Behavioral Health and Developmental Disabilities Administration
Prepaid Inpatient Health Plans

2018–2019 PIP Validation Report

Improving Diabetes Screening Rates for People With Schizophrenia or Bipolar Who Are Using Antipsychotic Medications

for

Region 7—Detroit Wayne Mental Health Authority

September 2019

For Validation Year 2

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Background

The Code of Federal Regulations (CFR), specifically 42 CFR §438.350, requires states that contract with managed care organizations (MCOs) to conduct an external quality review (EQR) of each contracting MCO. An EQR includes analysis and evaluation by an external quality review organization (EQRO) of aggregated information on healthcare quality, timeliness, and access. Health Services Advisory Group, Inc. (HSAG) serves as the EQRO for the State of Michigan, Department of Health and Human Services, (MDHHS)—responsible for the overall administration and monitoring of the Michigan Medicaid managed care program. MDHHS requires that the prepaid health plan (PIHP) conduct and submit performance improvement projects (PIPs) annually to meet the requirements of the Balanced Budget Act of 1997 (BBA), Public Law 105-33. According to the BBA, the quality of health care delivered to Medicaid enrollees in PIHPs must be tracked, analyzed, and reported annually. PIPs provide a structured method of assessing and improving the processes, and thereby the outcomes, of care for the population that a PIHP serves.

For State Fiscal Year (SFY) 2018–2019, the MHDDS required PIHPs to PIPs in accordance with 42 CFR §438.330(b)(1) and §438.330(d)(2)(i–iv). In accordance with §438.330(d)(2)(i–iv), each PIP must include:

- Measurement of performance using objective quality indicators.
- Implementation of systematic interventions to achieve improvement in quality.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

As one of the mandatory EQR activities required by 42 CFR §438.358(b)(1)(i), HSAG, as the State's EQRO, validated the PIPs through an independent review process. In its PIP evaluation and validation, HSAG used the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[1-1] HSAG's evaluation of the PIP includes two key components of the quality improvement (QI) process:

1. HSAG evaluates the technical structure of the PIP to ensure that **Detroit Wayne Mental Health Authority** designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., study question, population, indicator(s), sampling techniques, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: August 19, 2019.

this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.

2. HSAG evaluates the implementation of the PIP. Once designed, a PIP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well **Detroit Wayne Mental Health Authority** improves its rates through implementation of effective processes (i.e., barrier analyses, intervention design, and evaluation of results).

The goal of HSAG's PIP validation is to ensure that MDHHS and key stakeholders can have confidence that any reported improvement is related and can be directly linked to the quality improvement strategies and activities conducted by the PIHP during the PIP.

Rationale

The purpose of a PIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical or nonclinical areas.

For this year's 2018–2019 validation, **Detroit Wayne Mental Health Authority** submitted its ***Improving Diabetes Screening Rates for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*** PIP. The study topic selected by **Detroit Wayne Mental Health Authority** addressed CMS' requirements related to quality outcomes—specifically, the quality, timeliness, and accessibility of care and services.

Summary

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 **Detroit Wayne Mental Health Authority**.

Table 1-1 outlines the study indicator for the PIP.

Table 1-1—Study Indicator

PIP Topic	Study Indicator
Diabetes Screening Rates for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	The percentage of diabetes screenings completed during the measurement year for members with schizophrenia or bipolar disorder taking an antipsychotic medication.

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Validation Overview

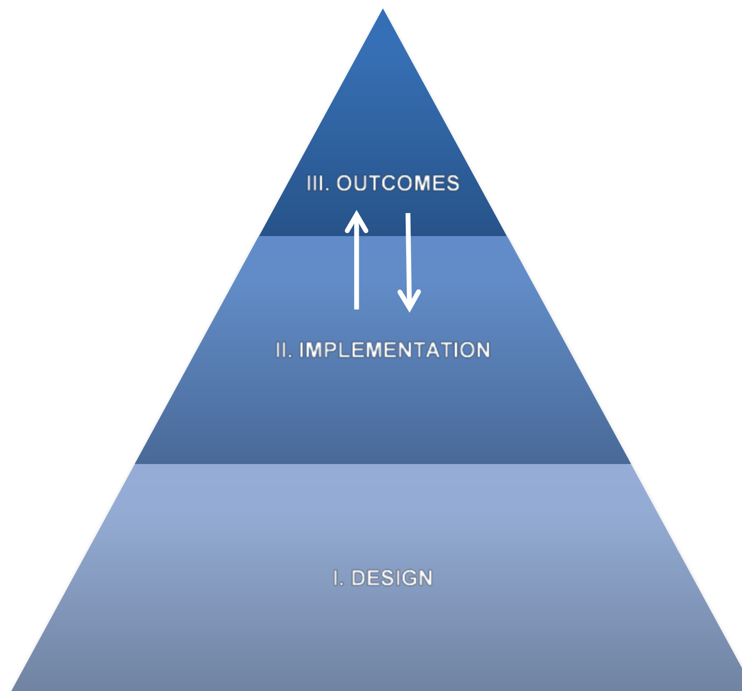
HSAG obtains the data needed to conduct the PIP validation from **Detroit Wayne Mental Health Authority**’s PIP Summary Form. This form provides detailed information about **Detroit Wayne Mental Health Authority**’s PIP related to the steps completed and evaluated by HSAG for the 2018–2019 validation cycle.

Each required step is evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designates evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements must be *Met*. Given the importance of critical elements to the scoring methodology, any critical element that receives a *Not Met* score results in an overall validation rating for the PIP of *Not Met*. **Detroit Wayne Mental Health Authority** would be given a *Partially Met* score if 60 percent to 79 percent of all evaluation elements were *Met* or one or more critical elements were *Partially Met*. HSAG provides a General Comment with a *Me*t validation score when enhanced documentation would have demonstrated a stronger understanding and application of the PIP activities and evaluation elements.

In addition to the validation status (e.g., *Met*) HSAG gives the PIP an overall percentage score for all evaluation elements (including critical elements). HSAG calculates the overall percentage score by dividing the total number of elements scored as *Met* by the total number of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculates a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met*.

Figure 1-1 illustrates the three stages of the PIP process—i.e., Design, Implementation, and Outcomes. Each sequential stage provides the foundation for the next stage. The Design stage establishes the methodological framework for the PIP. The steps in this section include development of the study topic, question, population, indicators, sampling techniques, and data collection. To implement successful improvement strategies, a methodologically sound study design is necessary.

Figure 1-1—Stages



Once **Detroit Wayne Mental Health Authority** establishes its study design, the PIP process progresses into the Implementation stage. This stage includes data analysis and interventions. During this stage, **Detroit Wayne Mental Health Authority** evaluates and analyzes its data, identifies barriers to performance, and develops active interventions targeted to improve outcomes. The implementation of effective improvement strategies is necessary to improve outcomes. The Outcomes stage is the final stage, which involves the evaluation of real and sustained improvement based on reported results and statistical testing. Sustained improvement is achieved when outcomes exhibit statistically significant improvement over the baseline and the improvement is sustained with a subsequent measurement period. This stage is the culmination of the previous two stages. If the outcomes do not improve, **Detroit Wayne Mental Health Authority** investigates the data collected to ensure that **Detroit Wayne Mental Health Authority** has correctly identified the barriers and implemented appropriate and effective interventions. If it has not, **Detroit Wayne Mental Health Authority** should revise its interventions and collect additional data to remeasure and evaluate outcomes for improvement. This process becomes cyclical until sustained statistical improvement is achieved.

Validation Findings

HSAG's validation evaluated the technical methods of the PIP (i.e., the study design). Based on its technical review, HSAG determined the overall methodological validity of the PIP. Table 2-1 summarizes the PIP validated during the review period with an overall validation status of *Met*, *Partially Met*, or *Not Met*. In addition, Table 2-1 displays the percentage score of evaluation elements that received a *Met* score, as well as the percentage score of critical elements that received a *Met* score. Critical elements are those within the validation tool that HSAG has identified as essential for producing a valid and reliable PIP. All critical elements must receive a *Met* score for a PIP to receive an overall *Met* validation status. A resubmission is a PIHP's updates to the previously submitted PIP with corrected/additional documentation.

Table 2-1 illustrates the validation scores for both the initial submission and resubmission. **Detroit Wayne Mental Health Authority** received technical assistance from HSAG, corrected the deficiencies, resubmitted the PIP for a second review, and improved the overall validation score to *Met*.

Table 2-1—2018–2019 PIP Validation Results for Detroit Wayne Mental Health Authority

Name of Project	Type of Annual Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Diabetes Screening Rates for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Submission	60%	50%	*Partially Met*
	Resubmission	100%	100%	*Met*

[1] **Type of Review**—Designates the PIP review as an annual submission, or resubmission. A resubmission means the PIHP was required to resubmit the PIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

[3] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Overall Validation Status**—Populated from the PIP Validation Tool and based on the percentage scores.

Table 2-2 displays the validation results for **Detroit Wayne Mental Health Authority**'s PIP evaluated during 2018–2019. This table illustrates the PIHP'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 Table 2-2 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 steps.

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

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

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

Design

Detroit Wayne Mental Health Authority designed a scientifically sound project supported by the use of key research principles, meeting all requirements in the Design stage. The technical design of the PIP was sufficient to measure and monitor PIP outcomes. **Detroit Wayne Mental Health Authority** indicated that it plans to include its entire eligible population in this PIP.

Implementation

In the Implementation stage, **Detroit Wayne Mental Health Authority** accurately calculated and interpreted the baseline results for the study indicator. **Detroit Wayne Mental Health Authority** progressed to completing a causal/barrier analysis using quality improvement tools and implementing interventions likely to impact outcomes.

Outcomes

Baseline performance was reported for the study indicator for this validation cycle. For the next annual validation, the study indicator outcomes will be assessed by comparing **Detroit Wayne Mental Health Authority**'s Remeasurement 1 results to the baseline measurement.

Analysis of Results

Table 2-3 displays outcomes data for **Detroit Wayne Mental Health Authority**'s ***Improving Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication*** PIP. **Detroit Wayne Mental Health Authority** reported baseline data for one study indicator.

Table 2-3—Performance Improvement Project Outcomes for Detroit-Wayne Mental Health Authority

Study Indicator Results				
Study Indicator	**Baseline (1/1/2017–12/31/2017)**	**Remeasurement 1 (1/1/2018–12/31/2018)**	**Remeasurement 2 (1/1/2019–12/31/2019)**	**Sustained Improvement**
Improving the Rates of Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Dispensed Atypical Antipsychotic Medications during the Measurement Year	78.6%			

For the baseline measurement period, **Detroit Wayne Mental Health Authority** reported that 78.6 percent of people with schizophrenia and bipolar disorder who were dispensed atypical antipsychotic medications had a diabetes screening. The Remeasurement 1 goal was set at 80.0 percent.

Barriers/Interventions

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. The PIHP's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the PIHP's overall success in achieving the desired outcomes for the PIP.

Detroit Wayne Mental Health Authority used an Ishikawa Fishbone diagram and feedback collected from providers to determine and prioritize barriers. From these tools, **Detroit Wayne Mental Health Authority** determined the following barriers:

- Lack of knowledge among providers to recommend diabetes screening for members with schizophrenia and bipolar disorder.
- Lack of follow through by enrollee/members to have labs drawn when ordered.

To address these barriers, **Detroit Wayne Mental Health Authority** initiated the following interventions:

- **Detroit Wayne Mental Health Authority** will monitor compliance with diabetes screening through clinical treatment chart audits. Findings from the chart audits will be provided to providers through the Quality Workgroup meetings and the Quality Improvement Steering Committee.
- **Detroit Wayne Mental Health Authority** will measure and monitor compliance with having labs ordered and drawn no less than quarterly through review of the SSD HEDIS-like data in Relias ProAct. Findings will be provided to providers through the Quality 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.
- **Detroit Wayne Mental Health Authority** will provide education on the Clinical Guidelines Procedures to service providers, practitioners, and **Detroit Wayne Mental Health Authority** staff members through the Quality Operations Workgroup meetings, Quality Improvement Steering Committee, and the Improvement Practices Leadership meetings.
- **Detroit Wayne Mental Health Authority** will educate the provider network through community outreach initiatives and training on the importance of diabetes screening.

3. Conclusions and Recommendations

Conclusions

The PIP received an overall *Met* validation status, with *Met* scores for 100 percent of critical evaluation elements and 100 percent overall for evaluation elements across all activities completed and validated. **Detroit Wayne Mental Health Authority**'s performance on this PIP suggests a thorough application of the PIP Design stage (Steps I through VI) and Implementation stage (Steps VII through VIII). The PIP included only baseline results for this validation cycle and had not progressed to the Outcomes stage.

Recommendations

As the PIP progresses, HSAG recommends the following:

- **Detroit Wayne Mental Health Authority** should address all General Comments documented in the PIP Validation Tool prior to the next annual submission. General Comments are associated with *Met* validation scores. If not addressed, the evaluation element may be scored down accordingly.
- **Detroit Wayne Mental Health Authority** should ensure that it follows the approved PIP methodology to calculate and report Remeasurement 1 data accurately in next year's annual submission.
- To impact the Remeasurement 1 study indicator rate, **Detroit Wayne Mental Health Authority** should complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers in a timely manner. Interventions implemented late in the Remeasurement 1 study period will not have enough time to impact the study indicator rate.
- **Detroit Wayne Mental Health Authority** should document the process and steps used to determine barriers to improvement and attach completed QI tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- **Detroit Wayne Mental Health Authority** should implement active, innovative interventions with the potential to directly impact study indicator outcomes.
- **Detroit Wayne Mental Health Authority** should have a process in place for evaluating the performance of each PIP intervention and its impact on the study indicators and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.
- **Detroit Wayne Mental Health Authority** should reference the PIP Completion Instructions annually to ensure that all requirements for each completed step have been addressed.

Appendix A. PIP Validation Tool

The following contains the PIP validation tool for **Detroit Wayne Mental Health Authority**.

Demographic Information			
Plan Name:	Region 7 - Detroit-Wayne Mental Health Authority		
Project Leader Name:	Tania Greason, MBA	Title:	QI Administrator
Telephone Number:	(313) 344-9099	E-mail Address:	tgreason@dwmha.com
Name of Project:	***Improving Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using An Antipsychotic Medication***		
Submission Date:	8/27/2019		

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		Evaluation Elements	Scoring	Comments
Performance Improvement Project/Health Care Study Evaluation				
I.	**Select the Study Topic(s): The study topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve processes and outcomes of healthcare. The topic may also be specified by the State. The study topic:**			
C*	1.	Was selected following collection and analysis of data. NA is not applicable to this element for scoring.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The study topic was selected following the collection and analysis of the plan-specific data.
	2.	Has the potential to affect consumer health, functional status, or satisfaction. The score for this element will be Met or Not Met.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The PIP has the potential to affect consumer health, functional status, or satisfaction.

Results for Step I

Total Evaluation Elements					**Critical Elements**				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*Not Applicable*	Critical Elements***	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
2	2	0	0	0	1	1	0	0	0

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

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Evaluation Elements		Scoring	Comments
Performance Improvement Project/Health Care Study Evaluation			
II.	**Define the Study Question(s): Stating the study question(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation. The study question:**		
C*	1. Was stated in simple terms and in the recommended X/Y format. NA is not applicable to this element for scoring.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The study question was stated in simple terms using the recommended X/Y format.

Results for Step II

Total Evaluation Elements					Critical Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*Not Applicable*	Critical Elements***	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
1	1	0	0	0	1	1	0	0	0

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

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		Evaluation Elements	Scoring	Comments
Performance Improvement Project/Health Care Study Evaluation				
III.		**Define the Study Population: The study population should be clearly defined to represent the population to which the study question and indicators apply, without excluding consumers with special healthcare needs. The study population:**		
C*	1.	Was accurately and completely defined and captured all consumers to whom the study question(s) applied. NA is not applicable to this element for scoring.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The PIHP accurately and completely defined the study population.

Results for Step III

Total Evaluation Elements					Critical Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*Not Applicable*	Critical Elements***	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
1	1	0	0	0	1	1	0	0	0

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

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	Evaluation Elements	Scoring	Comments
Performance Improvement Project/Health Care Study Evaluation			
IV.	**Select the Study Indicator(s): A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. Study indicator goals should be specific, measurable, attainable, relevant, and time-bound. The study indicator(s):**		
C*	1. Were well-defined, objective, and measured changes in health or functional status, consumer satisfaction, or valid process alternatives.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	In last year's PIP submission, the PIHP documented the baseline measurement period as calendar year (CY) 2018. In this year's PIP submission, the PIHP changed the baseline measurement period to CY 2017 but did not explain the change. The PIHP should provide an explanation for the change in measurement period dates. All PIHPs should be reporting baseline from 2018 unless they were directed and approved by MDHHS to use a different measurement period. **Re-review August 2019:** In the resubmission, the PIHP revised the baseline measurement period as calendar year (CY) 2018. The score for this evaluation element has been changed from *Partially Met* to *Met.*
	2. Included the basis on which the indicator(s) was adopted, if internally developed.	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	The study indicator was not internally developed.

Results for Step IV

Total Evaluation Elements						Critical Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*Not Applicable*		Critical Elements***	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
2	1	0	0	1		1	1	0	0	0

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

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	Evaluation Elements	Scoring	Comments
Performance Improvement Project/Health Care Study Evaluation			
V.	**Use Sound Sampling Techniques: (If sampling is not used, each evaluation element will be scored Not Applicable [NA]). If sampling is used to select consumers in the study, proper sampling techniques are necessary to provide valid and reliable information on the quality of care provided. Sampling methods:**		
	1. Included the measurement period for the sampling methods used (e.g., baseline, Remeasurement 1).	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	Sampling will not be used.
	2. Included the title of the applicable study indicator(s).	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	Sampling will not be used.
	3. Included the population size.	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	Sampling will not be used.
C*	4. Included the sample size.	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	Sampling will not be used.
	5. Included the margin of error and confidence level.	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	Sampling will not be used.
	6. Described in detail the method used to select the sample.	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	Sampling will not be used.
C*	7. Allowed for the generalization of results to the study population.	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	Sampling will not be used.

Results for Step V

Total Evaluation Elements					**Critical Elements**				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*Not Applicable*	Critical Elements***	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
7	0	0	0	7	2	0	0	0	2

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

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		Evaluation Elements	Scoring	Comments
Performance Improvement Project/Health Care Study Evaluation				
VI.	**Reliably Collect Data: The data collection process must ensure that the data collected on the study indicators are valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement. Data collection procedures include:**			
	1.	Clearly defined sources of data and data elements to be collected. NA is not applicable to this element for scoring.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The PIHP clearly and accurately defined the data elements and data sources.
C*	2.	A clearly defined and systematic process for collecting data that included how baseline and remeasurement data were collected. NA is not applicable to this element for scoring.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The PIHP did not include information about when the data will be retrieved for analysis. It should be noted that the *Point of Clarification* was not addressed from last years feedback resulting in the decline of the score. **Re-review August 2019:** In the resubmission, the PIHP addressed HSAG's initial PIP validation feedback correctly. The score for this evaluation element has been changed from *Partially Met* to *Met.*
C*	3.	A manual data collection tool that ensured consistent and accurate collection of data according to indicator specifications.	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	Manual data collection will not be used.
	4.	An estimated degree of administrative data completeness percentage. Met = 80 - 100 percent complete Partially Met = 50 - 79 percent complete Not Met = <50 percent complete or not provided	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The estimated degree of administrative data completeness was between 80 percent and 100 percent, and the PIHP explained how it determined the administrative data completeness.

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

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Evaluation Elements	Scoring	Comments
Performance Improvement Project/Health Care Study Evaluation		

Results for Step VI

Total Evaluation Elements					Critical Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*Not Applicable*	Critical Elements***	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
4	3	0	0	1	2	1	0	0	1

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

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	Evaluation Elements	Scoring	Comments
Performance Improvement Project/Health Care Study Evaluation			
VII.	**Analyze Data and Interpret Study Results: Clearly present the results for each study indicator(s). Describe the data analysis performed and the results of the statistical analysis, if applicable, and interpret the results. Through data analysis and interpretation, real improvement as well as sustained improvement can be determined. The data analysis and interpretation of the study indicator outcomes:**		
C*	1. Included accurate, clear, consistent, and easily understood information in the data table.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	In the Study Indicator Results table, the PIHP reported baseline (CY 2017) and Remeasurement 1 data (CY 2018); however, for this year's submission, the PIHPs were to report baseline data for CY 2018. The PIHP did not include the statistical testing *p* value results. In addition, the PIHP should include the study indicator title in the Study Indicator Results table. **Re-review August 2019:** In the resubmission, the PIHP addressed HSAG's initial PIP validation feedback correctly. The score for this evaluation element has been changed from *Partially Met* to *Met.*
	2. Include a narrative interpretation that addresses all required components of data analysis and statistical testing.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The narrative interpretation of results did not include an explanation for the change in the baseline measurement period dates from CY 2018 to CY 2017. The interpretation of results did not described how data analysis was conducted or how the baseline rate was calculated. **Re-review August 2019:** In the resubmission, the PIHP addressed HSAG's initial PIP validation feedback correctly. The score for this evaluation element has been changed from *Partially Met* to *Met.*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

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Evaluation Elements		Scoring	Comments
Performance Improvement Project/Health Care Study Evaluation			
VII.	**Analyze Data and Interpret Study Results: Clearly present the results for each study indicator(s). Describe the data analysis performed and the results of the statistical analysis, if applicable, and interpret the results. Through data analysis and interpretation, real improvement as well as sustained improvement can be determined. The data analysis and interpretation of the study indicator outcomes:**		
	3. Identified factors that threatened the validity of the data reported and ability to compare the initial measurement with the remeasurement.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The PIHP identified that no factors threatened the validity of the reported data.

Results for Step VII

Total Evaluation Elements					Critical Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*Not Applicable*	Critical Elements***	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
3	3	0	0	0	1	1	0	0	0

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

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	Evaluation Elements	Scoring	Comments
Performance Improvement Project/Health Care Study Evaluation			
VIII.	**Improvement Strategies (interventions for improvement as a result of analysis): Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis. The improvement strategies are developed from an ongoing quality improvement process that included:**		
C*	1. A causal/barrier analysis with a clearly documented team, process/steps, and quality improvement tools.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The PIHP documented its causal/barrier analysis process, described its quality improvement (QI) team, processes/steps, and tools used.
	2. Barriers that were identified and prioritized based on results of data analysis and/or other quality improvement processes.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The PIHP needs to include a description of the process used by the PIHP's workgroup to prioritize the barriers. It was noted that in the Barriers/Interventions table, all barriers had the same numeric ranking value assigned. The PIHP should assign one priority ranking to the barrier or provide a clear rationale as to why all barriers share the same priority rank. **Re-review August 2019:** In the resubmission, the PIHP addressed HSAG's initial PIP validation feedback correctly. The score for this evaluation element has been changed from *Partially Met* to *Met.*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

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Evaluation Elements			Scoring	Comments
Performance Improvement Project/Health Care Study Evaluation				
VIII.	**Improvement Strategies (interventions for improvement as a result of analysis): Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis. The improvement strategies are developed from an ongoing quality improvement process that included:**			
C*	3.	Interventions that were logically linked to identified barriers and will directly impact study indicator outcomes.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The PIHP included some passive interventions (i.e., newsletters and website). Passive interventions are not likely to impact the study indicator outcomes and difficult to track and evaluate for effectiveness. For the purposes of the improvement project, the PIHP should only include active interventions that have the potential to impact study indicator results and can be evaluated for effectiveness. For the sixth listed intervention in the Barrier/Intervention table, there appeared to be more than one barrier and intervention. Each intervention needs to be linked to an individual corresponding barrier. **Re-review August 2019:** In the resubmission, the PIHP addressed HSAG's initial PIP validation feedback correctly. The score for this evaluation element has been changed from *Partially Met* to *Met.*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

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	Evaluation Elements	Scoring	Comments
Performance Improvement Project/Health Care Study Evaluation			
VIII.	**Improvement Strategies (interventions for improvement as a result of analysis): Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis. The improvement strategies are developed from an ongoing quality improvement process that included:**		
	4. Intervention that were implemented in a timely manner to allow for impact of study indicator outcomes.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The interventions were implemented in a timely manner to allow for impact of the study indicator outcomes. **General Comment**: In the Barrier/Intervention table, the PIHP documented "Ongoing" for the date implemented for several interventions. For example, "April 2018 Ongoing." The PIHP should delete all references to "ongoing" and provide the month and date for each intervention listed in the table. **Re-review August 2019:** In the resubmission, the PIHP addressed the General Comment.

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

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Evaluation Elements		Scoring	Comments
Performance Improvement Project/Health Care Study Evaluation			
VIII.	**Improvement Strategies (interventions for improvement as a result of analysis): Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis. The improvement strategies are developed from an ongoing quality improvement process that included:**		
C*	5. Evaluation of individual interventions for effectiveness.	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	The PIHP has not progressed to the point of evaluating the effectiveness of interventions related to the PIP. **General Comment**: The PIHP provided minimal information regarding intervention-specific evaluation results. For example, how will the PIHP determine that the newsletters and website information were effective in improving diabetic screening for individuals with schizophrenia or bipolar disorder who are using antipsychotic medication? The PIHP should describe the evaluation process and results for each intervention included in the PIP. **Re-review August 2019:** In the resubmission, the PIHP did not address the General Comment; therefore, the General Comment will remain.

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

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Evaluation Elements		Scoring	Comments
Performance Improvement Project/Health Care Study Evaluation			
VIII.	**Improvement Strategies (interventions for improvement as a result of analysis): Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis. The improvement strategies are developed from an ongoing quality improvement process that included:**		
	6. Interventions that were continued, revised, or discontinued based on evaluation results.	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	The PIHP has not progressed to the point of being assessed for the continuation, revision, or discontinuation of interventions related to the PIP. **General Comment**: It appeared that the PIHP's decisions regarding interventions were not based on evaluation results. For example, the PIHP continued newsletters and website information; however, there were no results to support that decision. Decisions to continue, discontinue, or revise an intervention should be data-driven, based on intervention evaluation results. **Re-review August 2019:** In the resubmission, the PIHP did not address the General Comment; therefore, the General Comment will remain.

Results for Step VIII

Total Evaluation Elements					Critical Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*Not Applicable*	Critical Elements***	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
6	4	0	0	2	3	2	0	0	1

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

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	Evaluation Elements	Scoring	Comments
Performance Improvement Project/Health Care Study Evaluation			
IX.	**Assess for Real Improvement: Real improvement or meaningful change in performance is evaluated based on study indicator(s) results.**		
	1. The remeasurement methodology was the same as the baseline methodology.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	Not Assessed. The PIP had not progressed to the point of being assessed for real improvement.
	2. The documented improvement meets the State- or plan-specific goal.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	Not Assessed. The PIP had not progressed to the point of being assessed for real improvement.
C*	3. There was statistically significant improvement over the baseline across all study indicators.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	Not Assessed. The PIP had not progressed to the point of being assessed for real improvement.

Results for Step IX

Total Evaluation Elements						Critical Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*Not Applicable*		Critical Elements***	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
3	0	0	0	0		1	0	0	0	0

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

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		Evaluation Elements	Scoring	Comments
Performance Improvement Project/Health Care Study Evaluation				
X.		**Assess for Sustained Improvement: Sustained improvement is demonstrated through repeated measurements over comparable time periods.**		
C*	1.	Repeated measurements over comparable time periods demonstrated sustained improvement over the baseline.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	Not Assessed. Sustained improvement cannot be assessed until statistically significant improvement over the baseline has been achieved across all study indicators, and a subsequent measurement period has been reported.

Results for Step X

Total Evaluation Elements					**Critical Elements**				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*Not Applicable*	Critical Elements***	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
1	0	0	0	0	1	0	0	0	0

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

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Performance Improvement Projects

Table A-1—2018-2019 PIP Validation Tool Scores:
Improving Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using An Antipsychotic Medication
for Region 7 - Detroit-Wayne Mental Health Authority

Review Step		Total Possible Evaluation Elements (Including Critical Elements)	Total Met	Total Partially Met	Total Not Met	Total NA	Total Possible Critical Elements	Total Critical Elements Met	Total Critical Elements Partially Met	Total Critical Elements Not Met	Total Critical Elements NA
I.	Select the Study Topic(s)	2	2	0	0	0	1	1	0	0	0
II.	Define the Study Question(s)	1	1	0	0	0	1	1	0	0	0
III.	Define the Study Population	1	1	0	0	0	1	1	0	0	0
IV.	Select the Study Indicator(s)	2	1	0	0	1	1	1	0	0	0
V.	Use Sound Sampling Techniques	7	0	0	0	7	2	0	0	0	2
VI.	Reliably Collect Data	4	3	0	0	1	2	1	0	0	1
VII.	Analyze Data and Interpret Study Results	3	3	0	0	0	1	1	0	0	0
VIII	Improvement Strategies	6	4	0	0	2	3	2	0	0	1
IX.	Assess for Real Improvement	3	Not Assessed				1	Not Assessed			
X.	Assess for Sustained Improvement	1	Not Assessed				1	Not Assessed			
Totals for All Steps		**30**	**15**	**0**	**0**	**11**	**14**	**8**	**0**	**0**	**4**

Table A-2—2018-2019 PIP Validation Tool Overall Score:
Improving Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using An Antipsychotic Medication
for Region 7 - Detroit-Wayne Mental Health Authority

Percentage Score of Evaluation Elements Met*	**100%**
Percentage Score of Critical Elements Met**	**100%**
Validation Status***	***Met***

* The percentage score for all evaluation elements Met is calculated by dividing the total Met by the sum of all evaluation elements Met, Partially Met, and Not Met. The Not Assessed and Not Applicable scores have been removed from the scoring calculations.

** The percentage score of critical elements Met is calculated by dividing the total critical elements Met by the sum of the critical elements Met, Partially Met, and Not Met.

*** Met equals high confidence/confidence that the PIP was valid.
Partially Met equals low confidence that the PIP was valid.
Not Met equals reported PIP results that were not credible.

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EVALUATION OF THE OVERALL VALIDITY AND RELIABILITY OF PIP RESULTS

HSAG assessed the validity and reliability of the results based on CMS validation protocols and determined whether the State and key stakeholders can have confidence in the reported PIP findings. Based on the validation of this PIP, HSAG's assessment determined the following:

Met: **High confidence/confidence in reported PIP results. All critical evaluation elements were Met, and 80 to 100 percent of all evaluation elements were Met across all activities.**

Partially Met: **Low confidence in reported PIP results. All critical evaluation elements were Met, and 60 to 79 percent of all evaluation elements were Met across all activities; or one or more critical evaluation elements were Partially Met.**

Not Met: **All critical evaluation elements were Met, and less than 60 percent of all evaluation elements were Met across all activities; or one or more critical evaluation elements were Not Met.**

Summary of Aggregate Validation Findings

X	***Met***		***Partially Met***		***Not Met***

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Appendix B. PIP Summary Form

Appendix B contains the PIP Summary Form **Detroit Wayne Mental Health Authority** submitted to HSAG for validation. HSAG made only minor grammatical corrections to these forms; the content/meaning was not altered. This appendix does not include any attachments provided with the PIP submission.

Appendix B: State of Michigan 2018-2019 PIP Summary Form
Improving Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using An Antipsychotic Medication for Region 7 - Detroit Wayne Mental Health Authority

Demographic Information	
Plan Name: **Detroit Wayne Mental Health Authority**	Type of Delivery System: _____
Project Leader Name: ~~Brad Klemm, LMSW, ACSW~~ Tania Greason, MBA	Title: ~~Manager of Quality~~ QI Administrator
Telephone Number: 313-344-9099 x3583	Email Address: ~~bklemm@dwmha.com~~ tgreason@dwmha.com
Name of Project: Improving Diabetes Screening for People with Schizophrenia or Bipolar Disorder	
Submission Date: July 9th 2018 July 10, 2019, August 27, 2019	

Legend:

2018 data submitted July 10, 2019

2018 data resubmission August 27, 2019

2017 data submitted July 9, 2018

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Appendix B: State of Michigan 2018-2019 PIP Summary Form
Improving Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using An Antipsychotic Medication
for Region 7 - Detroit Wayne Mental Health Authority

Step I: Select the Study Topic. The study topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve processes and outcomes of healthcare. The topic may also be specified by the State.

Study Topic: Diabetes Screening for people with Schizophrenia or Bipolar Disorder who are Dispensed Atypical Antipsychotic Medications (SSD) and served in the DWMHA network.

Adults with serious mental illness, commonly treated with second-generation antipsychotic drugs, have up to two-times-greater prevalence of type 2 diabetes, dyslipidemia, and obesity than the normal population.

In February 2004, the American Diabetes Association published a consensus statement on antipsychotic drugs, obesity and diabetes with the American Psychiatric Association, the American Association of Clinical Endocrinologists, and the North American Association for the study of obesity. The consensus statement described the metabolic risks associated with atypical antipsychotics and recommended baseline and ongoing assessment of fasting serum glucose or HbA1c in all patients receiving these agents (Morrato, 2009).

Currently diabetes occurs in one out of five patients. Among patients with co-occurring schizophrenia and metabolic disorder, the non-treatment rate for diabetes is approximately 32 percent (Nasrallah, et.al, 2006). It is now well established that people with serious mental illness (SMI), including schizophrenia and bipolar disorder have excess morbidity and mortality leading to a reduced lifespan of 20-25 years compared with the rest of the population. The increased mortality is largely attributable to chronic physical illness, including metabolic abnormalities rather than factors that are directly associated with psychiatric illness, such as suicide (Shizaki 2015).

During 2015 and 2016, the Michigan Department of Health and Human Services (MDHHS) contracted with eleven health plans to provide managed care services to Michigan Medicaid enrollees. MDHHS uses HEDIS rates for the annual Medicaid consumer guide as well as for annual performance assessment. MDHHS selected thirty-five HEDIS measures to evaluate Michigan health plans. Performance levels for Michigan Medicaid Health Plans were established as specific and attainable rates based on national percentiles. DWMHA is the Prepaid Inpatient health plan (PIHP) for Detroit and Wayne County in Michigan. As the PIHP, DWMHA manages Medicaid resources for behavioral health, substance use and intellectual/developmental disability services for Medicaid enrollees. There are eight Medicaid Health Plans in Wayne County, and DWMHA is contractually obligated to collaborate with each of those health plans in an effort to improve performance on a subset of shared HEDIS metrics. Diabetes screening for people with a diagnosis of schizophrenia and/or bipolar disorder, who are 18-64 years of age, and who were dispensed an antipsychotic medication is one such measure. Using FY16 data DWMHA served 76,776 consumers; of those, 73.5 percent of these members had a diagnosis of schizophrenia and/or bipolar disorder. In 2015 and 2016, 10,221 of these members met the eligibility criteria for the relevant HEDIS measure. This HEDIS measure is of importance to DWMHA because of the volume of individuals with schizophrenia or bipolar disorder taking atypical antipsychotics served in the system, and the significant long-term health risks posed to this already vulnerable population. This measure was also identified by MDHHS as a key indicator and opportunity for collaboration with the

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Appendix B: State of Michigan 2018-2019 PIP Summary Form
Improving Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using An Antipsychotic Medication
for Region 7 - Detroit Wayne Mental Health Authority

Performance Improvement Projects

Step I: Select the Study Topic. The study topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve processes and outcomes of healthcare. The topic may also be specified by the State.

Medicaid Health Plans. The HEDIS 201~~7~~8 ~~(2016 data)~~ showed ~~75.9~~% 78.6% of the eligible population while the MDHHS goal in 80% of the eligible population screened for diabetes.

In addition, antipsychotics are associated with clearly documented weight gain, which can lead to obesity. Reducing obesity is a key priority in Michigan, as Michigan has one of the highest obesity rates in the nation, 31% of adults and 17% of youth are obese. Obesity directly impacts a person's overall health and is the root cause of many chronic illnesses, such as type 2 diabetes and heart disease. The Michigan Health and Wellness 4X4 plan is an initiative to address this health issue. Promoting the monitoring of BMI, blood pressure, cholesterol and blood sugar levels is an important part of this initiative. These measures are an important supplement to the education of members concerning the importance of healthy eating and exercise. MDHHS has identified the same medical complications for members that are taking antipsychotic medications and recognizes the importance of diabetic screening for this population of member, MDHHS began an initiative similar to the DWMHA Performance Improvement Project (PIP). The initiative offers incentives which adds additional reinforcement for DWMHA to meet the goal of the DWMHA PIP.

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Step II: Define the Study Question(s). Stating the question(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation.

The Study Question(s) should:

- Be structured in the recommended X/Y format: “Does doing X result in Y?”
- State the problem in clear and simple terms.
- Be answerable based on the data collection methodology and study indicator(s).

Study Question(s):

Will targeted interventions increase the rates of diabetic screening for adults aged 18-64 with schizophrenia or bipolar disorder dispensed atypical antipsychotics within the DWMHA network.

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Step III: Define the Study Population. The study population should be clearly defined to represent the population to which the study question and indicators apply, without excluding consumers with special healthcare needs.

The study population definition should:

- Include the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gap criteria.
- Include the age range and the anchor dates used to identify age criteria, if applicable.
- Include the inclusion, exclusion, and diagnosis criteria.
- Include a list of diagnosis/procedure/pharmacy/billing codes used to identify consumers, if applicable.
- Capture all consumers to whom the study question(s) applies.
- Include how race and ethnicity will be identified, if applicable.

Study Population:

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

Enrollment requirements (if applicable):

Individuals served by DWMHA of 18-64 years of age as of the last day of the relevant measurement year with a diagnosis of Schizophrenia or Bipolar Disorder who were dispensed an atypical antipsychotic medication. Members must have been continuously enrolled during the measurement year.

Allowable Gap: No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage.

Consumer age criteria (if applicable):

18-64 years of age as of the last day of the relevant fiscal year

Inclusion, exclusion, and diagnosis criteria:

Inclusion:

Medicaid members served by DWMHA age 18 to 64 years as of December 31 of the measurement year with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication

- Identify members with schizophrenia or bipolar disorder as those who met at least one of the following criteria during the measurement year:

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Step III: Define the Study Population. The study population should be clearly defined to represent the population to which the study question and indicators apply, without excluding consumers with special healthcare needs.

The study population definition should:

- Include the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gap criteria.
- Include the age range and the anchor dates used to identify age criteria, if applicable.
- Include the inclusion, exclusion, and diagnosis criteria.
- Include a list of diagnosis/procedure/pharmacy/billing codes used to identify consumers, if applicable.
- Capture all consumers to whom the study question(s) applies.
- Include how race and ethnicity will be identified, if applicable.

- At least one acute inpatient encounter, with any diagnosis of schizophrenia or bipolar disorder. Any of the following code combinations meet criteria:
  - BH Stand Alone Acute Inpatient Value Set *with* Schizophrenia Value Set
  - BH Stand Alone Acute Inpatient Value Set *with* Bipolar Disorder Value Set
  - BH Stand Alone Acute Inpatient Value Set *with* Other Bipolar Disorder Value Set
  - BH Acute Inpatient Value Set *with* BH Acute Inpatient POS Value Set *and* Schizophrenia Value Set
  - BH Acute Inpatient Value Set *with* BH Acute Inpatient POS Value Set *and* Bipolar Disorder Value Set
  - BH Acute Inpatient Value Set *with* BH Acute Inpatient POS Value Set *and* Other Bipolar Disorder Value Set
- At least two visits in an outpatient, intensive outpatient, partial hospitalization, emergency department (ED) or nonacute inpatient setting, on different dates of service, with any diagnosis of schizophrenia. Any two of the following code combinations meet criteria:
  - BH Stand Alone Outpatient/PH/IOP Value Set *with* Schizophrenia Value Set
  - BH Outpatient/PH/IOP Value Set *with* BH Outpatient/PH/IOP POS Value Set *and* Schizophrenia Value Set
  - ED Value Set *with* Schizophrenia Value Set
  - BH ED Value Set *with* BH ED POS Value Set *and* Schizophrenia Value Set
  - BH Stand Alone Nonacute Inpatient Value Set *with* Schizophrenia Value Set
  - BH Nonacute Inpatient Value Set *with* BH Nonacute Inpatient POS Value Set *and* Schizophrenia Value Set

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Step III: Define the Study Population. The study population should be clearly defined to represent the population to which the study question and indicators apply, without excluding consumers with special healthcare needs.

The study population definition should:

- Include the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gap criteria.
- Include the age range and the anchor dates used to identify age criteria, if applicable.
- Include the inclusion, exclusion, and diagnosis criteria.
- Include a list of diagnosis/procedure/pharmacy/billing codes used to identify consumers, if applicable.
- Capture all consumers to whom the study question(s) applies.
- Include how race and ethnicity will be identified, if applicable.

- At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of bipolar disorder. Any two of the following code combinations meet criteria:
  - BH Stand Alone Outpatient/PH/IOP Value Set *with* Bipolar Disorder Value Set
  - BH Stand Alone Outpatient/PH/IOP Value Set *with* Other Bipolar Disorder Value Set
  - BH Outpatient/PH/IOP Value Set *with* BH Outpatient/PH/IOP POS Value Set *and* Bipolar Disorder Value Set
  - BH Outpatient/PH/IOP Value Set *with* BH Outpatient/PH/IOP POS Value Set *and* Other Bipolar Disorder Value Set
  - ED Value Set *with* Bipolar Disorder Value Set
  - ED Value Set *with* Other Bipolar Disorder Value Set
  - BH ED Value Set *with* BH ED POS Value Set *and* Bipolar Disorder Value Set
  - BH ED Value Set *with* BH ED POS Value Set *and* Other Bipolar Disorder Value Set
  - BH Stand Alone Nonacute Inpatient Value Set *with* Bipolar Disorder Value Set
  - BH Stand Alone Nonacute Inpatient Value Set *with* Other Bipolar Disorder Value Set
  - BH Nonacute Inpatient Value Set *with* BH Nonacute Inpatient POS Value Set *and* Bipolar Disorder Value Set
  - BH Nonacute Inpatient Value Set *with* BH Nonacute Inpatient POS Value Set *and* Other Bipolar Disorder Value Set

Exclude members who met any of the following criteria:

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Step III: Define the Study Population. The study population should be clearly defined to represent the population to which the study question and indicators apply, without excluding consumers with special healthcare needs.

The study population definition should:

- Include the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gap criteria.
- Include the age range and the anchor dates used to identify age criteria, if applicable.
- Include the inclusion, exclusion, and diagnosis criteria.
- Include a list of diagnosis/procedure/pharmacy/billing codes used to identify consumers, if applicable.
- Capture all consumers to whom the study question(s) applies.
- Include how race and ethnicity will be identified, if applicable.

- Members with diabetes. There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify members with diabetes, but a member need only be identified by one method to be excluded from the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.
  - *Claim/Encounter Data*: Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years):
    - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two visits.
    - At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set)
  - *Pharmacy Data*: Members who were dispensed insulin or oral hypoglycemics/antihyperglycemics during the measurement year or year prior to the measurement year on an ambulatory basis (refer to Table CDC-A in the original measure documentation for a list of prescriptions to identify members with diabetes).
- Members who had no antipsychotic medications dispensed during the measurement year. There are two ways to identify dispensing events: by claim/encounter data and by pharmacy data. The organization must uses both methods to identify dispensing events, but an event need only be identified by one method to be counted.
  - *Claim/Encounter Data*: An antipsychotic medication (Long-Acting Injections Value Set)
  - *Pharmacy Data*: Dispensed an antipsychotic medication (refer to Table SSD-D in the original measure documentation for a list of antipsychotic medications) on an ambulatory basis.

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Step III: Define the Study Population. The study population should be clearly defined to represent the population to which the study question and indicators apply, without excluding consumers with special healthcare needs.

The study population definition should:

- Include the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gap criteria.
- Include the age range and the anchor dates used to identify age criteria, if applicable.
- Include the inclusion, exclusion, and diagnosis criteria.
- Include a list of diagnosis/procedure/pharmacy/billing codes used to identify consumers, if applicable.
- Capture all consumers to whom the study question(s) applies.
- Include how race and ethnicity will be identified, if applicable.

Members with Medicare and Medicaid insurance (dual eligible) are excluded.

Diagnosis/procedure/pharmacy/billing codes (if applicable):
CPT for glucose test-80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951
CPT for HbA1c-83036, 83037
CPT II-3044-3046

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Step IV: **Select the Study Indicator(s). A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. Study indicator goals should be specific, measurable, attainable, relevant, and time-bound.**

The description of the study Indicator(s) should:

- Include the complete title of the study indicator(s).
- Include a narrative description of the numerator(s) and denominator(s).
- Include the rationale for selecting the study indicator(s).
- If indicators are based on nationally recognized measures (e.g., HEDIS), include the year of the HEDIS technical specifications used for the applicable measurement year and update the year annually.
- Include complete dates for all measurement periods (with the day, month, and year).
- Include plan-specific goals for the remeasurement periods that are specific, measurable, attainable, relevant, and time-bound.
- Include the State-designated goal, if applicable.

Study Indicator 1: Improving the Rates of Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Dispensed Atypical Antipsychotic Medications during the Measurement Year	DWMHA selected this measure because it is a nationally recognized HEDIS measure and has been identified by MDHHS as a performance metric and is imbedded into the contract with the State of Michigan. This study will utilize the HEDIS measures The only change in the HEDIS 2018 to HEDIS 2019 was the replaced medication table references with references to medication list. This was not a significant change. Data for baseline 2018 noted in Section VII.
Numerator Description:	Those enrollees/members 18-64 years of age as of the last day of the relevant measurement year with a diagnosis of Schizophrenia or Bipolar Disorder who were dispensed an atypical antipsychotic medication that had a FBS or HbA1c screening during the measurement year.
Denominator Description:	Inclusions: Medicaid members age 18 to 64 years as of December 31 of the measurement year with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication. • Identify members with schizophrenia or bipolar disorder as those who met at least one of the following criteria during the measurement year:

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Step IV: **Select the Study Indicator(s). A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. Study indicator goals should be specific, measurable, attainable, relevant, and time-bound.**

The description of the study Indicator(s) should:

- Include the complete title of the study indicator(s).
- Include a narrative description of the numerator(s) and denominator(s).
- Include the rationale for selecting the study indicator(s).
- If indicators are based on nationally recognized measures (e.g., HEDIS), include the year of the HEDIS technical specifications used for the applicable measurement year and update the year annually.
- Include complete dates for all measurement periods (with the day, month, and year).
- Include plan-specific goals for the remeasurement periods that are specific, measurable, attainable, relevant, and time-bound.
- Include the State-designated goal, if applicable.

	• At least one acute inpatient encounter, with any diagnosis of schizophrenia or bipolar disorder. Any of the following code combinations meet criteria: • BH Stand Alone Acute Inpatient Value Set with Schizophrenia Value Set • BH Stand Alone Acute Inpatient Value Set with Bipolar Disorder Value Set • BH Stand Alone Acute Inpatient Value Set with Other Bipolar Disorder Value Set • BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set and Schizophrenia Value Set • BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set and Bipolar Disorder Value Set • BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set and Other Bipolar Disorder Value Set • At least two visits in an outpatient, intensive outpatient, partial hospitalization, emergency department (ED) or non-acute inpatient setting, on different dates of service, with any diagnosis of schizophrenia. Any two of the following code combinations meet criteria: • BH Stand Alone Outpatient/PH/10P Value Set with Schizophrenia Value Set • BH Outpatient/PH/MP Value Set with BH Outpatient/PH/TOP POS Value Set and Schizophrenia Value Set • ED Value Set with Schizophrenia Value Set

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- If indicators are based on nationally recognized measures (e.g., HEDIS), include the year of the HEDIS technical specifications used for the applicable measurement year and update the year annually.
- Include complete dates for all measurement periods (with the day, month, and year).
- Include plan-specific goals for the remeasurement periods that are specific, measurable, attainable, relevant, and time-bound.
- Include the State-designated goal, if applicable.

	• BH ED Value Set with BH ED POS Value Set and Schizophrenia Value Set • BH Stand Alone Non acute Inpatient Value Set with Schizophrenia Value Set • BH Non-acute Inpatient Value Set with BH Non-acute Inpatient POS Value Set and Schizophrenia Value Set • At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or non-acute inpatient setting, on different dates of service, with any diagnosis of bipolar disorder. Any two of the following code combinations meet criteria: • BH Stand Alone Outpatient/PI-HOP Valle Set with Bipolar Disorder Value Set • BH Stand Alone Outpatient/PH/TOP Value Set with Other Bipolar Disorder Value Set • BH Outpatient/PH/10P Value Set with BH Outpatient/PH/10P POS \Take Set and Bipolar Disorder Value Set • BIT Outpatient/PH/TOP Value Set with BH Outpatient/PH/LOP POS Value Set and Other Bipolar Disorder Value Set • ED Value Set with Bipolar Disorder Value Set • ED Value Set with Other Bipolar Disorder Value Set • BH ED Value Set with BH ED POS Value Set and Bipolar Disorder Value Set

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- Include a narrative description of the numerator(s) and denominator(s).
- Include the rationale for selecting the study indicator(s).
- If indicators are based on nationally recognized measures (e.g., HEDIS), include the year of the HEDIS technical specifications used for the applicable measurement year and update the year annually.
- Include complete dates for all measurement periods (with the day, month, and year).
- Include plan-specific goals for the remeasurement periods that are specific, measurable, attainable, relevant, and time-bound.
- Include the State-designated goal, if applicable.

	• BH ED Value Set with BH ED POS Value Set and Other Bipolar Disorder Value Set • BH Stand Alone Non-acute Inpatient Value Set with Bipolar Disorder Value Set • BH Stand Alone Non-acute Inpatient Value Set with Other Bipolar Disorder Value Set • BH Non-acute Inpatient Value Set with BH Non-acute Inpatient POS Value Set and Bipolar Disorder Value Set • BH Non-acute Inpatient Value Set with BH Non-acute Inpatient POS Vale Set and Other Bipolar Disorder Value Set • Members must have been continuously enrolled during the measurement year. • Allowable Gap: No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified remit (the member may not have more than a 1-month gap in coverage. Exclusions:

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	Exclude members who met any of the following criteria: • Members with diabetes. There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify members with diabetes, but a member need only be identified by one method to be excluded from the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year. *Claim/Encounter Data*: Members who net any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years): At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or non-acute inpatient encounters (Non-acute Inpatient Value Set) on different dates of service,

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The description of the study Indicator(s) should:

- Include the complete title of the study indicator(s).
- Include a narrative description of the numerator(s) and denominator(s).
- Include the rationale for selecting the study indicator(s).
- If indicators are based on nationally recognized measures (e.g., HEDIS), include the year of the HEDIS technical specifications used for the applicable measurement year and update the year annually.
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- Include plan-specific goals for the remeasurement periods that are specific, measurable, attainable, relevant, and time-bound.
- Include the State-designated goal, if applicable.

	with a diagnosis of diabetes (Diabetes Vale Set). Visit type need not be the sane for the two visits. At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set) *Pharmacy Data*: Members who were dispensed insulin or oral hypoglycemics/antihyperglycemics during the measurement year or year prior to the measurement year on an ambulatory basis (refer to Table CDC-A in the original measure documentation for a list of prescriptions to identify members with diabetes). • Members who had no antipsychotic medications dispensed during the measurement year. There are two ways to identify dispensing events: by claim/encounter data and by pharmacy data. The organization mist uses both methods to identify dispensing events, but an event need only be identified by one method to be counted. • Claim/Encounter Data: An antipsychotic medication (Long-Acting Injections Value Set) • Pharmacy Data: Dispensed an antipsychotic medication (refer to Table SSD-D in the original measure documentation for a list of antipsychotic medications) on an ambulatory basis.

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- Include the rationale for selecting the study indicator(s).
- If indicators are based on nationally recognized measures (e.g., HEDIS), include the year of the HEDIS technical specifications used for the applicable measurement year and update the year annually.
- Include complete dates for all measurement periods (with the day, month, and year).
- Include plan-specific goals for the remeasurement periods that are specific, measurable, attainable, relevant, and time-bound.
- Include the State-designated goal, if applicable.

Baseline Measurement Period (include date range) MM/DD/YYYY to MM/DD/YYYY	January 1, 201~~7 2018~~ 2018-through December 31, 201~~7~~ 2018
Remeasurement 1 Period (include date range) MM/DD/YYYY to MM/DD/YYYY	January 1, 2018 ~~2019~~ 2019 through December 31, 2018 ~~2019~~ 2019
Remeasurement 1 Period Goal	80%
Remeasurement 2 Period (include date range) MM/DD/YYYY to MM/DD/YYYY	January 1, 20~~19~~ 2020 through December 31, 20~~19~~ 2020
Remeasurement 2 Period Goal	~~80%~~ To Be Determined
State-Designated Goal or Benchmark	~~80%~~ 83.09%

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Source of Benchmark	~~The benchmark is based on the data presented in the Michigan statewide aggregate report for 2017 showing the average for all reporting health plans to be 83.09%. The DWMHA was at 77.24% for 2017.~~ The benchmark is based on the data presented in the Michigan Department of Health and Human Services 2018 Aggregate Report for Michigan Medicaid showing the average for all reporting health plans to be 84.31 %. The DWMHA report for 2018 is 78.6%. Please see the hyperlink below for the HEDIS – Aggregate Report https://www.michigan.gov/documents/mdhhs/MI2018_HEDIS-Aggregate_Report_F1_638961_7.pdf
Study Indicator 2: [Enter title] ***Not applicable***	Provide a narrative description and the rationale for selection of the study indicator. Describe the basis on which the indicator was adopted, if internally developed.
Numerator Description:	
Denominator Description:	

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Step IV: **Select the Study Indicator(s). A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. Study indicator goals should be specific, measurable, attainable, relevant, and time-bound.**

The description of the study Indicator(s) should:

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- Include a narrative description of the numerator(s) and denominator(s).
- Include the rationale for selecting the study indicator(s).
- If indicators are based on nationally recognized measures (e.g., HEDIS), include the year of the HEDIS technical specifications used for the applicable measurement year and update the year annually.
- Include complete dates for all measurement periods (with the day, month, and year).
- Include plan-specific goals for the remeasurement periods that are specific, measurable, attainable, relevant, and time-bound.
- Include the State-designated goal, if applicable.

Baseline Measurement Period (include date range) MM/DD/YYYY to MM/DD/YYYY	
Remeasurement 1 Period (include date range) MM/DD/YYYY to MM/DD/YYYY	
Remeasurement 1 Period Goal	
Remeasurement 2 Period (include date range) MM/DD/YYYY to MM/DD/YYYY	
Remeasurement 2 Period Goal	
State-Designated Goal or Benchmark	

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Step IV: **Select the Study Indicator(s). A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. Study indicator goals should be specific, measurable, attainable, relevant, and time-bound.** The description of the study Indicator(s) should: • Include the complete title of the study indicator(s). • Include a narrative description of the numerator(s) and denominator(s). • Include the rationale for selecting the study indicator(s). • If indicators are based on nationally recognized measures (e.g., HEDIS), include the year of the HEDIS technical specifications used for the applicable measurement year and update the year annually. • Include complete dates for all measurement periods (with the day, month, and year). • Include plan-specific goals for the remeasurement periods that are specific, measurable, attainable, relevant, and time-bound. • Include the State-designated goal, if applicable.	
Source of Benchmark	
Study Indicator 3: [Enter title] ***Not Applicable***	Provide a narrative description and the rationale for selection of the study indicator. Describe the basis on which the indicator was adopted, if internally developed.
Numerator Description:	
Denominator Description:	
Baseline Measurement Period (include date range) MM/DD/YYYY to MM/DD/YYYY	
Remeasurement 1 Period (include date range) MM/DD/YYYY to MM/DD/YYYY	
Remeasurement 1 Period Goal	

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Step IV: **Select the Study Indicator(s). A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. Study indicator goals should be specific, measurable, attainable, relevant, and time-bound.**

The description of the study Indicator(s) should:

- Include the complete title of the study indicator(s).
- Include a narrative description of the numerator(s) and denominator(s).
- Include the rationale for selecting the study indicator(s).
- If indicators are based on nationally recognized measures (e.g., HEDIS), include the year of the HEDIS technical specifications used for the applicable measurement year and update the year annually.
- Include complete dates for all measurement periods (with the day, month, and year).
- Include plan-specific goals for the remeasurement periods that are specific, measurable, attainable, relevant, and time-bound.
- Include the State-designated goal, if applicable.

Remeasurement 2 Period (include date range) MM/DD/YYYY to MM/DD/YYYY	
Remeasurement 2 Period Goal	
State-Designated Goal or Benchmark	
Source of Benchmark	

Use this area to provide additional information, if necessary.

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Step V: Use Sound Sampling Techniques. If sampling is used to select consumers of the study, proper sampling techniques are necessary to provide valid and reliable information on the quality of care provided. **Sampling techniques should be in accordance with generally accepted principles of research design and statistical analysis.**

The description of the sampling methods should:

- Include components identified in the table below.
- Be updated annually for each measurement period and for each study indicator.
- Include a detailed narrative description of the methods used to select the sample and ensure sampling techniques support generalizable results.

Measurement Period	Study Indicator	Population Size	Sample Size	Margin of Error and Confidence Level
	Not applicable because no sampling is used. All members meeting eligibility criteria are included.			

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Step VI: Reliably Collect Data. The data collection process must ensure that data collected for the study indicators are valid and reliable.

The data collection methodology should include the following:

- Identification of data elements and data sources.
- When and how data are collected.
- How data are used to calculate the study indicators.
- A copy of the manual data collection tool, if applicable.
- An estimate of the administrative data completeness percentage and the process used to determine this percentage.

Data Sources (Select all that apply)
[ ] Hybrid—Both medical/treatment record review (manual data collection) and administrative data.

<table>
<tr>
<td>[ ] Medical/Treatment Record Abstraction

Record Type
[ ] Outpatient
[ ] Inpatient
[ ] Other ____________

Other Requirements
[ ] Data collection tool attached
[ ] Other data ____________</td>
<td>[x] Administrative Data

Data Source
[x] Programmed pull from claims/encounters
[ ] Complaint/appeal
[x] Pharmacy data
[ ] Telephone service data/call center data
[ ] Appointment/access data
[ ] Delegated entity/vendor data ____________
[ ] Other ____________

Other Requirements
[x] Codes used to identify data elements (e.g., ICD-9/ICD-10, CPT codes)
CPT for glucose test-80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951
CPT for HbA1c-83036, 83037
CPT II-3044-3046
[ ] Data completeness assessment attached
[ ] Coding verification process attached</td>
<td>[ ] Survey Data

Fielding Method
[ ] Personal interview
[ ] Mail
[ ] Phone with CATI script
[ ] Phone with IVR
[ ] Internet
[ ] Other ____________

Other Requirements
[ ] Number of waves ____
[ ] Response rate ____
[ ] Incentives used ____</td>
</tr>
</table>

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Step VI: Reliably Collect Data. The data collection process must ensure that data collected for the study indicators are valid and reliable.

The data collection methodology should include the following:

- Identification of data elements and data sources.
- When and how data are collected.
- How data are used to calculate the study indicators.
- A copy of the manual data collection tool, if applicable.
- An estimate of the administrative data completeness percentage and the process used to determine this percentage.

	Estimated percentage of administrative data completeness: 90% after 90-days. The HEDIS data will be retrieved for analysis greater than 90 days past December 31 of the measurement period (i.e. after March 31 of the following year) to allow for the 90-day claims lag and data completeness at the time of the data retrieval to ensure accuracy in the study indicator rates. Describe the process used to determine data completeness: The data is downloaded from the State's data warehouse (CC 360) and is subject to the Medicaid Health Plan and PIHP claims verification process outlined by the State. The DWMHA quality department conducts biannual Medicaid claim verification and quarterly case record reviews. For DWMHA Network Provider claims: Claims/Encounters are generated at the provider organization and input into DWMHA directly into MHWIN. DWMHA processes continuously. There can be up to a 90-day lag in the reporting of claims/encounters into MHWIN. These claims are added to the State's data warehouse (CC360).	

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Step VI: Determine the Data Collection Cycle.	Determine the Data Analysis Cycle.
[x] Once a year [ ] Twice a year [ ] Once a season [ ] Once a quarter [ ] Once a month [ ] Once a week [ ] Once a day [ ] Continuous [ ] Other (list and describe):	[x] Once a year [ ] Once a season [ ] Once a quarter [ ] Once a month [ ] Continuous [ ] Other (list and describe):

Describe the data collection process:

Universal Specifications:

- Technical guidance for all measurements comes directly from NCQA's HEDIS volume 2 value set directory. A value set is the complete set of codes used to identify the service(s) or condition(s) included in the measure
- All measures are only performed on the Medicaid eligible population that DWMHA serves
- There are three primary data sources used for the measures:
  - Insurance eligibility data to determine Medicaid eligibility is from the state of Michigan's CHAMPS system. We receive monthly 834 files along with daily 834 updates. We also utilize a 270/271 file, which gives real-time eligibility data, as well as, additional fields that are not included in the 834 file.
  - Claims data comes from Care Connect 360. This system is managed by MDHHS and contains all physical and behavioral health pharmacy, institutional, and professional claims data on the Medicaid eligible population that we serve. Data set does not contain Substance Abuse or SUD claims data.
  - Demographics data, such as age, comes from our internal claims processing system – MHWIN. Data is entered at the time a consumer is opened to our services and updated throughout the course of their service history.

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Appendix B: State of Michigan 2018-2019 PIP Summary Form
Improving Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using An Antipsychotic Medication for Region 7 - Detroit Wayne Mental Health Authority

Step VII: Study Indicator **Results.** Enter the results of the study indicator(s) in the table below. For HEDIS-based PIPs, the data reported in the PIP Summary Form should match the validated **performance measure rate(s)**.

Enter results for each study indicator—including the goals, statistical testing with complete *p* values, and the statistical significance—in the table provided.

Study Indicator 1 Title: [Improving Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using An Antipsychotic Medication **]**

Time Period Measurement Covers	Indicator Measurement	Numerator	Denominator	Rate or Results	Goal	Statistical Test, Statistical Significance, and *p* Value
MM/DD/YYYY–MM/DD/YYYY 1/1-12/31/201~~7~~8	**Baseline**	~~4076~~ 3703	~~5277~~ 4712	~~77.24~~ 78.6	~~80.00~~	Enter *p* Value – Not available for the baseline submission. p Value will be available after the 2019 Re-measurement 1 data.
1/1-12/31/201~~8~~9	**Remeasurement 1**	~~3703~~	~~4712~~	~~78.6~~	80%	~~This was a 1.36 percentage point increase but was not determined to be statistically significant as evidenced by using Chi-square with Yates correction~~
	Remeasurement 2					
	Remeasurement 3					

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Step VII: Study Indicator **Results.** Enter the results of the study indicator(s) in the table below. For HEDIS-based PIPs, the data reported in the PIP Summary Form should match the validated **performance measure rate(s)**.

Enter results for each study indicator—including the goals, statistical testing with complete *p* values, and the statistical significance—in the table provided.

Study Indicator 2 Title: [Enter title of study indicator]

Time Period Measurement Covers	Indicator Measurement	Numerator	Denominator	Rate or Results	Goal	Statistical Test, Statistical Significance, and *p* Value
MM/DD/YYYY–MM/DD/YYYY	**Baseline**					
	Remeasurement 1					
	Remeasurement 2					
	Remeasurement 3					

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Step VII: Data Analysis and **Interpretation of Study Results.** Clearly document the results for each of the study indicator(s). Describe the data analysis performed and the results of the statistical analysis, and interpret the results. Through data analysis and interpretation, real improvement as well as sustained improvement can be determined.

The data analysis and interpretation of study indicator results should include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, including a comparison of the results to the goal and the type of statistical test completed. Statistical testing *p* value results should be calculated and reported to four decimal places (e.g., 0.0235).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether or not factors that could threaten (a) the validity of the findings for each measurement period and/or (b) the comparability of measurement periods were identified. If there were no factors identified, this should be documented in Step VII.

Describe the data analysis process and provide an interpretation of the results for each measurement period.

Baseline Measurement: Baseline rate for 2018 noted at 78.6% with a goal of 80% for the Remeasurement 1 data. The baseline rate was calculated following the HEDIS specifications noted in Section VI.

~~Review of the 2017 data indicates that DWMHA's results on the HEDIS measure "Diabetes screening for schizophrenia and bipolar members on antipsychotic medication" shows DWMHA contracted providers to be below both the Michigan health plan and the national average of health plan data from NCQA for this measure according to the state HSAG report and NCQA 2017 State of Quality. DWMHA is currently in the 25th percentile for this HEDIS measure. DWMHA's Improvement Practice Leadership Team (IPLT) reviewed data findings and the recommended improvement project and had no additional suggestions.~~

~~State of Quality. DWMHA is currently in the 25th percentile for this HEDIS measure.~~

There was one significant change in the administrative structure of DWMHA, the removal of an administrative layer -the Managers of Comprehensive Providers Networks (MCPN) which began on October 1, 2018 and completed on June 30, 2019. While this may not have impacted

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Step VII: Data Analysis and **Interpretation of Study Results.** Clearly document the results for each of the study indicator(s). Describe the data analysis performed and the results of the statistical analysis, and interpret the results. Through data analysis and interpretation, real improvement as well as sustained improvement can be determined.

The data analysis and interpretation of study indicator results should include the following for each measurement period:

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- A clear and comprehensive narrative description of the data analysis process, including a comparison of the results to the goal and the type of statistical test completed. Statistical testing *p* value results should be calculated and reported to four decimal places (e.g., 0.0235).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether or not factors that could threaten (a) the validity of the findings for each measurement period and/or (b) the comparability of measurement periods were identified. If there were no factors identified, this should be documented in Step VII.

the HEDIS 2018 data; it may impact the HEDIS 2019 as DWMHA contracts directly with the Network Providers. Beyond this change there were no other factors that impacted the validity nor no random variance was noted.

Baseline to Remeasurement 1~~: DWMHA saw an increase in its HEDIS measure of Diabetes Screening for Schizophrenia and Bipolar Disorder members from 77.24% in 2017 (HEDIS 2018) to 78.6% in 2018 HEDIS 2019). This was a 1.36 percentage point increase but was not determined to be statistically significant as evidenced by using Chi-square with Yates correction.~~

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Step VII: Data Analysis and **Interpretation of Study Results.** Clearly document the results for each of the study indicator(s). Describe the data analysis performed and the results of the statistical analysis, and interpret the results. Through data analysis and interpretation, real improvement as well as sustained improvement can be determined.

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- A clear and comprehensive narrative description of the data analysis process, including a comparison of the results to the goal and the type of statistical test completed. Statistical testing *p* value results should be calculated and reported to four decimal places (e.g., 0.0235).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether or not factors that could threaten (a) the validity of the findings for each measurement period and/or (b) the comparability of measurement periods were identified. If there were no factors identified, this should be documented in Step VII.

~~DWMHA will continue its goal for 2018 at 80% to move from the 25th to the 50th percentile. DWMHA has added additional interventions to assist in achieving this goal.~~

Baseline to Remeasurement 2:

Baseline to Remeasurement 3:

Baseline to Final Remeasurement:

Not Applicable (2017)

Describe the causal/barrier analysis process, quality improvement team consumers, and quality improvement tools:

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Step VII: Data Analysis and **Interpretation of Study Results.** Clearly document the results for each of the study indicator(s). Describe the data analysis performed and the results of the statistical analysis, and interpret the results. Through data analysis and interpretation, real improvement as well as sustained improvement can be determined.

The data analysis and interpretation of study indicator results should include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, including a comparison of the results to the goal and the type of statistical test completed. Statistical testing *p* value results should be calculated and reported to four decimal places (e.g., 0.0235).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
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DWMHA's Improvement Practice Leadership Team (IPLT) reviewed data findings and recommended the improvement project (See attachment C, C.a).

There is an opportunity for improvement. Detroit Wayne Mental Health Authority 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 DWMHA 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.

In an effort to determine the root cause for DWMHA's current performance, DWMHA did literature searches as well as obtained feedback from providers and the following barriers have been identified:

1. Lack of knowledge/consistent practice among providers of the prevalence of diabetes in this population and the need for screening.

2. Physician belief that diabetes prevalence is low in their practice.

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3. Lack of knowledge among providers of recommendations for screening for diabetes in members with schizophrenia and bipolar disorder.

4. Lack of knowledge among providers of HEDIS measure or DWMHA's HEDIS measure results.

5. Lack of knowledge by enrollee/members that they are at risk for diabetes if on atypical antipsychotic medication.

6. Lack of follow-through by enrollee/members to have labs drawn when ordered.

7. Lack of knowledge by enrollee/members on importance of healthy eating and exercise to help control any weight gain associated with antipsychotic medication.

8. Enrollee/Members may not be linked to a primary care physician or not consistent in follow up.

Describe the processes, tools, and/or data analysis results used to identify and prioritize barriers:

For 2018 DWMHA identified the barriers utilizing the Ishikawa Fishbone Diagram. Going forward DWMHA will utilize the Plan Do Study Act process to review current barriers and possible interventions. See attachment A. for the Ishikawa Fishbone Diagram used to identify the barriers with the providers and QI staff.

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Describe the processes and measures used to evaluate the effectiveness of each intervention:

For 2018 DWMHA utilized the process of provider monitoring. Providers are monitored by Quality staff as well as required to complete self - monitoring through quarterly case record reviews. When scores fall below 95% for compliance for two consecutive quarters provider are to assess reasons for the low scores and implement a plan to improve outcomes. Coordination of care outcomes are also reviewed at the Quality Operations Workgroup Meetings where Quality Directors from various providers are in attendance to discuss monitoring outcomes and barriers (See Attachment B, B.a and B.b)

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Barriers/Interventions Table:
Use the table below to list barriers, corresponding intervention descriptions, intervention type, target population, and implementation date. For each intervention, select if the intervention was (1) new, continued, or revised, and (2) consumer, provider, or system. Update the table as interventions are added, discontinued, or revised.

Date Implemented (MM/YY)	Select if Continued, New, or Revised	Select if Consumer, Provider, or System Intervention	Priority Ranking	Barrier	Intervention That Addresses the Barrier Listed in the Previous Column
	Continued	System Intervention	1	-	
	Continued	System Intervention	1	.	
	Continued	System Intervention	1	-	

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	Continued	System Intervention	1	-	
	Continued	System Intervention	1	- -	
	Continued	System Intervention	1	.	
	Continued	System Intervention	1	.	
	Continued	System Intervention	1	-	
April 20189 – June 2020	New	System Intervention	2	Lack of knowledge among providers of recommendation for screening for diabetes in members	DWMHA will track the current level of compliance with the Clinical Practice Improvement Guidelines for members

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				with schizophrenia and bipolar disorder.	that require Diabetic Screening who are on Atypical Antipsychotics medications. Through DWMHA quality performance monitoring process, DWMHA will monitor compliance with Diabetic Screenings through clinical treatment chart audits. Information is provided back to providers through our Quality Operations Workgroup meetings and the Quality Improvement Steering Committee to be evaluated for effectiveness. In addition, information is monitored by the providers as part of the quarterly case record self-monitoring reviews. The Biopsychosocial Assessment

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					completed no less than annually includes the following questions: • If the individual has not visited a Primary Care Physician for more than 12 months, there is evidence of a basic health care screening, including height, weight, BMI and blood pressure and • There is evidence that the psychiatrist or Primary Care provider ordered a diabetic screening that includes an HbA1C or fasting blood sugar (FBS), BMI, blood pressure, and LDL cholesterol for consumers

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					prescribed an atypical antipsychotic medication. ~~(See Attachment B, B.a and B.b)~~ (see attachment E).
April 20~~8~~19 – June 2020 ~~Ongoing~~	New	System Intervention	2	Lack of knowledge among providers of recommendation for screening for diabetes in members with schizophrenia and bipolar disorder.	DWMHA track HEDIS scores to identify the 2018 baseline. Going forward, we will continue to measure and monitor compliance with having labs ordered and drawn no less than quarterly through review of the SSD HEDIS like data in Relias ProACT. Tracking will involve a review of enrolled members who are in the eligible group but do not meet the HEDIS standards and have not had the screening for allowing the Care

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					Coordination team and Providers the ability to follow up. Information will be provided back to providers through our Quality Operations Workgroup meetings and Quality Improvement Steering Committee to be evaluated for effectiveness.
~~March 2018~~	~~New~~	~~System Intervention~~	~~1~~	~~-Lack of knowledge by enrollee/members that they are at risk for developing diabetes when on atypical antipsychotics.~~ ~~-Lack of follow-through by enrollee/members to have labs drawn when ordered.~~	~~Develop article and publish in member Spring newsletter regarding importance of screening for diabetes for enrollee/members with schizophrenia and bipolar disorder on antipsychotic medication.~~
~~April 2018 and Ongoing~~ May	New	Enrollee Intervention	1	Lack of follow-through by enrollee/members to have labs drawn when ordered.	Enrollee/members will be educated on the importance of having labs completed through Community Outreach Initiatives

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2019 – June 2020					and training on the importance of Diabetic Screening. Follow through will be monitored through the Case Management progress notes and clinical treatment chart audits DWMHA Access Center (Wellplace) submits text messages to members reminding them of required lab testing. DWMHA will track and monitor for effectiveness through compliance reviews.
~~May 2018 and Ongoing~~	~~New~~	~~System Intervention~~	~~1~~	~~Lack of follow-through by enrollee/members to have labs drawn when ordered.~~	~~Providers will have the ability to . and appointments.~~
~~June 2018~~	~~New~~	~~System Intervention~~	~~1~~	~~Lack of knowledge among providers of recommendation for screening for diabetes in members~~	~~Provide MCPN's with quarterly report of members who need a diabetes screening. MCPN's coordinated with~~

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				~~with schizophrenia and bipolar disorder.~~	~~the providers to arrange for diabetes screening.~~
~~June 2018 and Ongoing~~	~~New~~	~~System Intervention~~	~~1~~	~~Lack of knowledge among providers of recommendation for screening for diabetes in members with schizophrenia and bipolar disorder.~~	~~Clinical Practice Guidelines Policy and Clinical Guidelines published on DWMHA website (See Attachment D, D.a and D.b).~~
May 2019 – June, 2020	New	Provider Intervention	1	Lack of knowledge among providers of recommendation for screening for diabetes in members with schizophrenia and bipolar disorder.	~~Roll out~~ DWMHA will educate on the Clinical Guidelines Procedures to service providers, practitioners and DWMHA staff through the Quality Operations Workgroup meetings, Quality Improvement Steering Committee and the Improvement Practices Leadership meetings. ~~website (See Attachment D, D.a and D.b).~~

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March 20189-June 2020	New	Provider Intervention	1	Lack of knowledge among providers of recommendation for screening for diabetes in members with schizophrenia and bipolar disorder.	DWMHA will educate the provider network through Community Outreach Initiatives and training on the importance of Diabetic Screening. DWMHA will track and monitor for effectiveness through compliance reviews.

Through DWHA's Quality Steering Improvement Committee, ranking priorities were based on potential needs and planned actions in identified areas for improvement within DWMHA's provider network and for improving the overall health and safety for our members. Interventions that received a # 1 priority ranking is due to the importance of educating our members and providers while improving the health, outcomes and coordination of members served.

Report the evaluation results for each intervention and describe the steps taken based on the evaluation results. Was each intervention successful? How were successful interventions continued or implemented on a larger scale? How were less-successful interventions revised or discontinued?

Describe evaluation results for each intervention: See below

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Describe next steps for each intervention based on evaluation results:

DWMHA analyzed their interventions up to this point and summarized the outcomes of some of the most key interventions above.

The largest barrier continues to be the compliance of members to follow through on getting the lab tests despite education and follow-up reminders. DWMHA plans on conducting face to face meetings with members to obtain feedback on what the members perceive as barriers to completing orders for tests, filling medications and understanding to find better ways to address this barrier. DWMHA holds monthly data sharing meetings with its Medicaid Health Plan partners and will also enlist their help with educating their primary care practitioners on the importance of diabetes screening in this population.

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