be assessed for the symptoms of depression via the PHQ-A screening tool.	There have been some slight improvements in the number of members receiving an initial PHQA screening at intake as indicated by the 2018 baseline data query as compared to FY2020 data.	**Met**: Goal will be continued in FY2020-2021.	Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.
V.7j	Improve ACT Fidelity w/ACT Step-Down	Clinical Practice Improvement	FY 2019-2020	Improve medication adherence for adults and children who have challenges taking their medications in the prescribed manner.	Those who participate have a 90% or better medication adherence rate, a reduction in psychiatric hospitalization usage and in crisis home usage. Established a pilot program called ACT Step down (ACT-SD) involving 3 providers; ACT-SD served 10 members all of which have not had any inpatient hospital admissions since being connected to the program.	**Met**; Goal will be continued in FY2020-2021.	Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.
V.7k	Decreasing Wait for Autism Services	Children's initiative	FY 2019-2020	Achieve greater efficiency in processing denials and appeals. Reducing the number of delegated functions is not only cost effective, but positions DWIHN as a leader in integrated care	Timeliness of authorizations reached (98%) in FY 20. continues to struggle to provide services within 90 days of MDHHS approval (15:1 is the requirement set forth by the national guidelines of the Behavior Analysis Certification Board). Another barrier is that Behavior Technicians are unable to provide ABA Direct Services until IPOS and Authorization is input timely and BCBAs are expending time and energy into getting Support Coordinators to update IPOSs and input authorizations timely.	**Partially Met**; Goal will be continued in FY2020-2021.	Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.

Attachment A

QAPIP Work Plan
FY 2019-2020

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Responsible Department	Timeframe for Each Activity's Completion	Monitoring of Previously Identified Issues	Evaluation	Outcomes	Oversight of QI Activities by Committee
	Advocacy Pillar						
Goal VI.	**Increase Community Inclusion and Integration**						
VI.1	Home and Community Based Services (HCBS)	Quality Improvement	FY 2019-2020	Ensure full compliance in the network with the Home and Community Based Settings requirements by March 2023. Outcome: FY18/19 aggregate score (34%) Goal: FY 19/20 (60%)	Currently, 65 out of 118 non-residential sites and 133 out of 471 residential sites in the region have been assessed by DWIHN's Quality Improvement (QI) unit as compliant with the HCBS final rule requirements. DWIHN will continue to provide providers a reasonable length of time to remediate identified issues as specified in their CAP as long as the provider is making progress to come into full compliance with the HCBS rule.	**Partially Met**; Goal will be continued in FY2020-2021.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
Goal VII	**Assure Compliance with Applicable National Accreditation, Legislative, Federal/State**						
VII.1	MDHHS Certification	QI, MCO, CS, ORR, Finance, Workforce, Credentialing, IHC and Administration	FY 2019-2020	Achieve 95% compliance for all standards of Annual MDHHS Review.	DWIHN is required to submit to MDHHS a CAP for all elements scored Not Met. For each component that requires correction, DWIHN must identify the planned interventions to achieve compliance with the requirement(s), the individual(s) responsible for each intervention, and the timeline, including scheduled dates of completion for each intervention.	**Partially Met**; Goal will be continued in FY2020-2021.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
VII.2	NCQA Accreditation	QI, MCO, CS, ORR, Finance, Workforce, Credentialing, IHC and Administration	FY 2019-2020	Achieve full 3-Year Re-accreditation for all standards of NCQA Review.	Look back period for 2021 Accreditation has started effective February 1, 2019.	Goal will be continued in FY2020-2021.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
VII.3	Health Services Advisory Group (HSAG)	QI, MCO, CS, ORR, Finance, Workforce, Credentialing and IHC	FY 2019-2020	Achieve full compliance for all three separate reviews as required by MDHHS: Performance Improvement Project (PIP), Performance Measure Validation (PMV) and the Compliance Monitoring review.	85% of all applicable evaluation elements received a score of Met for the Performance Improvement Project (PIP). However, The identification and prioritization of barriers through causal/barrier analysis and the selection of appropriate active interventions to address these barriers are necessary steps to improve outcomes. Detroit Wayne Integrated Health Network demonstrated strong performance in the Compliance Review, scoring 90 percent or above in three standards, with two of those standards achieving full compliance. These areas of strength include QAPIP Plan and Structure, Members' Rights and Protections, and Coordination of Care. Lastly, DWIHN demonstrated full compliance with PMV, with the exception of BH-TEDS Data Elements (Disability Designation). The standard is 95% and DWIHN scored 87.65%. We will continue to strive for Continuous Quality Improvement.	**Partially Met**; Goal will be continued in FY2020-2021.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.

Attachment A

QAPIP Work Plan
FY 2019-2020

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Responsible Department	Timeframe for Each Activity's Completion	Monitoring of Previously Identified Issues	Evaluation	Outcomes	Oversight of QI Activities by Committee
VII.4	Annual Needs Assessment	QI, MCO, CS, ORR, Finance, Workforce, Credentialing and IHC	FY 2019-2020	DWIHN targeted and prioritized planned actions through meaningful feedback that was ascertained from providers meetings, focus groups and members.	Annual Needs Assessment submitted to MDHHS on March 28, 2019. Ongoing work in the areas of planning, policy, process monitoring and program evaluation.	**Partially Met**; Goal will be continued in FY2020-2021.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.