Detroit Wayne Integrated Health Network

(DWIHN)

Quality Assurance Performance Improvement Plan
Annual Evaluation Fiscal Year 2021

Submitted by:

April L. Siebert - Director of Quality Improvement

Approved:

Approved by the Quality Improvement Steering Committee (QISC)	2/22/2022
Approved by Program Compliance Committee (PCC)	3/9/2022
Approved by the Full Board of Directors	3/16/2022

Table of Contents

Introduction

The Detroit Wayne Integrated Health Network (DWIHN) is the Pre-Paid Inpatient Health Plan (PIHP) and Community Mental Health Service Provider (CMHSP) for Detroit and Wayne County. DWIHN is the largest community mental health service provider in the State of Michigan. The Quality Assurance Performance Improvement Plan (QAPIP) Evaluation is an annual document that assesses the results, Improvements and outcomes DWIHN has made with respect to the Annual Work Plan for FY2021.

Executive Summary

This QAPIP evaluation provides a description of completed and ongoing quality improvement activities that address timeliness, clinical care and quality of services. The goals and objectives from the 2020 QAPIP Work Plan were evaluated and are included in the QAPIP evaluation for FY21. HEDIS scores were used as one of the measurement tools to identify progress or barriers for the Quality Improvement Projects. The QAPIP evaluation follows a structured format including a description of the activity, quantitative analysis and trending of measures, evaluation of effectiveness, barrier analysis and identified opportunities for improvement. The QAPIP evaluation also includes the six (6) pillars that are identified in DWIHN's Strategic Plan. The Quality Improvement Steering Committee (QISC) is the decision-making body that is responsible for the oversight of DWIHN's QAPIP Description, Evaluation and Work Plan. The Program Compliance Committee (PCC) Board gives the authority for implementation of the plan and all of its components. The QAPIP evaluation was presented to QISC, PCC and the full Board of Directors for review and approval.

Description of Service Area

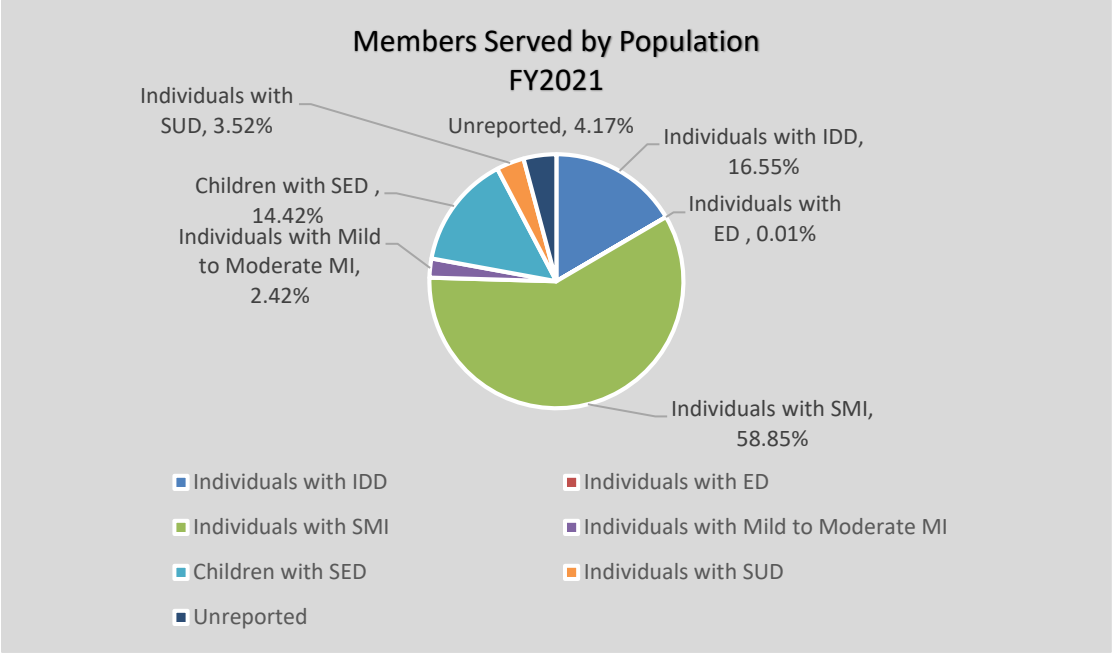
Wayne County is the most populous county in the State of Michigan. As of 2020, the United States Census estimated its population as 1.7 million, and ranked 19th in population in the United States. Wayne County is comprised of 34 cities and 9 townships covering roughly 673 miles. The municipality of Detroit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

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

Demographics

DWIHN provided services to an unduplicated count of 73,408 members during FY21, which is an increase of 3,378 (4.8%) from FY20 (70,030). Of those served 46,230 (62.98%) received services through Medicaid funding, 18,147 (24.72%) received services through Healthy Michigan Plan funding, 7,127 (9.71%) received services through General Fund, 6,197 (8.44%) through SUD Block Grant, 5,864 (7.99%) through MI Health Link, 5,864 (7.99%) through State Disability Assistance (SDA), 1,064 (1.45%) through Habilitation Supports Waiver. The percent of adults who reported having a SMI in FY21 43,208 (58.85%), demonstrated an increase of (12.9%) from the previous year. Followed by 10,585 (14.42%) (SED), 12,150 (16.55%) (IDD), 2,586 (3.52%) (SUD), 1,774 (2.42%) (MI), 5,444 (7.42%) Co-Occurring, and 3,053 (4.17%) unreported. Of those served 40,338 (54.95%) were of African American decent. This reflect an increase of 1,728 (4.4%) from FY20. The Caucasian count was 23,175 (31.57%). The remaining (13.47%) were identified as other, two or more races, unreported, Asian, American Indian, Native Hawaiian and Alaskan.

The largest group of individuals served are in the age group of 22-50 years-old 33,095 (45.08%), demonstrating an increase of 2,443 (7.9%) from FY20. Followed by the age group of 0-17 years-old,15,430 (21.02%) and the age group of 51-64 years-old, 15,365 (20.93%). The growth of persons served 65 and over continues to increase by (3.5%) from the previous year. *Data was extracted for this report on February 1, 2022.



Customer Pillar

Member Experience with Services

Activity Description

DWIHN conducted the Experience of Care and Health Outcomes (ECHO) survey to receive feedback from members who accessed behavioral health services in the past 12 months. DWIHN annually reviews the data and develops improvement activities and interventions to impact ECHO scores. DWIHN combines the ECHO data with other data sources throughout the organization to have a comprehensive view of member satisfaction with DWIHN services. Data sources include appeals and grievances, focus groups, internal member surveys, post-survey and member feedback received directly from customer service.

Quantitative Analysis and Trending of Measures

The analysis shows that the initiatives and interventions that were implemented in FY2020 were generally effective in improving service goals. A significant positive trend appeared in the question that asks respondents to rank their overall services from 0 to 10, where 10 is the best. When responding to the question, about getting treatment quickly overall satisfaction rate for FY 21 was 46%, which is a 3% increase when compared to the last fiscal year (43%). There were two measures with scores of higher than (50%): Treatment after benefits used up (56%) and Counseling and Treatment (51%). The score for Perceived Improvement has remained stagnant in the low 30's since 2017. More information about member rights was given in 2021. In 2021, members rated that they were helped more by their services, and their overall mental health was better. Overall, scores were slightly higher in FY 21 than during the subsequent measurement periods as displayed in the table below.

ECHO Reporting Measures, Comparison Across Years

Composite Measures and Global Rating	2021	2020	2017
Treatment after benefits are used up	56%	55%	48%
Counseling and treatment	51%	51%	46%
Getting treatment quickly	46%	43%	37%
Office Wait	44%	36%	33%
Perceived improvement	29%	31%	29%

Evaluation of Effectiveness

In FY21, in collaboration with Wayne State University, exceeded the goal to collect 600 surveys for adult and children's Annual ECHO Surveys. DWIHN scored well on several of measures, notably parents/guardians reporting receiving information on patient rights (95%), confidence in the privacy of their information (93%), and completely discussing the goals of their child's treatment (93%). However, there were four measures with scores of less than (50%): Perceived improvement (25%); Getting treatment quickly (42%); Counseling and treatment (49%); and Amount helped (49%). The chart below illustrates the composite scores in the ECHO Child reporting measures compared to Adult reporting measures for FY21. There was variation in the overall rating for "Perceived improvement" (28% compared to 29%); How Well Clinicians Communicate" (73% compared to 68%); and rating of counseling and treatment (54% compared to 51%).

ECHO Reporting measures, Child Comparison to Adult Results FY21

Composite Measures and Global Rating	Children	Adult
Getting treatment quickly	46%	46%
How well clinicians communicate	73%	68%
Getting treatment and information from the plan or MBHO	51%	51%
Perceived improvement	28%	29%
Counseling and Treatment	54%	51%

Barrier Analysis

The causal analysis of barriers to improving member satisfaction and experience continues to remain relatively the same from one year to the next. It is apropos to mention that these surveys were conducted during a major pandemic and thinking about Perceived Improvement most members will not consider themselves better off during that timeframe. Also, DWIHN continues to receive low response rates on getting members to complete the ECHO survey. The data that is gathered is not entirely representative of all DWIHN members that access behavioral health services. The survey is a sample of member scores and is a barrier to representative data for the populations served and who received behavioral health services. Members may not always be aware of how to access behavioral health materials from the service provider and are not aware of behavioral health services offered.

There was a statistically significant difference in subgroups. Respondents 18 to 24 had lower scores than the other age groups on several measures. Overall, (43%) of the respondents reported always seeing someone as soon as they wanted, 21% of respondents were 18 to 24. A lower percentage of people with guardians (50%) reported clinicians always listened carefully to them, compared to 66% overall. Respondents with substance use disorders were more likely to report that they always felt safe with people they went to for counseling or treatment (96% compared to 78% overall).

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

DWIHN will continue to address questions about treatment and access to behavioral health services. DWIHN's behavioral health case management/supports coordination team will work directly with parents/guardians of its minor-aged members with a behavioral health condition and encourages medication adherence. Case managers/supports coordinators will review medications with members and talk about the importance of timely medication refills, provide education about timely follow-up and assist members with scheduling appointments. Each provider was shared personal measure data to be incorporated into their annual workplan and to address areas of concern.

Interventions and Actions

DWIHN will continue to focus on access to care for behavioral health services based on the 2021 survey results. Each intervention is designed to address an identified barrier in the treatment related factors:

- Analyze outcomes and work with providers to improve outcomes.
- Service providers to identify barriers to, and potential improvements that would support, members being seen within 15 minutes of appointment time.
- Service providers and members to identify barriers to members being able to get treatment quickly, particularly as it pertains to getting help over the telephone.
- Service providers to ensure all members, including those with DD or SUD, are confident in the privacy of their information and that those with guardians feel clinicians listen carefully to them.
- Review the provider network for access to behavioral health services, especially in more urban counties and reducing the amount of services that require a prior authorization, increasing behavioral health staff, and expanding to telehealth services.
- Service providers and members to explore the reasons why more families do not perceive improvements in their children, particularly with regard to social situations, and whether their self-assessments reflect clinicians' assessments.
- Service providers and families to identify barriers to members being able to get treatment quickly, particularly as it pertains to getting help over the telephone.
- Service providers to help them to understand the feedback their clients offered via the ECHO survey, particularly for those providers given lower scores on members' experience.

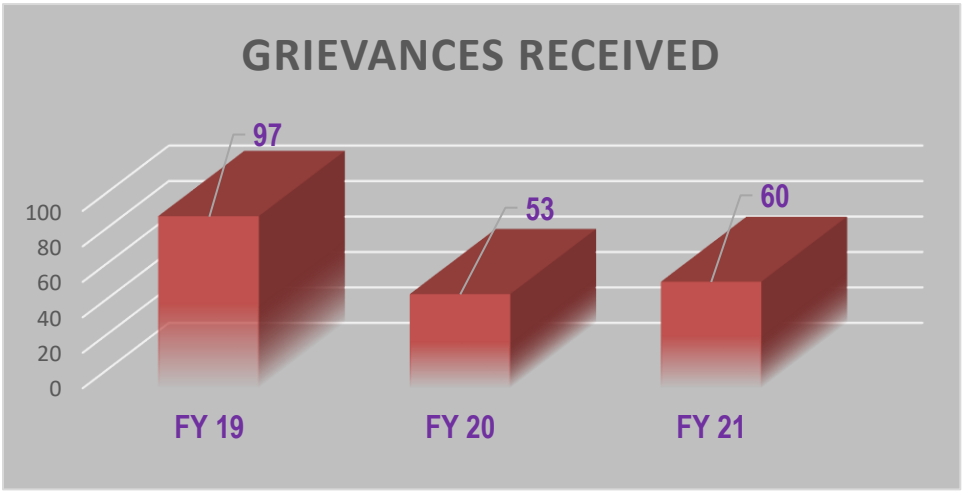
Member Grievances

Activity Description

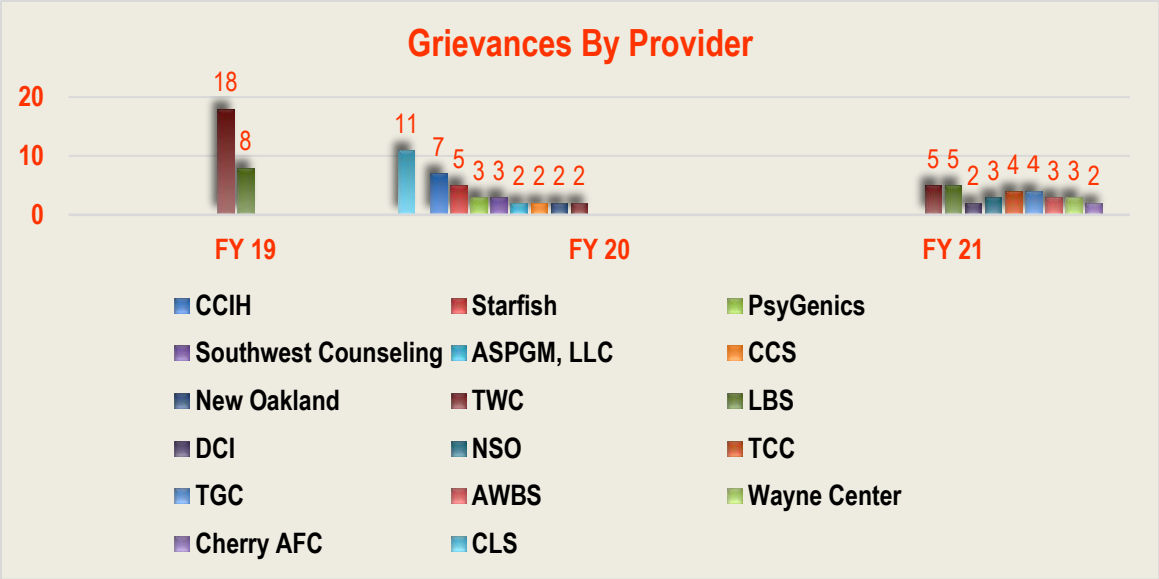
DWIHN's Customer Service completes an analysis of member experience trends and occurrences through review of Grievances, Appeals, Recipient Rights and Sentinel Events data. DWIHN uses this data and other initiatives to determine priority actions and improvements to better engage members and stakeholders.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

Quantitative Analysis and Trending of Measures

The results described below include responses from members who received services in fiscal year 2021. There was a total of 210 grievances reported within the last three fiscal years. Grievances originated with either the Service Provider or DWIHN. As the graph below indicates the most grievances were reported in FY '19. with a decrease by 35% in FY '20, and 29% decline in FY '21. However, there was a slight increase by 4% in the number of grievances reported in FY '21 compared to FY '20. It is believed that the number of member grievances has declined over the past two years due to the COVID 19 pandemic and most services have been provided via telehealth.



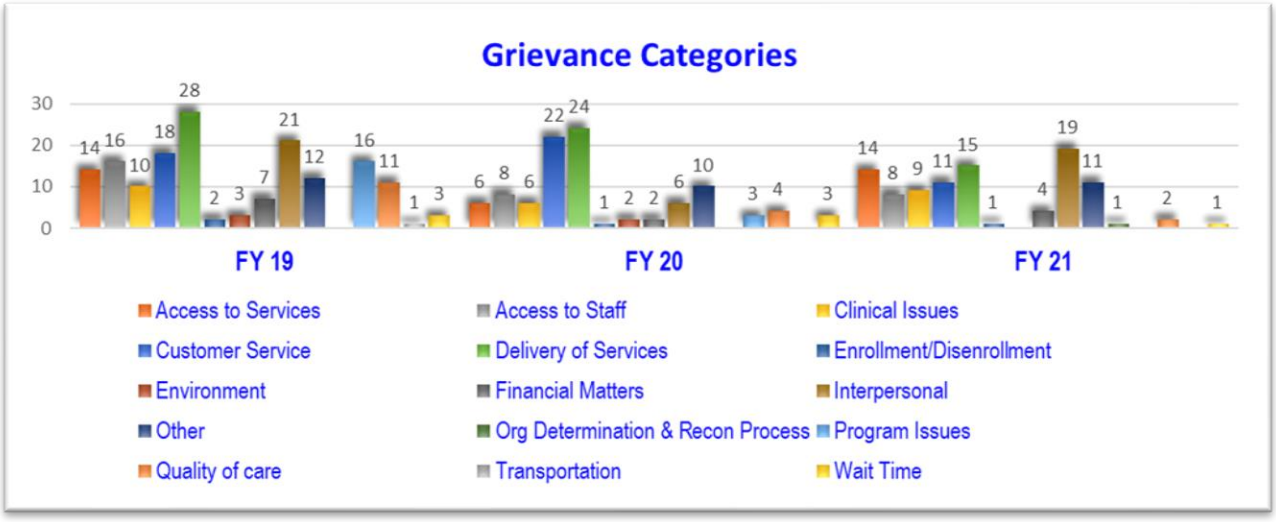
DWIHN has network of approximately 120 providers. However, grievances were not reported against every provider. Although grievances were filed against several providers. For the purpose of this report, recipients filed the most grievances against the providers as identified in the graph below.



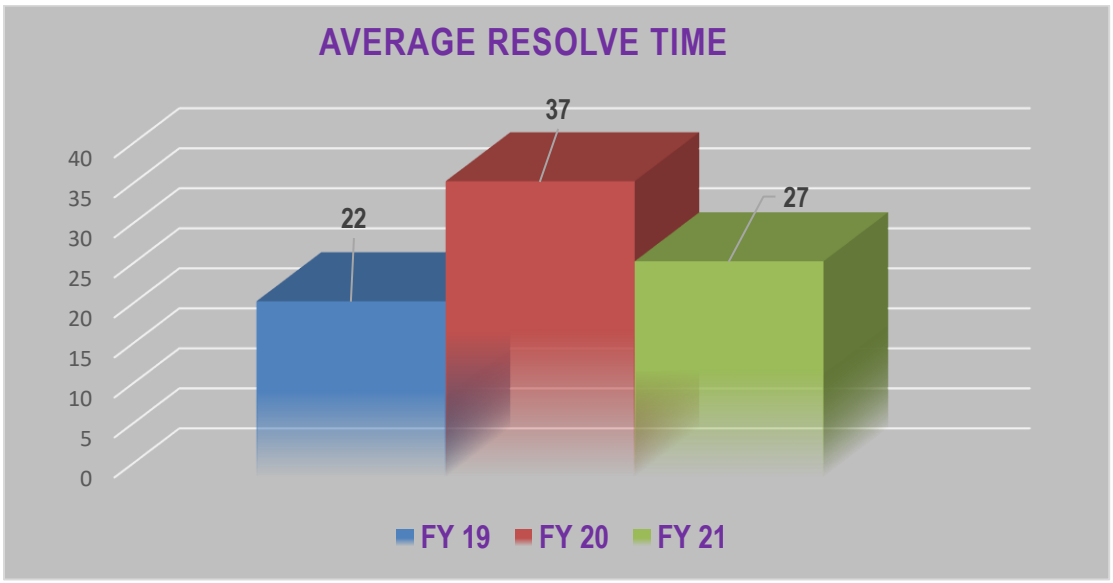
Team Wellness Center (TWC) had the highest volume of grievances, total of 25, reported over the past three years. It is important to note there was a decrease by 92% in FY '20 and 80% decrease in FY '21 compared to the number of grievances reported in FY '19 LBS had the second highest number of grievances reported against them over the past three years. There were eight grievances reported in FY ;19 and five in FY '21 which equates to a total of 13 grievances with none in FY '20. FY '19. CLS had the third highest number of grievances, total 11 which were noted in FY '19 and none reported in FY '20 or 21. Seven grievances were reported against CCIH in FY '20.

Evaluation of Effectiveness

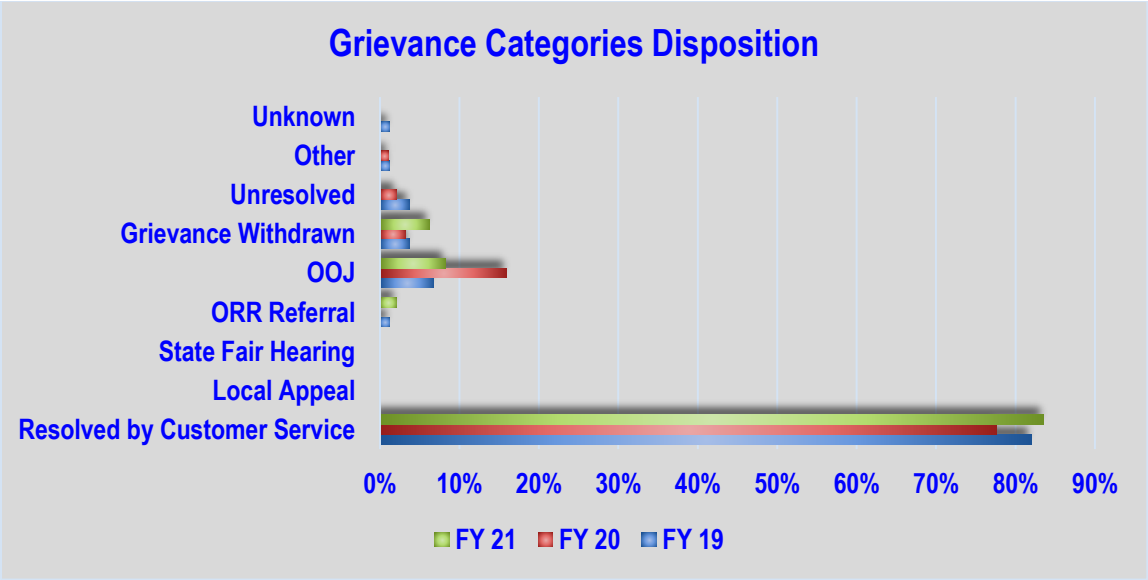
The number of categories identified within a grievance can be significantly greater than the number of grievances received. However, a grievance is not considered resolved until all the categories within a grievance have been thoroughly investigated and considered appropriate for closure. DWIHN identifies grievance categories in alignment with MDHHS requirements as illustrated in the graph below. During FY '19 there were 97 grievances reported in which 162 issues were identified. In FY '20, there were 97 issues identified within the 53 grievances reported. During FY '21, there were 60 grievances reported in which there were 96 issues identified. Delivery of Service and Customer Services were consistently high over each of the three years. Interpersonal relations came in third with a total of 46 complaints. There had been a decline in this area in FY '20 by 87% compared to FY '19. However, there was an increase by 76% in FY /21. There was a consistent decline in the number of grievances in the following categories over the past three years: 1.) Quality of Care; 2.) Program Issues and 3.) Environmental.



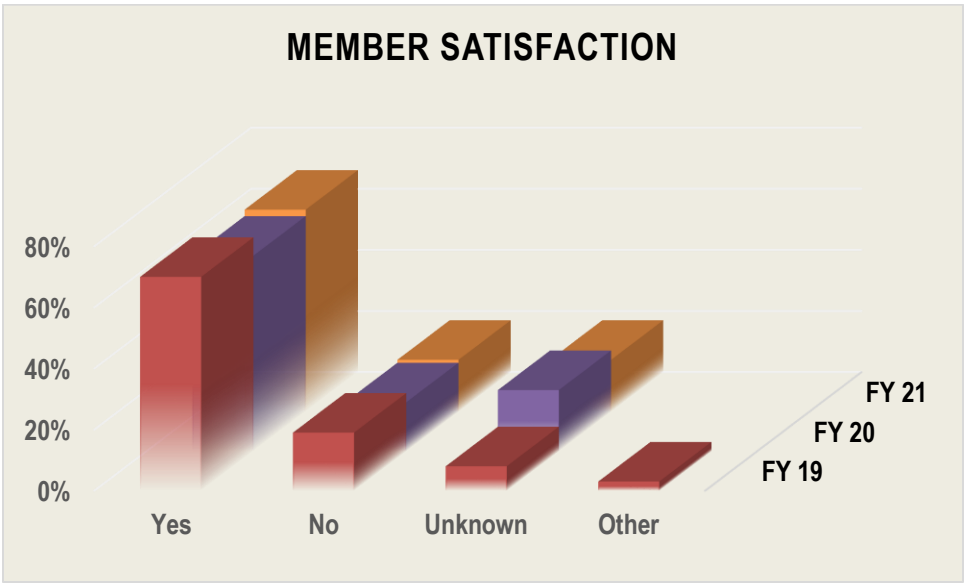
A total of 11 grievances were reported for the five ICOs over the last three fiscal years. Molina has consistently had the highest number of grievances reported. Six grievances were received in FY ’21, four in FY ’20 and one in FY’19 and. Those eleven (11) grievances are included in the total number of grievances reported for each year and same for the grievance categories. Medicaid and MI Health Link grievances are required to be resolved within ninety (90) calendar days, whereas Non-Medicaid grievances must be resolved within sixty (60) calendar days. Grievances were resolved within the average number of 22 days during FY ’19. The average timeframe for resolution of a grievance was 37 days in FY ’20 and 27 days in FY ’21.



Of the 355 grievance categories reported over the last three fiscal years, 287 or 81% were resolved within the Customer Service unit at either the Service Provider or DWIHN**.** Those grievances were usually coordinated with other departments for resolution. Nineteen (19) or 4.3% of the grievance categories were suspected recipient rights violations and therefore, referred to ORR for further follow-up and investigation. There were 34 (9.5%) grievances received during the same time frames that were determined not to be in DWIHN jurisdiction and therefore referred to outside entities for further assistance and follow-up. 3% or 13 of the grievances reported were later withdrawn by the grievant. The remaining 7% of the grievance categories were either not resolved or disposition is unknown. Typically, in such a case as this, the member cannot be reached to determine satisfaction



There were 236 grievances reported over the last three fiscal years (FY ’18, FY ’19 and FY ’20). 163 or 69% of those grievances were resolved to the satisfaction of the grievant. 19% were not satisfied with the resolution of his/her grievance. Unable to determine the satisfaction disposition for 8% of the members due to inability to speak with the member. The remaining 5% of the member satisfaction fell in the other category as those grievances were not resolved.



Barrier Analysis

Overall, member ratings of quality, satisfaction, appropriateness, and outcomes were positive. Measures of outcomes tended to be lower than other scales. This may be due to the fact that consumers are still in services and their ultimate goals have not been attained. Majority of the open-ended comments were positive. Members made request for more flexibility with scheduling including requests for weekend appointments and more reliable transportation. Members also made requests to get back to face to face contact due to the COVID 19 pandemic.

Opportunities of Improvement

DWIHN continues to expand our collaboration with community partners to further support our most vulnerable population and improve the health and safety of members through innovative services and partnerships.

- Providing relevant training on cultural competence and cross-cultural issues to health professionals and creating policies that reduce administrative and linguistic barriers to member care.
- Continue to work with our Member Engagement division to provide outreach, education, advocacy, peer development, and surveying member experiences.
- Continue the Constituents' Voice Advisory Committee which addresses consumer legislative issues including the delivery of service, interpersonal relations and customer service.
- Review and discuss grievance data with the Member Engagement Division which will allow for an additional avenue for evaluating member experiences.
- Continue to identify continuous quality improvement opportunities through use of patterns and trends of grievances reported.
- Continue to support members by resolving issues of dissatisfaction with DWIHN.
- Offer continuous training and education on customer service and the delivery of services.
- Continue to offer education and training for the provider network and enrollees on grievances and other due process rights.
- Review and discuss grievance data with the Member Engagement Division which will allow for an additional avenue for evaluating member experiences.

Provider/Practitioner Survey

Quantitative Analysis and Trending of Measures

DWIHN administered the Provider and Practitioner Surveys for FY21 during the month of September related to service access, service provision, treatment experiences and outcomes. The surveys were distributed to approximately 400 organizations in which there was a 35% increase in responses which is 13% higher than FY20. The Practitioner Survey was distributed in late September, resulting in 280 responses, a 17% increase from last year's responses of 232. Both surveys are comprised of 76 questions and covered all areas of DWIHN's operations.

Evaluation of Effectiveness

The total number of actual respondents for FY 21 from provider organizations was 140 out of 529. The total number of actual respondents for FY 21 from individual practitioners was 280 respondents out of 1243 individual practitioners. Percentage wise the provider and individual practitioner's response rates were 26% and 23%, respectively. In total, 420 surveys were returned out of 1772 surveys with an overall percentage response rate of about 24%. "*Note DWIHN's targeted response rate is 50-60% a response rate".*

Intervention and Action Taken

In FY 20-21, DWHIN instituted the following improvements to close the gap between the actual response rates and DWIHN's targeted response rates of 50%-60%:

- Provider Survey Ad-Hoc Task Force reviewed the survey instruments to assess and identify opportunities for improvement aimed at increasing the response rate, inclusive of shortening questionnaire and time to complete the survey.
- Alerts sent to Providers and Practitioners of the issuance of the survey prior to release.
- Notifications were posted in MHWIN prompting providers and practitioners to complete the survey.
- Provider Network Managers prompted and reminded providers and practitioners via email and phone to complete the survey.

Barrier Analysis

The most critical barrier to the response rates not increasing was the Covid 19 Global Pandemic. The Covid 19 Global Pandemic adversely impacted providers' and practitioners' ability to provide services inclusive of closures, staffing shortages and getting acclimated to operating remotely. The survey results also revealed that reducing the number of questions which will shorten the time to complete survey will likely increase the number of completed surveys returned.

Opportunities for Improvement

As was identified in FY 19-20, the length of the surveys (76 questions) may dissuade provider organizations and practitioners to complete the survey. A Task Force, Provider Survey Task Force, was established prior to the release of the Provider Surveys to determine if the survey instruments should be revised, inclusive of shortening questions, in an effort to increase the response rate. The decision was made not to revise the study because changing the survey tools could adversely impact comparisons with previous years' surveys. The Provider Survey Ad-Hoc Task Force will reconvene and revisit the revision of the FY 21-22 Annual Provider Surveys to include decreasing the number of questions and shortening the amount of time it takes to complete the survey in an effort to achieve DWIHN's targeted response rate. In addition, DWIHN will continue the following actions implemented in FY 20-21.

- Alert Providers and Practitioners of the issuance of the survey prior to release.
- Post notifications in MHWIN prompting providers and practitioners to complete the survey.
- Increase the number of reminders to complete the survey per the providers assigned Provider Network Manager.

National Core Indicators (NCI) Survey

Another measure to assess the satisfaction of services and to improve satisfaction of persons served and quality of care, is the National Core Indicators Survey (NCI), which surveys adults with intellectual developmental disabilities. The NCI survey is conducted by MDHHS annually. Ongoing COVID-19 issues has delayed the operation of the survey. This activity will continue as a quality improvement project for FY22 to improve access to service and quality of care. DWIHN will use the results of the NCI Survey to identify and investigate areas of dissatisfaction and implement interventions for improvement.

Complex Case Management (CCM)

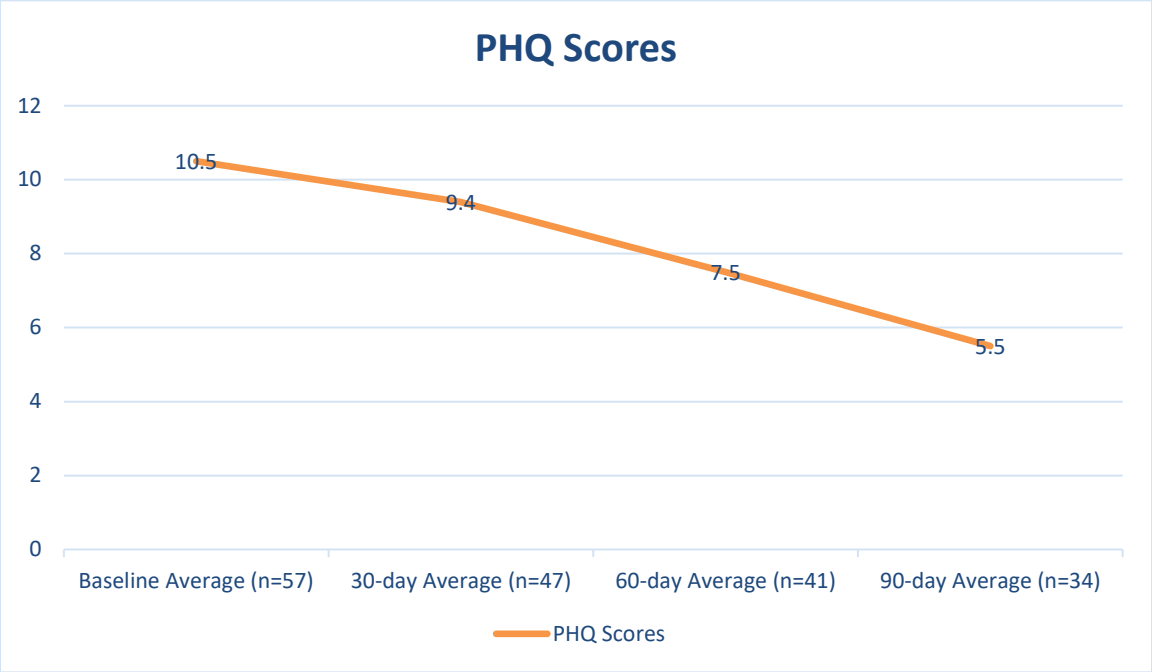
DWIHN's CCM program has innovative methods to identify and proactively reach out to members who are at high risk for psychiatric hospitalization, to help them understand their behavioral health clinical condition, adhere more closely to outpatient treatment recommendations and gain condition self-management skills.

Quantitative Analysis and Trending Measure

- Improve medical and/or behavioral health concerns and increase overall functional status as well as improve overall quality of life as evidenced by a 10% improvement in PHQ scores and/or a 10% improvement in WHO-DAS scores at CCM closure.
- To provide early intervention for members appropriate for Complex Case Management to prevent recurrent crisis or unnecessary hospitalizations as evidenced by 10% reduction in Emergency Department (ED) utilization and/or 10% reduction hospital admissions from 90 days prior to receiving CCM services to 90 days after receiving CCM services.
- Increased participation in out-patient treatment as evidenced by a 10% increase in out-patient behavioral health services from 90 days prior to receiving CCM services to 90 days after receiving CCM services.
- Assist members to access community resources and obtain a better understanding of the physical and/or behavioral health conditions as evidenced by improved compliance with behavioral health and physical health appointments and decrease in ED visits and/or inpatient admissions.
- 80% or greater member satisfaction scores for members who have received CCM services.

Evaluation of Effectiveness

Sixty (60) members were enrolled in CCM services during FY21. Forty-seven (47) members were enrolled in CCM for at least 60 days during FY21. During FY2021, information was gathered to identify member rates of symptoms of depression. Depression symptoms were measured using the Patient Health Questionnaire (PHQ-9) for adults (18 and older) and Patient Health Questionnaire – Adolescent (PHQ-A) for children (under 18). The PHQ assessments are embedded in the CCM assessments for adults and children and are completed when the assessment is completed at the start of CCM services and every 30 days thereafter until CCM services end. The higher the score on the PHQ-9/PHQ-A, the greater the symptoms of depression are present. A decrease in PHQ score indicates an improvement in symptoms of depression. PHQ scores were gathered from the CCM assessments that were completed at the start of CCM services and at 30, 60 and 90 days after starting CCM services. Members PHQ baseline scores ranged from 2 to 22, with an average score of 10.5. Members participating in CCM services demonstrated overall improvement in their PHQ scores, and the improvement increased the longer that the members participated in CCM services. As displayed in the table below, average PHQ scores improved 10% from baseline at 30 days, 20% at 60 days and 27% at 90 days of receiving CCM services.



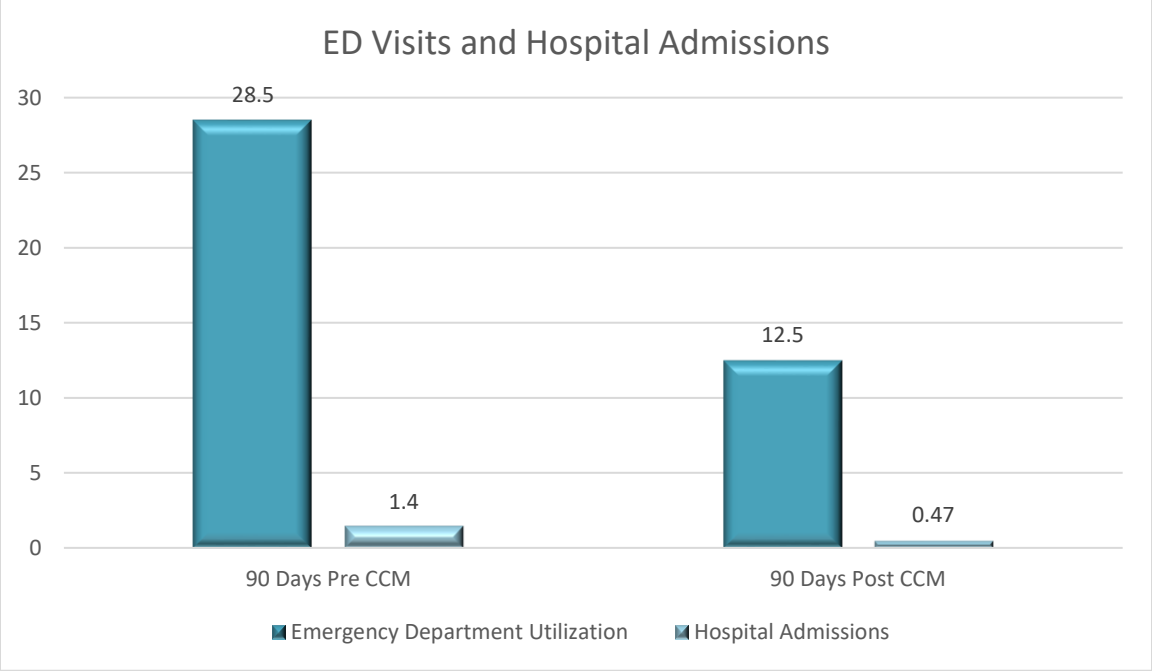
57 out of 60 members were included in the denominator for the initial PHQ scores. 3 of the members were not included in the denominator due to being unable to reach for assessment completion. 47 out of 60 members were included in the denominator for the 30-day PHQ scores. 13 of the members were not included in the denominator, in which 3 were unable to reach for assessment completion, 2 members CCM cases closed prior to completion of 30-day PHQ assessment and 8-member assessments were completed after the end of the FY date (after 9/30/2021). 41 out of 60 members were included in the denominator for the 60-day PHQ scores. 19 of the members were not included in the denominator, in which 5 were unable to reach for assessment completion, 4 members CCM case closed prior to completion of 60-day PHQ assessment and 10-member assessments were completed after the end of the FY date (after 9/30/2021). 34 out of 60 members were included in the denominator for the 90-day PHQ scores. 26 of the members were not included in the denominator, in which 5 were unable to reach for assessment completion, 9 members CCM case closed prior to completion of 90-day PHQ assessment, and 12-member assessments were completed after the end of the FY date (after 9/30/2021). 47 out of 60 members were included in the denominator for overall PHQ scores, in which 2 members were excluded due to only having one PHQ assessment completed. 8 members were excluded due to assessments being completed after the end of the FY date (after 9/30/2021) and 3 members excluded due to being unable to reach and having no PHQ assessments completed. 41/47 members (87%) met the goal of having a 10% improvement in PHQ scores from the start of CCM services to closure of CCM services.

<u>Causal Analysis</u>

Three members did not show an improvement in PHQ scores from baseline to the time that CCM services were ended. Three members PHQ scores increased while in CCM services, in which 2 of those members had continued high hospital admission utilization rates and 1 of those members went to a detention center and residential treatment while participating in CCM services. Two members showed an increase in PHQ scores but the improvement did not meet the 10% threshold. In order to continue to promote an improvement in PHQ scores, CCM will review and update Crisis Plans with members and existing care team after hospitalization. CCM will also encourage a connection with Members and Peer Support Specialists as an added support.

During FY21, information was gathered to assess member quality of life using the World Health Organization's Disability Assessment Schedule (WHO-DAS). Members WHO-DAS baseline scores ranged from 7 to 48, with an average score of 16. Members participating in CCM services demonstrated overall improvement in their WHO-DAS scores, and the improvement increased the longer that the members participated in CCM services. Average WHO-DAS scores showed improvement from baseline to 30 days of receiving CCM services. Average WHO-DAS scores improved 8.8% from baseline at 30 days, 17% at 60 days and 22% at 90 days of participating in CCM services. Overall, 38/47 members (80%) met the goal of having a 10% improvement in WHO-DAS scores from the start of CCM services to closure of CCM services.

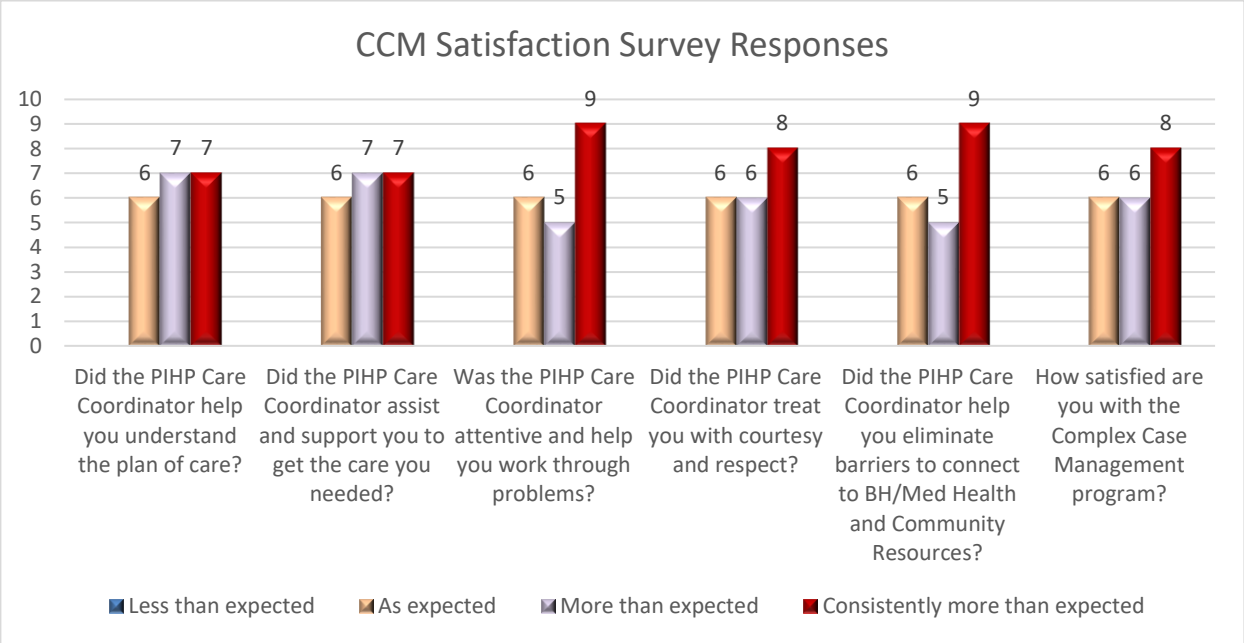
DWIHN analyzed member Admission, Discharge and Transfer (ADT) alerts and DWIHN claims data to measure utilization of Emergency Department and Hospital Admissions 90 days prior to participating in CCM services and 90 days after starting CCM services. Members participating in CCM services showed an average 48% reduction in Emergency Department utilization and average 74% reduction in Hospital Admissions from 90 days prior to 90 days after starting CCM services. Members had an average of 28.5 Emergency Department visits and 1.47 Hospital admissions during the 90 days prior to receiving CCM services and had an average of 12.5 Emergency Department visits and 0.47 Hospital admissions during the 90 days after starting CCM services.



DWIHN also measured the number of members who attended two out-patient behavioral health services within 60 days of starting CCM services. Out of 41 members that were available to participate in 2 out-patient services after starting CCM services, 36 members (87%) attended two out-patient behavioral health services within 60 days of starting CCM services. Fourteen members were not included in this measure due to not being enrolled in CCM services for 60 days at the time of the report. Five members were not included due to not being open for longer than 90 days. For FY21 as an area of improvement, DWIHN measured the number of members who attended two out-patient behavioral health services within 60 days of the closure CCM services. Out of 38 members that were available to participate in 2 out-patient services after CCM case closure, 16 members (42%) attended two out-patient behavioral health services within 60 days of CCM case closure. Seventeen members were not included in this measure due to not being enrolled in CCM services for 60 days at the time of the report. Five members were not included due to not being open for longer than 90 days.

Satisfaction surveys were offered to all members upon closure of Complex Case Management services. Members were informed that completion of the Survey was not mandatory, but that they were encouraged to complete the Survey to provide feedback regarding their experience receiving CCM services. Of the 60 CCM cases opened during FY21, 42 members had Complex Case Management services closed during FY21. 20 (48%) Satisfaction Surveys were completed and returned. The Satisfaction Survey consisted of 6 questions with Likert Scale response options of *Less than expected, As expected, More than expected, and Consistently more than expected*. There was also a section for members to write in comments if they chose. A response of 'Less than expected' is considered a report of dissatisfaction. A response of 'As expected' is considered a neutral response. Responses of 'More than expected' and 'Consistently more than expected' are considered reports of satisfaction.

No members reported responses of 'Less than expected' to the Survey questions. Six members provided a response of 'As expected' to the first question. All other members provided responses of 'More than expected' and 'Consistently more than expected'. The first question had a 70% of the questions were 'More Than Expected' and were 'Consistently more than expected'. 30% of the responses were 'As expected', as indicated in Table below satisfaction surveys were offered to all members upon closure of CCM services. Members were informed that completion of the Survey was not mandatory, but that they were encouraged to complete the Survey to provide feedback regarding their experience receiving CCM services. Of the 60 CCM cases opened during FY21, 42 members had CCM services closed during FY21. Forty-eight (48%) Satisfaction Surveys were completed and returned. The Satisfaction Survey consisted of 6 questions with Likert Scale response options of *Less than expected*, *As expected*, *More than expected*, and *Consistently more than expected*. There was also a section for members to write in comments if they chose. No members reported responses of 'Less than expected' to the Survey questions. The results of the survey are reported below.



The results of the FY21 analysis of CCM services can be compared to the results of analysis completed for FY20 and FY19. Comparisons can be made in the areas of PHQ scores, WHO-DAS scores, hospital admissions, behavioral health engagement, and Satisfaction Survey results. PHQ and WHO-DAS scores were lower than PHQ and WHO-DAS scores at baseline, 30 days and 60 days after starting CCM services in FY21 compared to FY20. PHQ and WHO-DAS scores were lowest in FY19, this could be an issue of interrater reliability as a result of staff changes that occurred during FY19. The two staff that provided CCM services during FY19 timeframes transferred to other positions within the organization during FY19. The number of members who met the goal of a 10% reduction in their PHQ scores at time of closure from CCM services remained the same in FY21 compared to FY20 and decreased from FY19. While the number of members who met the goal of a 10% reduction in their WHO-DAS scores at time of closure from CCM services increased in FY21 compared to FY20 and FY19.

Barrier Analysis

The causal analysis of barriers to improving member satisfaction and the experience continues to remain relatively the same from one year to the next (FY21 to FY20 48%). DWIHN would like to increase the return rate to 55% in FY22. DWIHN will continue offer a $10 Walmart Gift Card to all members who complete and return a CCM Satisfaction Survey. In addition, the Clinical Specialist of Complex Case Management will continue to contact any members who have not returned their satisfaction survey within 30 days of the satisfaction survey being mailed to encourage them to complete by telephone. Also, in effort to increase member sustainability and engagement in out-patient behavioral health services after they are no longer receiving CCM services, the percentage of members who engage in at least two out-patient behavioral health services within 60 days of closure of CCM services will continue to be measured. Care Coordinators will mail out educational material to members about the benefits of attending Behavioral Health Outpatient appointments within 2-3 weeks after case closure. Care Coordinators will contact members around 30 days post case closure for follow up. Care Coordinators will also contact members CRSP to speak with the assigned Case Manager or Supports Coordinator to ensure members barriers are being addressed and care team is working with member to increase outpatient visit participation.

Opportunities of Improvement

An area identified as an opportunity for improvement during FY20 was reduction in Emergency Department utilization. During FY21, Care Coordinators emphasized the importance of familiarization with crisis plans, and becoming more knowledgeable of managing conditions. Care Coordinators also emphasized the importance of member attendance and participation at outpatient behavioral health appointments. Care Coordinators also worked with members to address barriers of attending appointments, including arranging transportation, rescheduling appointments to accommodate member schedules, and connecting members to service providers of members preference. Care Coordinators completed transition of care calls to members to encourage FUH appointment attendance and ensure needs were met. Care Coordinators also contacted members assigned Clinically Responsible Service Provider (CRSP) for increased coordination to improve member attendance for aftercare appointments. As a result of these efforts, 95% of members who received CCM services met the goal of a 10% reduction in Emergency Department Utilization.

DWIHN will continue to place greater emphasis on developing, reviewing and updating crisis plans with members in an effort to reduce utilization of Emergency Department services. Teach back methods will be used once the crisis plans are developed to ensure that members can articulate back their crisis plans and know what actions to take when symptoms start to occur. DWIHN will also continue working with current care team to increase members participation in Follow up after Hospitalization appointments as well as attendance for regular outpatient appointments. This goal will be continued through fiscal year 21/22.

Cultural and Linguistic Needs

Quantitative Analysis and Trending of Measures

How well providers communicate impacts members' overall satisfaction and has remained consistent over the three-year period from 2019 to 2022 with slight upward movement. The Cultural and Linguistic needs data reports that literacy; language and cultural barriers are inherent in the DWIHN's populations and cause frustration often resulting in member dissatisfaction surrounding access to care and/or the customer service they receive from their provider. Focus studies show that members with complex medical needs are frustrated with their experiences and believe they are receiving low-quality medical coverage. Members have reported frustration and suggest that office staff receive training on how to treat and communicate with people of different cultures and ethnicities. Members report that they are unaware of free interpreting services although this is highly promoted to DWIHN members.

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

Evaluation of Effectiveness

As the nation continued to grapple with the realization of racism and the impacts of oppression on health outcomes, the development of professionals that are able to recognize and respond to their implicit biases is critical and has been a primary objective for the development and retention of providers. Trauma-informed approaches to care includes addressing minority stress and race-based trauma. During FY21, staff supported 6,005 callers. Using the least restrictive methods to access services, callers that live, work, play, worship, and learn in Wayne County are able to access behavioral health support that is consistent with their current stage of change. As callers are often pre-contemplative, staff provided support and encouragement without requiring identifying information to receive services. The focus on engagement has led to a majority of individuals reporting an increased level of comfort in accessing services that positively affect their behavioral health. When callers demonstrate an ongoing need for services, staff provided a direct referral with a community mental health provider.

Barrier Analysis

It is recommended that partner organizations create a trauma-informed culture, safe work environment that includes physical and work place policies that prevent harassment, stalking, and violence. Promote respectful interactions amongst staff members at all levels. In addition, implement regular and consistent clinical supervision for all clinical staff members and provide ongoing training related to trauma-informed care and evidence-based interventions. Develop consistent hiring practices to ensure the best candidate for the role, be clear and concise about role expectations, and offer training that will build staff competencies. Lastly, utilize general approaches and techniques of building a rapport, providing a safe and comfortable environment to increase consumer participation.

Opportunities for Improvement

Through discussion and feedback, the following have been identified as opportunities for improvement:

- Continue to advance health equity, improve quality and help eliminate health care disparities by implementing culturally and linguistically appropriate services.
- Address barriers to accessing interpreters and language services.
- Increase data collection to document cultural linguistic competency need, include cultural linguistic competency in staff evaluations and creating recruitment strategies for bilingual and diverse staff.
- Place greater emphasis on policy change related to sexual orientation and gender identity and expression.
- Continue to utilize the data so the Implementation team and participating agencies and organizations can develop best practices that promote cultural linguistic competency and enrich workforce development on cultural linguistic competency specific needs.
- Continue efforts toward the recruitment and retention of providers and practitioners with cultural, linguistic, or special needs expertise.
- Continue Cultural Competency training to staff and network providers as required.
- Continue to meet the cultural, ethnic and linguistic needs of members by assuring a diverse provider network.

Credentialing and Re-Credentialing

Activity Description

Detroit Wayne Integrated Health Network credentials practitioners and providers that provide Behavioral Health and Substance Use Disorders services. The credentialing standards comply with 42 CFR 422.204, NCQA, and Michigan Department of Health and Human Services. Medversant Technologies LLC, a National Committee for Quality Assurance (NCQA) Credentialing Verification Organization, primary source verifies the electronic applications and supporting documentation for practitioners and providers. Once that occurs the information is submitted to the DWIHN Credentialing Committee. This committee is composed of DWIHN's the Chief Medical Officer or their physician designee, the Credentialing Administrator, DWIHN staff and various quality members from Core Provider Agencies. The committee reviews and votes on moving the files to the CMO's que for approval. The committee also discuss disposition for files that do not meet the credentialing threshold. The CVO sends letters to the practitioners or providers of the credentialing decision. The Credentialing Committee also monitors the following databases monthly to determine if practitioners or providers have been excluded or sanctioned:

- Michigan Department of Health and Human Services Sanctions
- System for Award Management
- Office of Inspector General
- Medicare Opt Out
- Preclusion

Quantitative Analysis and Trending of Measures

DWIHN analyzed trends in service delivery and health outcomes over time, including whether there have been improvements and barriers impacting in the quality of health care services for members as a result of the activities. On a monthly basis, DWIHN credential and re-credential licensed practitioners who need to complete this process upon hire and every two years thereafter for participation in the DWIHN provider network. In FY21, DWIHN completed verification for 913 practitioner files for credentialing and 73 providers, which is a significant increase compared to last fiscal year of 537. All files were clean, had appropriate checks done, and had no issues or concerns.

Barrier Analysis

No barriers identified.

Office of Recipient Rights

Activity Description

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

Quantitative Analysis and Trending of Measures

During FY21, the Office of Recipient Rights (ORR) received 1,111 allegations, investigated 889 cases, and substantiated 251 investigations. The ORR received allegations from 474 recipients and 376 employees which represents the highest number of individuals that filed complaints. There was a significant decline in the number of allegations reported in FY20 1,383 (17%) compared to 1,631 reported allegations in FY19. The difference in the four years represents a (5%) decrease in complaint allegations since 2017; (3%) increase in complaint investigations since 2017; and (1%) increase in substantiated complaint allegations since 2017.

ORR also oversees the training for all DWIHN and provider employees, for the FY 20-21, the Recipient Rights Trainers registered 5,159 participants, 2,590 attended and passed the virtual class, and there were 2,569 no shows. This is significant and supports the fact that recipients and employees are one of our greater resources in protecting the rights of the ones we serve.

Evaluation of Effectiveness

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

Barrier Analysis

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

Opportunities for Improvement

DWIHN has identified the following as opportunities for improvement:

- Continue to education and trained the provider network to assist in the Code mandated provision
- Continue to monitor recipient rights compliance through the review of incident and death reports, behavior plans, contracts and service provider locations.
- Ensure uniformly high standard of recipient rights protection across all service providers
- Continue resolution through the recipient review and investigation of suspected or alleged rights violations.

Access Pillar

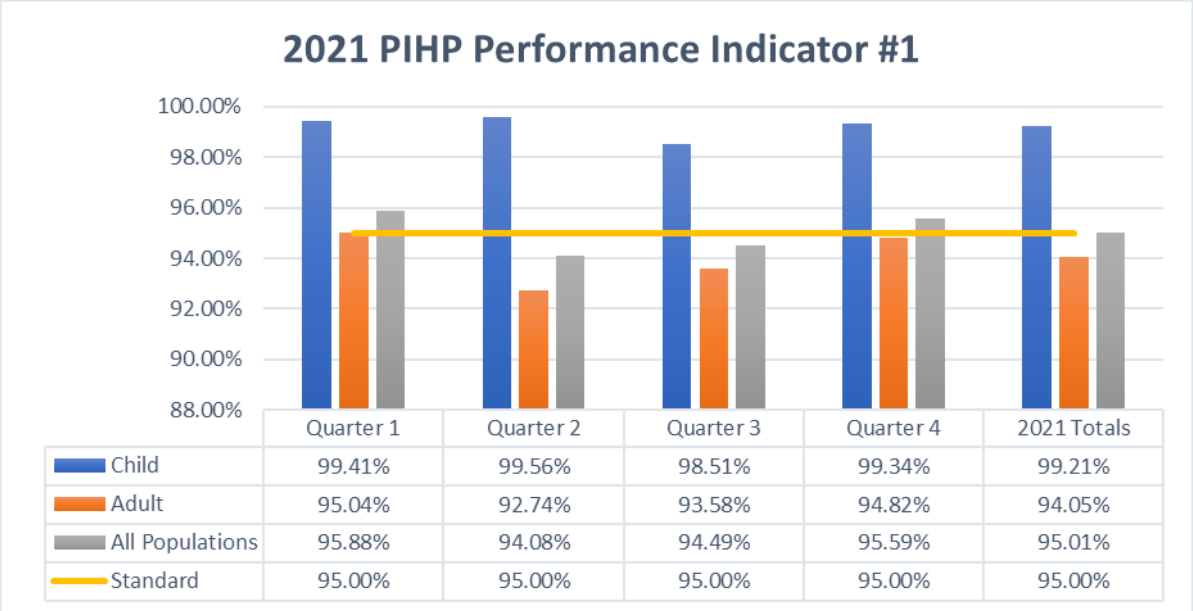
Michigan Mission Based Performance Indicators (MMBPI)

Activity Description

The Michigan Mission Based Performance Indicators data are a way of measuring how well we are helping the people we serve by meeting standards of care like timeliness; by reducing problems like hospitalization; or by helping people improve their lives in other ways. There are five (5) indicators that have been established by Michigan Department of Health and Human Services (MDHHS) that are the responsibility of the PIHP to collect data and submit on a quarterly basis. The established standards for indicators #1 and #4 are (95% or above) and the standard for indicator #10 is (15% or less). Indicators #2 (The percentage of new persons during the period receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service) and Indicator #3 (The percentage of new persons during the period starting any medically necessary on-going service within 14 days of completing a non-emergent biopsychosocial assessment) are new indicators in which there are no established standard/benchmark set by MDHHS.

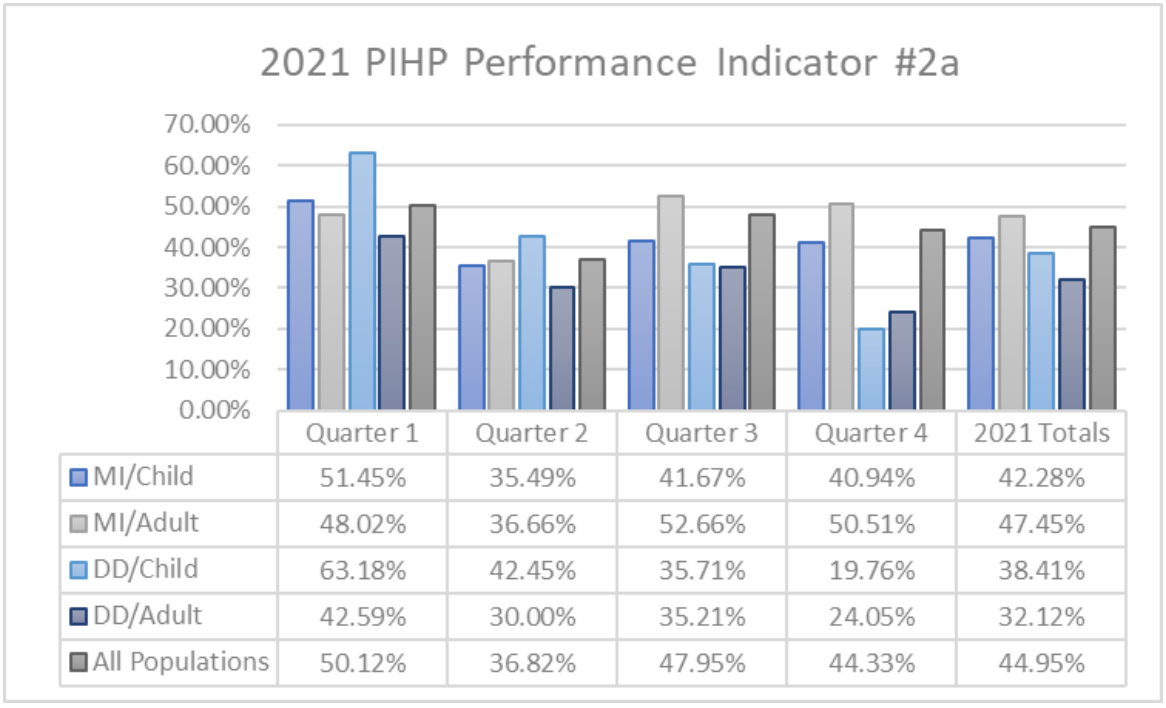
Quantitative Analysis and Trending of Measures

The percentage of persons during 2021 receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. **Goal**: The goal is to attain and maintain performance standards as set by the MDHHS contract. Standard 95% or above. **Results:** FY21 standard met for all populations with the exception of Q2 Adult (92.74%), Q3 Adult (93.58%) and Q4 Adult (94.82). Total population rate (95.01%).



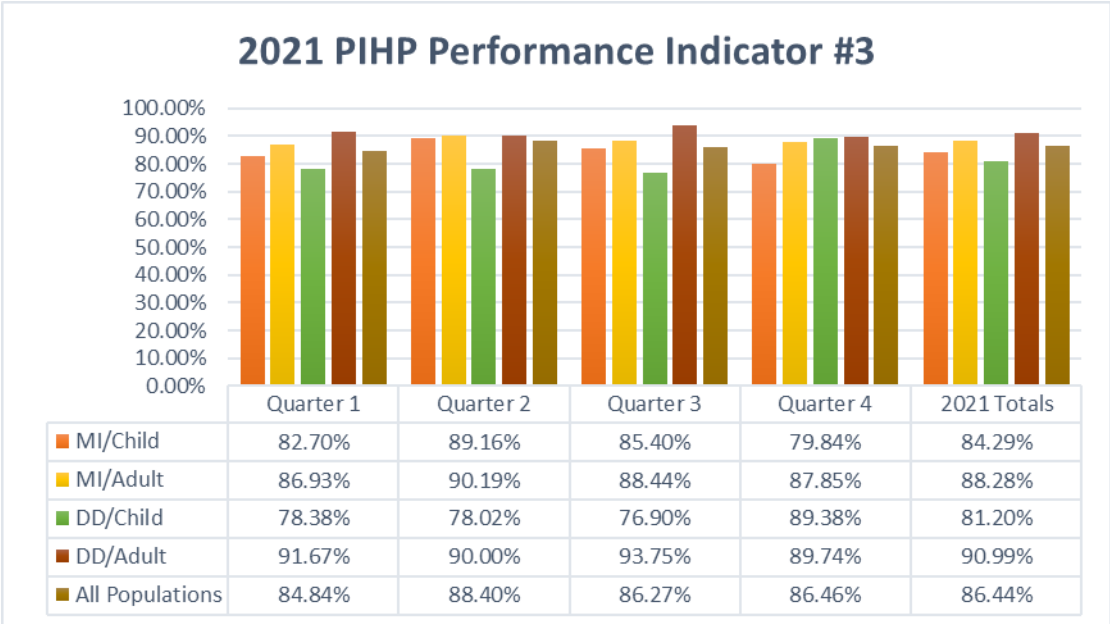
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2021 Totals
Child	99.41%	99.56%	98.51%	99.34%	99.21%
Adult	95.04%	92.74%	93.58%	94.82%	94.05%
All Populations	95.88%	94.08%	94.49%	95.59%	95.01%
Standard	95.00%	95.00%	95.00%	95.00%	95.00%

The percentage of persons during FY 2021 receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service. No standard/benchmark has been set by MDHHS. This measure allows for no exceptions. **Results**: Q1(50.12%), Q2 (36.82%), Q3 (47.95%) and Q4 (44.33%). Total population rate (44.95%).



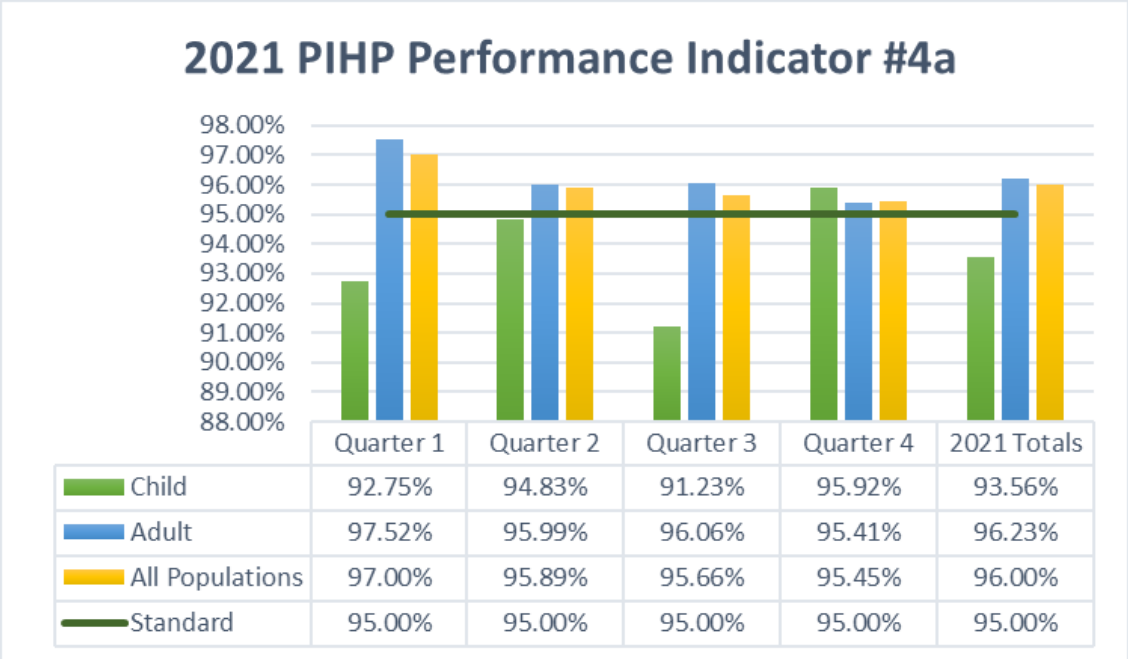
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2021 Totals
MI/Child	51.45%	35.49%	41.67%	40.94%	42.28%
MI/Adult	48.02%	36.66%	52.66%	50.51%	47.45%
DD/Child	63.18%	42.45%	35.71%	19.76%	38.41%
DD/Adult	42.59%	30.00%	35.21%	24.05%	32.12%
All Populations	50.12%	36.82%	47.95%	44.33%	44.95%

The percentage of persons during FY 2021 needed on-going service within 14 days of a non-emergency request for service. No standard/benchmark has been set by MDHHS. This measure allows for no exceptions. **Results:** Q1(84.84%), Q2 (88.40%), Q3 (86.27%) and Q4 (86.46%). Total population rate (86.44%).



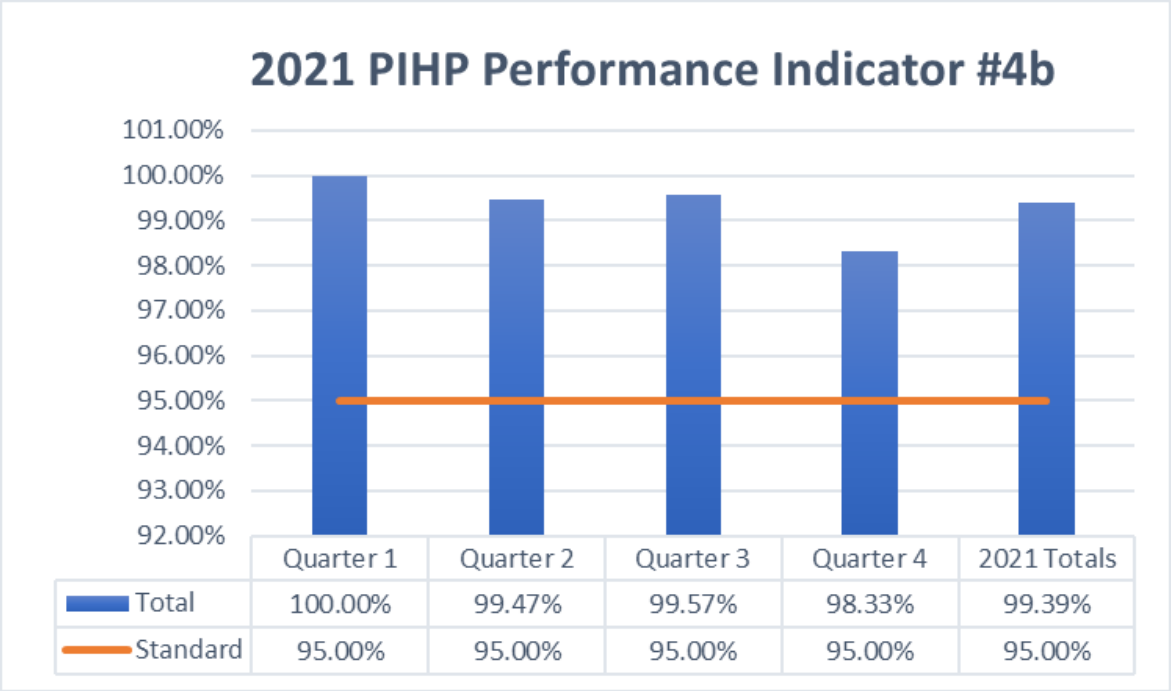
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2021 Totals
MI/Child	82.70%	89.16%	85.40%	79.84%	84.29%
MI/Adult	86.93%	90.19%	88.44%	87.85%	88.28%
DD/Child	78.38%	78.02%	76.90%	89.38%	81.20%
DD/Adult	91.67%	90.00%	93.75%	89.74%	90.99%
All Populations	84.84%	88.40%	86.27%	86.46%	86.44%

The percentage of discharges from a psychiatric inpatient unit during FY2021 who are seen for follow-up care within seven days. **Goal**: The goal is to attain and maintain performance standards as set by the MDHHS contract. Standard 95% or above. **Results**: FY21 standard met for all populations with the exception of Q1 Child (92.75%), Q2 Child (94.83%) and Q3 Child (91.23%). Total population rate (96.00%).



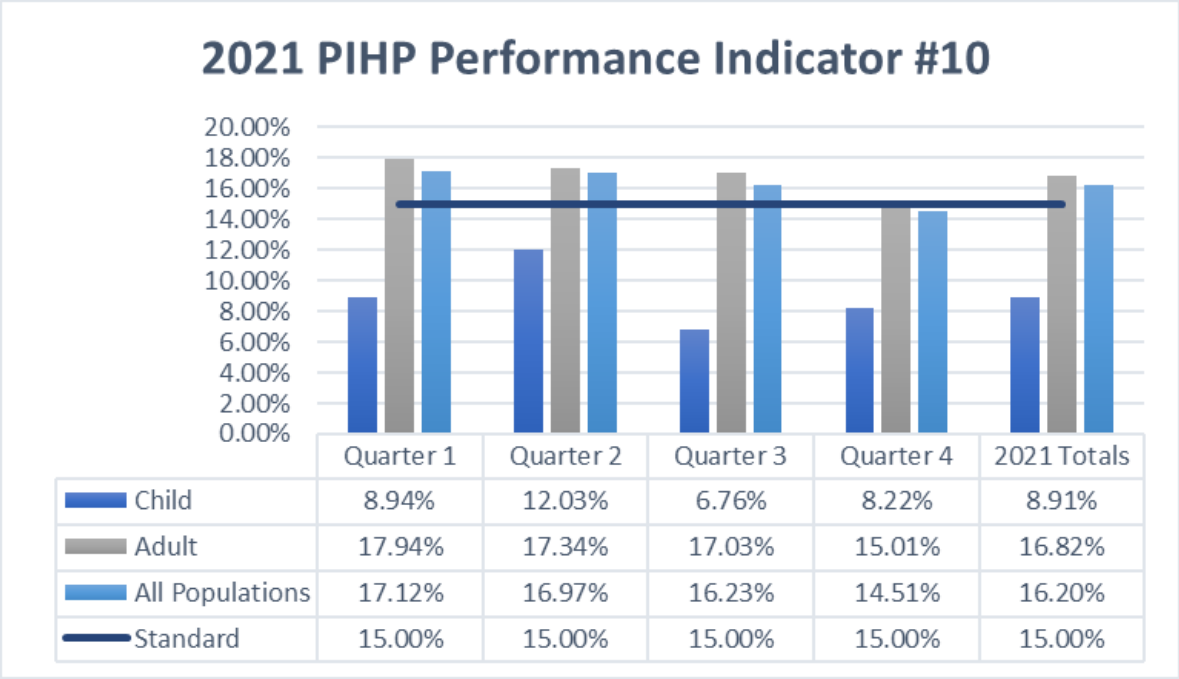
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2021 Totals
Child	92.75%	94.83%	91.23%	95.92%	93.56%
Adult	97.52%	95.99%	96.06%	95.41%	96.23%
All Populations	97.00%	95.89%	95.66%	95.45%	96.00%
Standard	95.00%	95.00%	95.00%	95.00%	95.00%

The percentage of discharges during FY 2021 from a Substance Abuse Detox Unit who are seen for follow- up care within 7 days. **Goal**: To achieve MDHHS established benchmark of (95% or above) for (4) quarters during FY21. Standard 95% or above. **Results**: FY21 standard met for all 4 quarters. Total rate (99.39%).



	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2021 Totals
Total	100.00%	99.47%	99.57%	98.33%	99.39%
Standard	95.00%	95.00%	95.00%	95.00%	95.00%

The percentage of readmissions of children and adults during FY 2021 to an inpatient psychiatric unit within 30 calendar days of discharge from a psychiatric inpatient unit. **Goal**: The goal is to attain and maintain performance standards as set by the MDHHS contract. Standard 95% or above. **Results:** FY21 standard met for the children population. Standard not met for the adult population for all quarters Q1 (17.94%), Q2 (17.34%), Q3 (17.03%), Q4 (15.01). Total population rate (16.20%).



	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2021 Totals
Child	8.94%	12.03%	6.76%	8.22%	8.91%
Adult	17.94%	17.34%	17.03%	15.01%	16.82%
All Populations	17.12%	16.97%	16.23%	14.51%	16.20%
Standard	15.00%	15.00%	15.00%	15.00%	15.00%

Evaluation of Effectiveness

The results below show that the initiatives and interventions that were implemented in FY2020 were generally effective in reducing recidivism rates. In FY21, as a result of 447 conversations, DWIHN has been able to divert 64% of those members considered to be familiar faces to the least restrictive environment. Also, as displayed in the table below, DWIHN's Recidivism Workgroups which includes our Clinically Responsible Service Providers (CRSP) (led by DWIHN Crisis/Access team) initiatives have led to a decrease with the adult recidivism rate from 22% during Quarter 2 in FY20 to 15.01% for Quarter 4 for FY21, with a total population rate of 14.51%, which is the second lowest rate in the last 2 years. The threshold for PI# 10 is 15% or less.

	Population	FY20Q1	FY20Q2	FY20Q3	FY20Q4	FY21Q1	FY21Q2	FY21Q3	FY21Q4
ndicator 10a: Percentage who had a Re-Admission to Psychiatric Unit within 30 Days (<15% Standard)	Children	10.91%	9.09%	8.09%	11.11%	8.94%	12.03%	6.76%	8.22%
	Adults	20.41%	22.00%	20.83%	16.60%	17.94%	17.34%	17.03%	15.01%
	Total								14.51%

DWIHN continued to meet the standards for PI#1 (Children), PI#4a (Adult), 4b (SUD) and PI#10 (Children) for all quarters during FY21. DWIHN provided access to treatment/services for 95% or more members receiving a pre-admission screening for psychiatric inpatient care within 3 hours of a request for service with 95% or more receiving follow-up care within 7 days of an assessment. DWIHN provided access to treatment/services for 95% or more members discharge from a Substance Abuse Unit who are seen for follow-up care within 7 days. DWIHN demonstrated an 8.9% performance rate for Children who were re-admitted within 30 days of being discharged from a psychiatric hospitalization. This was a significant improvement in performance from the previous reporting period.

For Q2 (92.74%), Q3 (93.58%) and Q4 (94.82%), PI #1 the percentage of persons of adults during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours did not meet the 95% compliance standard. Efforts for PI#1 (Adults) include DWIHN's Access/Crisis team monitoring Community Outreach for Psychiatric Services (COPE) documentation in MH-WIN for cases that are not meeting the three (3) hour threshold. There was a slight increase of .84 percentage points from Q2 to Q3. For Q1(92.75%), Q2 (94.83%) and Q3 (91.23%) #4a the percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days" (Children) did not meet the 95% standard. Root Cause Analysis (RCA) revealed that three (3) follow-up appointments were scheduled in error with a provider not accepting new members. One (1) IDD provider reported that a member should have been scheduled with a SED provider. The last event was scheduled outside of the 7-day period but with no explanation. Performance Improvement Plans (PIP) and discussions with DWIHN's Access Center will be completed as a result of these out of compliance events. Ongoing efforts to include review of potential barriers for members that are not following through with their 7-day follow up appointments.

Data Analysis

- PI#1 - The adult rate was 94.82% for Q4 (95% standard), an increase of 2.4 percentage points from Q1(95.04%).
- PI#1's - Overall rate was 95.59% (95% standard), up 0.81 percentage points from Q1 (95.88%).
- PI#10 - The adult rate was 15.01% for Q4 (15% standard), a decrease of 16.33 percentage point from Q1 (17.94).
- PI#10's - Overall rate was 14.95% (15% standard), a decrease of 15.24 percentage points from Q1(17.12%).

Beginning Q3 of FY 2020, separate indicators were developed for PI#2a new persons receiving a completed Biopsychosocial Assessment within 14 calendar days of a non-emergency request for service, PI#2b SUD Services and indicator #3 new persons starting any medically necessary on-going covered service within 14 days of completing a non-emergent Biopsychosocial Assessment. There is no established standard for these indicators until one year of baseline data has been collected. The indicators are for persons with mental illness, developmental disabilities and substance use disorder. During FY21, the total compliance rates ranged from 36.02% - 50.12% for 2a, 86.10% - 89.81% for 2b and 84.84% -88.4% for #3.

Barrier Analysis

DWIHN developed dashboards to measure and track the outcomes for evidence-based practices, which are tied to DWIHN value-based service models. These dashboards will track incentives related to outcomes on four the performance indicators (2a, 3a, 4a and 10). For Q2 and Q3 DWIHN has failed to meet the threshold (95%) for PI# 1. DWIHN's Access/Crisis team has been working with COPE to review and request Corrective Action Plans (CAP) and Root Cause Analysis (RCA) as required. During the COVID-19 pandemic, COPE has expressed issues with being understaffed, which has attributed to the lower compliance scores. Several meetings have occurred with COPE and DWIHN and there was a slight increase from Q2 to Q3. DWIHN is optimistic with the interventions and initiatives that have been implemented that Q4 reporting data will improve to meet the threshold of 95% as required. PI#2a continues to demonstrate low scores. Providers are reporting a staffing shortage of intake workers due to the pandemic. Appointment meetings with DWIHN's clinical team, the Access Center, Quality and providers' executive leadership have been occurring in the last month to discuss solutions.

Those areas that perform below the standard DWIHN has developed a workplan to address areas of deficiency to increase the reported scores. Providers are reporting a staffing shortage of intake workers due to the pandemic. Appointment meetings with DWIHN's clinical team, the Access Call Center, Quality and providers' executive leadership have been occurring in the last month to discuss solutions. However, DWIHN is optimistic with the interventions and initiatives that have been implemented that Q4 reporting data will improve to meet the threshold of 95% as required. Efforts will continue to include working with DWIHN's Access Center unit, IT and PCE to review and identify barriers from scheduling the first appointment to completing the biopsychosocial assessment within 14 calendars.

Efforts to decrease hospital admissions and readmissions have continued to be a challenge. DWIHN seeks to reduce psychiatric inpatient admissions and provide safe, timely, appropriate and high-quality treatment alternatives while still ensuring members receive the appropriate required care. DWIHN continues its efforts to expand the comprehensive continuum of crisis services, supports, and improve care delivery. Rates continue to decrease slightly from quarter to quarter. Q3 2021 overall rate of 16.23% is the second lowest rate in the last 2 years.

Those areas that perform below the standard DWIHN has developed a workplan to address areas of deficiency to increase the reported scores. Providers are reporting a staffing shortage of intake workers due to the pandemic. Appointment meetings with DWIHN's clinical team, the Access Call Center, Quality and providers' executive leadership have been occurring in the last month to discuss solutions. DWIHN remains optimistic with the interventions and initiatives that have been implemented to meet the threshold of 95% as required. Efforts will continue to include working with DWIHN's Access Center unit, IT and PCE to review and identify barriers from scheduling the first appointment to completing the biopsychosocial assessment within 14 calendars.

Opportunities of Improvement

DWIHN will continue to focus on utilizing a system for formal tracking in order to identify trends where systemic change may be helpful:

- For Indicators 2 and 3 baseline data collection, improvements will be focused on ensuring valid, reliable, and actionable data is being collected.
- Continue to work with DWIHN's Crisis Team to identify potential delays in care.
- Working on expansion of "Med Drop" Program to improve outpatient compliance with goals to decrease need for higher level of care inpatient hospitalizations.
- Continue engagement and collaboration with members' outpatient (CRSP) providers to ensure continuity of care and when members present to the ED in crisis but may not require hospitalization.
- Continue efforts to chart alerts which notify the screening entities and the Clinically Responsible Service Provider (CRSP) of members who frequently present to the ED.
- Properly navigated and diverted members to the appropriate type of service and level of care.
- Provide referrals to Complex Case Management (CCM) for members with high behavioral needs.
- Continue coordination and collaboration with crisis screeners on measures to decrease inpatient admissions.

Improving Access and Crisis Services

Activity Description

In Fiscal Year 2021, DWIHN brought its Access Call Center in-house as a newly hired team began to champion the mission of providing the community we serve prompt and efficient service while ensuring that all members are treated with dignity and respect. The intent of this goal was to improve access to services. Implementing "First Call Resolution" empowers the Access Call Center staff to be sensitive to members' needs including those that need special accommodations and to accommodate specific needs so that appropriate services are always provided upon the first request. This service principle allows for calls to be managed with efficiency and care.

Quantitative Analysis and Trending of Measures

The data collected by the call center phone system software in FY21 indicates that performance exceeded the National Standards for Call Centers:

- Abandonment Percentage: from 1.2% to 4.9% less than standard.
- Average Speed to Answer: from 13 seconds to 17 seconds less than standard Percent of Calls.
- Answered: from 16.2 to19.2 % greater than standard.
- Service Level Percent: from 8.2% to 17.4% greater than standard.

Requests for service (RFS) data shows a decreased for the 2nd year in a row, though the decrease is slight FY 20/21. Diversion rates improved for children, though decreased slightly, by 1% for adults. The Crisis Services unit has been working diligently, with increased face to face assessments, to improve outcomes of members in crisis, and has continued efforts to improve recidivism rates despite increasing staff shortages in several areas of care within the provider network. Crisis Services staff have continued efforts to improve communication with CRSP providers and community contacts to alleviate re-admissions to an inpatient level of care, and have been assisting in appropriate discharges of members into the least restrictive environments. Outreach efforts continue with a newly added mobile outreach clinician, providing education and access to DWIHN services, and this is occurring in the communities for those in need in the partnership with Wayne Health.

Evaluation of Effectiveness

The Request for Service (RFS) is slightly lower (0.75%) than FY 19/20. Diversion rates increased by 4% as compared to last year. The increase in diversion rates seem to have been impacted with crisis screeners resuming face to face screening and an increase in crisis stabilization services. The number of RFS decreased in FY 20/21 by 5%, however the overall percentage admitted slightly increased (1%) and diversions slightly decreased (1%). Inpatient due to no Crisis Residential Unit (CRU) bed available decreased by 68% from last year, though CRU capacity has deceased during COVID. Inpatient admits are due to higher acuity cases. There was 2.2% increase in (CRU) admissions in comparison to last FY. CRU capacity increased from 14 to 16 beds. As CDC guidelines allow, more beds will open gradually. COPE (DWIHN's Crisis Stabilization Unit) services increased by 5.3 as compared to the last FY. Team Wellness CSU number served increased by 732 cases from last year (last year numbers were for a period of 5 months).

FY	# Incoming Calls	# Calls Answered	% answer w/in 30 secs	Avg. Speed of answer	Abandonment rate
19/20	15,450	14,721	85% (avg)	22 secs	3.35
20/21	11,291	10,591	77.25	31.5	4

The call volume for the year decreased by 27%, however, the performance outcomes are out of compliance, with the exception of the abandonment rate. ProtoCall (DWIHN's Crisis Vendor) reports addressing staffing concerns and are working on recruiting and retention. A plan of correction has been requested and will continue to be monitored.

Barriers Analysis

Recidivism to inpatient hospitalization is an opportunity for improvement. The total number of Crisis Alerts received for the year is 447 and the diversion rate for the alerts received was 64% which positively impacted recidivism. The hospital rate of recidivism decreased from 17.12% in Quarter 1 to 14.59% in Quarter 4 and the average length of stay for FY21 was 11 days.

Opportunities of Improvement

The following opportunities were identified:

- Establish contract with Beaumont Hospital Psychiatric Inpatient facility.
- Implement next phase of mobile outreach to include mobile crisis services, expand to shelters.
- Develop Workplan and RFP for Crisis Care Center.
- Apply for RFP for Crisis Stabilization Unit with the state.
- Implement recommendations from the Steering Committee to reduce inpatient and recidivism.

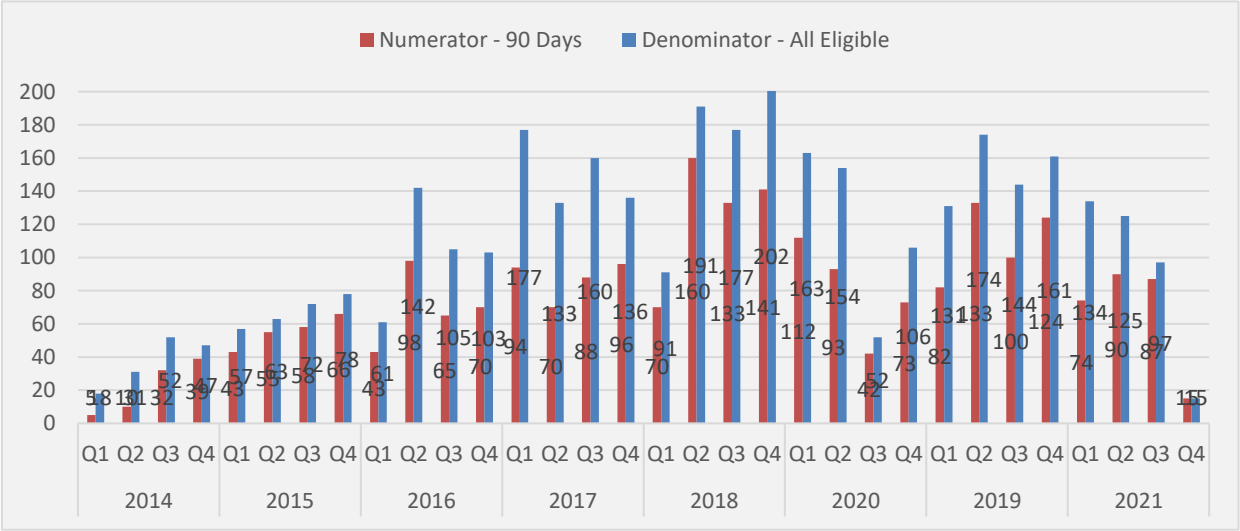
Access to Autism Services

Activity Description

Another significant area in which DWIHN strive to improve is eligible members access to Applied Behavior Analysis (ABA) treatment either on or before 90-days of entering DWIHN's system of care.

Quantitative Analysis and Trending of Measures

In FY21, DWIHN saw an increase in referrals from the previous year by 261 cases. In FY20, referrals reduced by (20%) due to COVID-19. This increase may suggest that members and their families are feeling more comfortable engaging in center and home-based ABA now than they had at the onset of COVID-19. Data below is a visual display of cumulative data across 2014 to present on eligible members access to ABA treatment either on or before 90-days of entering DWIHN's system of care. Data outlined in blue is the denominator which depicts all eligible members enrolled in the ASD Benefit. Data outlined in orange is the numerator which depicts all members that entered services on or before 90-days.



Evaluation of Effectiveness

The DWIHN ASD Benefit continues to grow each quarter. Fiscal year 20/21 4th quarter ended with 2,009 open cases which was an increase of 261 cases from the beginning of the fiscal year. An RFP was issued to meet the growing demands of accessing services in specific demographic areas in Wayne County. The RFP was awarded to 2 new ABA providers increasing member choice to 5 new sites bringing the number of sites to 31 with a total of 15 ABA Providers across Wayne County. DWIHN made a significant change in the ASD Benefit process flow by adding 2 Independent Evaluators through a Request for Proposal (RFP) to improve the timeliness standards and reduce conflict of interest and potential bias of treatment providers providing initial diagnoses of autism to the network. The two Independent Evaluators averaged 123 referrals for diagnostic evaluations across three months.

Barrier Analysis

Expand the ABA provider network to demographic areas with limited access to “brick and mortar” locations in the County. There continues to be an increase in referrals for autism services. DWIHN is currently reviewing applications to add additional locations in identified gap areas within the county. DWIHN also has an increased need for autism evaluation services and is working with an identified provider to provide temporary assistance in this area until a new provider is added. DWIHN continues to struggle to provide services within 90 days of MDHHS approval (15:1 is the requirement set forth by the national guidelines of the Behavior Analysis Certification Board). Another barrier is that Behavior Technicians are unable to provide ABA Direct Services until IPOS and Authorization is input timely and BCBAs are expending time and energy into getting Support Coordinators to update IPOSs and input authorizations timely. DWIHN has a (38) percent denial rate and (62) percent approval rate for meeting ASD benefit enrollment criteria and Medical Necessity criteria for FY21.

Opportunities of Improvement

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

- Streamline workflow and timeliness from referral to access to 1:1 ABA therapy for eligible members.
- Expand the ABA provider network to demographic areas with limited access to “brick and mortar” locations in the County.
- Improved reporting integrity on Behavior Assessment Worksheets.
- Provide support and training to the ASD Network to improve on accessing the ASD benefit.
- Increase provider meetings to monthly to increase communication, education, and support for providers from DWIHN.
- Encourage providers to increase number of consumers per BCBA to reach 15:1 ratio.
- Begin tracking number of Behavior Technicians in DWIHN’s network.
- Continued training and technical assistance for supports coordinators submitting authorizations.
- Hosted Supports Coordinator Roundtable.

Access to Substance Use Disorder (SUD) Services

Activity Description

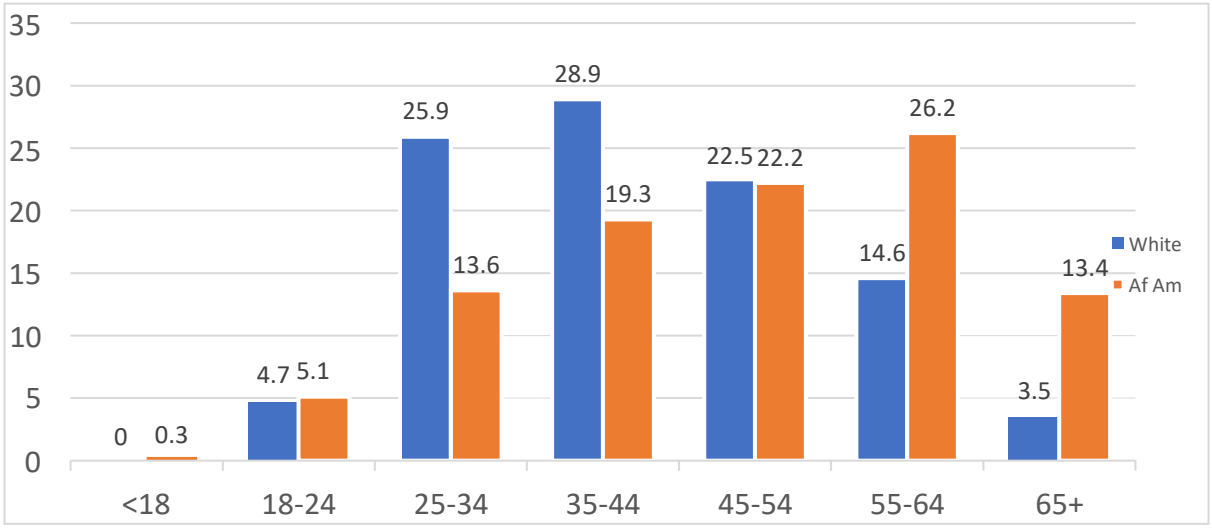
In FY21, the Substance Use Division focused on improving treatment services for individuals with opioid use disorder. The goal of this improvement was to develop and implement an Opioid Health Home (OHH) model of care. An Opioid Health Home is a model of care that provides comprehensive care management and coordination services to Medicaid beneficiaries with opioid use disorder. The model takes a holistic approach to health care and provides one “home” base for coordinating recovery and health needs while functioning as the central point of contact for directing patient-centered care across the broader health care system. The Substance Use Division successfully recruited and contracted with two new Office Based Opioid Treatment providers and expanded this service with three 17 additional contracted Opioid Treatment Providers. Procedures were developed to identify and enroll individuals into the OHH program, training on the procedures, MDHHS data base, and OHH requirements was provided to all participating programs. A data tracking system has been developed to manage enrollment and disenrollment within the system.

Quantitative Analysis and Trending of Measures

The Substance abuse treatment admissions data is an indicator of how many individuals received treatment for their substance abuse. There were 6,197 individuals that received SUD services for FY21, a 15.74% decrease from FY 21. This decrease can be attributed to COVID-19 which greatly reduced the capacity of many providers to serve members in both residential and outpatient settings. The age distribution metric has remained relatively constant over the last several years. During FY20, (68%) percent of individuals admitted were between 25-54 years of age. Twenty-eight (28%) of individuals admitted were for 55+ years of age. Four (4%) were for individuals age 18-24, and less than (1%) were admissions individuals between 0-17. DWIHN demonstrated a 99.39% performance rate for individuals who were seen for follow-up care within 7 days of discharge from a detox unit. This is an increase of 2.56% from FY20 (96.90%).

Evaluation of Effectiveness

In FY21, DWIHN met the standards for all 4 quarters for indicator 4b (timeliness of Substance Abuse Detox) follow-up care within 7 days) Q1(100%), Q2(99.47%), Q3(99.57%), Q4(98.33%). DWIHN continues to train first responders, its providers, drug court staff, inmates/jail staff and the community on how to reverse an opioid overdose. DWIHN is increasing the number of providers that can train and distribute Naloxone in the community. The medical examiners provisional data suggest that drug overdose deaths declined by 9.3% since April 2020 to April 2021 in Wayne County. We saw the following: Slight decrease in whites by 1% and a slight increase in African American by 1%.



Evaluation of Effectiveness

In FY21, DWIHN conducted 56 Narcan trainings and distributed 3,103 Narcan kits during FY'21. Community outreach and engagement remain a top priority within the SUD department. Staff offers free lifesaving Naloxone (Narcan) training to various local businesses, law enforcement, companies, and organizations throughout Wayne County. During the training, information and resources are shared and attendees receive a free Narcan kit. One component of this program includes outreach to local Detroit barbershops as DWIHN providers work with customers on educating them about substance use disorder and mental health matters. This is especially important because many times men do not want to discuss mental health and this is a safe environment in their community where they can share information with professionals who can offer resources to them and their families. So far, 38 barbershops have participated in this program and almost 90 men have been given mental health and SUD resources.

Barrier Analysis

Fentanyl remains the driving force in the drug overdose deaths. The COVID-19 pandemic continues to impact service delivery throughout the provider network by workforce shortages across disciplines, adjusting to the use of telehealth for the delivery of behavioral health services and limited resources. DWIHN continue to work with our provider network to ensure that services are not interrupted for those we serve but also recognizing that we must increase our level of communication and outreach.

Opportunities for Improvement

DWIHN will continue to educate and improve understanding about substance use disorder, increase access to effective treatment and support recovery through working across the criminal justice systems, hospital settings, and other systems within Wayne County.

Quality Pillar

Provider Network

Activity Description

Each year the performance monitoring staff conducts reviews of provider services and programs to ensure the safety and wellness of all persons served.

Quantitative Analysis and Trending of Measures

In FY21, DWIHN saw an increase in audits performed compared to FY20 through virtual monitoring. The reviews include the Clinically Responsible Service Provider (CRSP), Autism, SUD, MI Health Link and Residential Treatment Providers. The average scores of these reviews ranged from 77% being the lowest and 96% being the highest. 274 staff records were reviewed this fiscal year with an average score of 93%. Those providers who scored below 95% were placed on a corrective action plan.

The CRSP Providers were found to have good, thorough assessments and implementation of person-centered planning process when changes or amendments were needed to the plan. Progress notes were detailed and provided a snapshot of the person being served. However, reviewers found that members' Individual Plans of Service did not include "SMART" goals, goals in the members' own words, and/or had a lack of specific amount, scope, frequency, & duration of supports and services. There was also a lack of evidence members received a copy of their IPOS within 15 business days. Reviewers also found that documentation frequently lacked evidence of members' signature. Coordination of care was also noted as a challenge this fiscal year as many providers lacked evidence of this occurring.

An additional challenge that was identified was following the BTPRC requirements for intrusive / restrictive interventions and for medications prescribed to manage behaviors. There were also some discrepancies in agency policies reflecting the most updated DWIHN policies. Providers reportedly experienced many barriers related to the COVID-19 pandemic, including but not limited to, staff turnover, adjusting to tele-health services, etc. It was noted that providers displayed a vast amount of adaptability and flexibility to ensure members received appropriate, high quality services throughout the pandemic. Many providers developed their own comprehensive tele-health consents during this time.

DWIHN will continue to evaluate applicable policies and procedures to more effectively support the evaluation and improvement of access and availability to the provider network. The goal will be to streamline data collection and evaluation efforts to enhance quality reporting. This will include exploring additional or new quantitative and qualitative assessment tools and metrics regarding accessibility.

Evaluation of Effectiveness

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

Barrier Analysis

The COVID-19 pandemic continues to impact service delivery throughout the provider network by workforce shortages across disciplines, adjusting to the use of telehealth for the delivery of behavioral health services and limited resources. Providers reportedly experienced many barriers related to the COVID-19 pandemic, including but not limited to, staff turnover, adjusting to tele-health services, etc. It was noted that providers displayed a vast amount of adaptability and flexibility to ensure members received appropriate, high quality services throughout the pandemic. Many providers developed their own comprehensive tele-health consents during this time.

DWIHN will continue to monitor the network to determine if additional contracts need to be executed to provide more access to services. DWIHN will also engage with providers to expand the behavioral health providers including diverse ethnic and cultural service. Further identification of these providers will provide a more personalized member experience. DWIHN will continue to evaluate applicable policies and procedures to more effectively support the evaluation and improvement of access and availability to the provider network. The goal will be to streamline data collection and evaluation efforts to enhance quality reporting. This will include exploring additional or new quantitative and qualitative assessment tools and metrics regarding accessibility. This will include continuing quarterly forums with member-facing staff to discuss the barriers and challenges members are experiencing while accessing care across our service provider network, especially ancillary providers.

Opportunities of Improvement

- Increase monitoring of the providers corrective active plans.
- Provide technical assistance as needed.
- Ensure providers are self-monitoring through quarterly reviews.
- Monitor the information in the Autism Dashboard to provide continuous feedback to the providers.
- Continue to conduct procedure trainings to educate SUD providers on proper credentialing for billing.
- Continue to educate and train the provider system for areas in which compliance.

Critical Incident (CI), Sentinel Events (SE), Unexpected Deaths (UD) and Risk Event (RE) Reporting

Activity Description

The following data represents fiscal years 2018 through 2021 system reports of Critical/Sentinel events gathered from the Clinically Responsible Service Provider (CRSP) reports into the Mental Health Wellness Information Network (MH-WIN). The reporting represents only those events entered into the system; however, of important note is the underreporting throughout the system based on the monitoring and review of Quality Performance Improvement findings.

Each contracted clinically responsible service provider (CRSP) is responsible to enter the Critical Event, Critical Incident, Sentinel Event, and Risk thereof events into the Critical/Sentinel Event Module in MH-WIN for members actively receiving services assigned to their organization. These events include CI's that occur at residential treatment provider settings.

Quantitative Analysis and Trending of Measures

DWIHN prior year's performance goal was met. In FY21, the Quality Performance Improvement Team processed 3158 Critical/Sentinel Events, which is a decrease of (29.19%) in FY20. Of those incidents, the SERC reviewed and analyzed over eight-hundred and thirty (830) critical incidents. Critical Incidents include arrests, deaths, emergency medical treatment due to injuries or medication errors, and hospitalizations due to injuries or medication errors. If a CI is determined to be a Sentinel Event, DWIHN requests that a Root Cause Analysis (RCA) be conducted by the Provider. The SERC reviews and approves the RCAs. In FY21, the highest category being reported Physical Illness Requiring Emergency Room (975); the next top category is Serious Challenging Behavior (609); and the lowest number of critical incidents is Medication Error (16).

Based on various audits, this report has been expanded to include data for each CRSP and the Sentinel Event Committee/Peer Review Committee (SEC/PRC) Trends and Patterns with recommendations. SEC/PRC is represented by clinicians and administrative staff members of DWIHN. Committee membership is represented by psychiatry, nursing, social work, psychology, counseling, law, and business.

Annual Summary by Category	FY 2020/2021	FY 2019/2020	FY 2018/2019
ARREST	71	83	161
Behavior Treatment NEW- FY 20/21	61	0	0
DEATHS	551	731	480
ENVIRONMENTAL EMERGENCIES	79	38	65
Injuries Requiring ER	227	259	498
Injuries Requiring Hospitalization	47	70	88
Medication Errors	16	27	123
Physical Illness Requiring ER	975	634	1039
Physical Illness Requiring Hospitalization	445	400	763
Serious Challenging Behavior	609	815	1322
Other/Administrative	77	166	409
TOTAL	**3158**	**3223**	**4948**

Evaluation of Effectiveness

Common Issues #1—Death: DWIHN analysis considered all Unexpected Deaths (UD) (those that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect), including aggregated mortality data over time to identify possible trends. Though death is unavoidable, some issues leading to death can be prevented or highly mitigated. Congestive Heart Failure/Coronary Artery Disease, COVID-19, Pneumonia, and Substance Use Toxicity (Overdose) were the leaders in our deaths within the FY 2020/2021. All of these issues can be prevented though education, access to health care preventative modalities, and frequent monitoring our of members. Oftentimes, we find that providers are reporting death months after a member has died. Things to be considered:

- ✓ How much emphasis are we putting on medical health?
- ✓ Are we routinely making sure that members have a PCP and are attending their appointments?
- ✓ What does our physical health education look like and are we placing emphasis on holistic health care or JUST mental health?
- ✓ How often between appointments/visits are we checking in and monitoring our SUD clients?
- ✓ Could our monitoring processes be revised?
- ✓ What are other barriers that need to be addressed in our SUD population that would lower or mitigate substance use toxicity (perhaps different treatment modalities)?

Common Issue #2—Serious Challenging Behavior: Many providers report hundreds of events in this category, as it is the second widely used category behind physical illnesses. Oftentimes providers are reporting at the *FIRST* instance of serious challenging behavior rather than after *three instances in a 30-day period* as noted in the Guidance Manual, which causes an influx of unnecessary reporting. Many times, we don't have access to the IPOS. When the case is "closed", rarely do we see changes being made to the IPOS to address this behavior and reporting continues. Also, there is underreporting in this area because we often find multiple inpatient psychiatric discharge summaries uploaded into the member's chart with no CE reported. Things to be considered:

- ✓ How many of these members are candidates for a Behavior Treatment Plan and are these discussions being had at the provider level when a member has an increase of events?
- ✓ How can we emphasize/restructure in training or in MH-WIN the fact that serious challenging behavior is more than THREE instances in a 30-day period?
- ✓ How often are medication reviews being done?
- ✓ How often are providers ensuring information for crisis lines, suicide information, and resources for crisis is explained and provided?
- ✓ How often are providers utilizing other treatment modalities rather than talk therapy and medication such as yoga, psychotherapy (EMDR), skill building, etc.?

Common Issue #3— Physical Illness: This issue is multifaceted, as the issues in which people are hospitalized vary greatly, are caused by different precipitating factors, and are managed differently based on member setting. On a general note, we often have issues getting hospital discharge documents in this category as opposed to inpatient psychiatric hospitalizations where documentation is usually uploaded shortly after discharge. Many providers simply do not ask for hospital documentation nor show evidence of follow up after a member is released from the hospital. Many CEs in this category are vague, and providers often don't have other information to add, even after more information is requested. Many of these cases are "administratively" closed due to lack of information, documentation, and provider follow up. This leads to re-admissions, and possible increased mobility and mortality. Things to be considered:

- ✓ If Coordination of Care letters are signed, what then is the barrier to receiving hospital discharge documentation?
- ✓ Are providers offering services to help members to get access to care and following up with appointments after hospitalizations?

- ✓ What can we implement in MH-WIN to have easy access to this information without having to go through the provider?
- ✓ (*Tying back into common issue #1*) How can we integrate the member's health care to not just focus on getting services to mental health, but physical health as well?

An appropriate response to a sentinel event includes a thorough and credible Root Cause Analysis, implementation of improvements to reduce risk, and monitoring of the effectiveness of those improvements.

Patterns, Trends, and Recommendations:
Substance Use Disorder

- ✓ Consider distribution of Naloxone kits at MAT provider locations.
- ✓ Look at prevalence of overdose by location (residential providers, outpatient service providers independent member home/community), to develop methods to reduce or eliminate incidents.
- ✓ Identify all providers and determine where there is low to no reporting.
- ✓ Consider Discharge Planning to include distribution of Naloxone kits and,
- ✓ Fentanyl houses are "popping up" in neighborhoods – some close to clinics (possibility of working with law enforcement if addresses/locations are identified).

Behavioral Health

- ✓ Fall/Risk Protocols and Choking Hazard Protocols training throughout entire DWIHN system based on the number of falls and choking events reported in the past 1 ½ years.
- ✓ Inclusion of Constituents in making recommendations through their committee.
- ✓ Bring MCO into the notification process when CRSP providers are not responding to assist in contract compliance.
- ✓ Add to SEC/PRC Committee representation of Director/Designee from Clinical Practice departments.
- ✓ Updating Policies and Procedures and Contract language details for Critical/Sentinel Events Reporting.
- ✓ Clear and concise guidelines required when there is evidence of regression only face-2-face or telehealth face-2-face should be added to protocols for services.
- ✓ Every member has to have a Crisis Plan and it must be reviewed with the member as a reminder of what to do in times of crisis, loneliness, depression, etc.
- ✓ Is there adequate funding for chronic conditions – systems have to be designed to address the real issues.
- ✓ Residential providers not consistently notifying CRSP timely (or at all) of events involving members not providing hospital documentation or police reports.

Barrier Analysis

Though death is unavoidable, some issues leading to death can be prevented or highly mitigated. Congestive Heart Failure/Coronary Artery Disease, COVID-19, Pneumonia, and Substance Use Toxicity (Overdose) were the leaders in our deaths within the FY 2020/2021. All of these issues can be prevented though education, access to health care preventative modalities, and frequent monitoring our of members.

Many providers report hundreds of events in this category, as it is the second widely used category behind physical illnesses. Oftentimes providers are reporting at the FIRST instance of serious challenging behavior rather than after three instances in a 30-day period as noted in the Guidance Manual, which causes an influx of unnecessary reporting. Many times, we don't have access to the IPOS. When the case is "closed", rarely do we see changes being made to the IPOS to address this behavior and reporting continues. Also, there is underreporting in this area because we often find multiple inpatient psychiatric discharge summaries uploaded into the member's chart with no CE reported. Things to be considered:

- How many of these members are candidates for a Behavior Treatment Plan and are these discussions being had at the provider level when a member has an increase of events?
- How can we emphasize/restructure in training or in MH-WIN the fact that serious challenging behavior is more than THREE instances in a 30-day period?
- How often are medication reviews being done?
- How often are providers ensuring information for crisis lines, suicide information, and resources for crisis is explained and provided?
- How often are providers utilizing other treatment modalities rather than talk therapy and medication such as yoga, psychotherapy (EMDR), skill building, etc.?

This issue is multifaceted, as the issues in which people are hospitalized vary greatly, are caused by different precipitating factors, and are managed differently based on member setting. On a general note, we often have issues getting hospital discharge documents in this category as opposed to inpatient psychiatric hospitalizations where documentation is usually uploaded shortly after discharge. Many providers simply do not ask for hospital documentation nor show evidence of follow up after a member is released from the hospital. Many CEs in this category are vague, and providers often don't have other information to add, even after more information is requested. Many of these cases are "administratively" closed due to lack of information, documentation, and provider follow up. This leads to re-admissions, and possible increased mobility and mortality. Things to be considered:

- If Coordination of Care letters are signed, what then is the barrier to receiving hospital discharge documentation?
- Are providers offering services to help members to get access to care and following up with appointments after hospitalizations?
- What can we implement in MH-WIN to have easy access to this information without having to go through the provider?

Opportunities for Improvement

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

- Fall/Risk Protocols and Choking Hazard Protocols training throughout entire DWIHN system based on the number of falls and choking events reported in the past 1 ½ years.
- Inclusion of Constituents in making recommendations through their committee.
- Bring MCO into the notification process when CRSP providers are not responding to assist in contract compliance.
- Add to SEC/PRC Committee representation of Director/Designee from Clinical Practice departments.
- Updating Policies and Procedures and Contract language details for Critical/Sentinel Events Reporting.
- Clear and concise guidelines required when there is evidence of regression only face-2-face or telehealth face-2-face should be added to protocols for services.
- Every member has to have a Crisis Plan and it must be reviewed with the member as a reminder of what to do in times of crisis, loneliness, depression, etc.
- Is there adequate funding for chronic conditions – systems have to be designed to address the real issues.
- Residential providers not consistently notifying CRSP timely (or at all) of events involving members not providing hospital documentation or police reports.

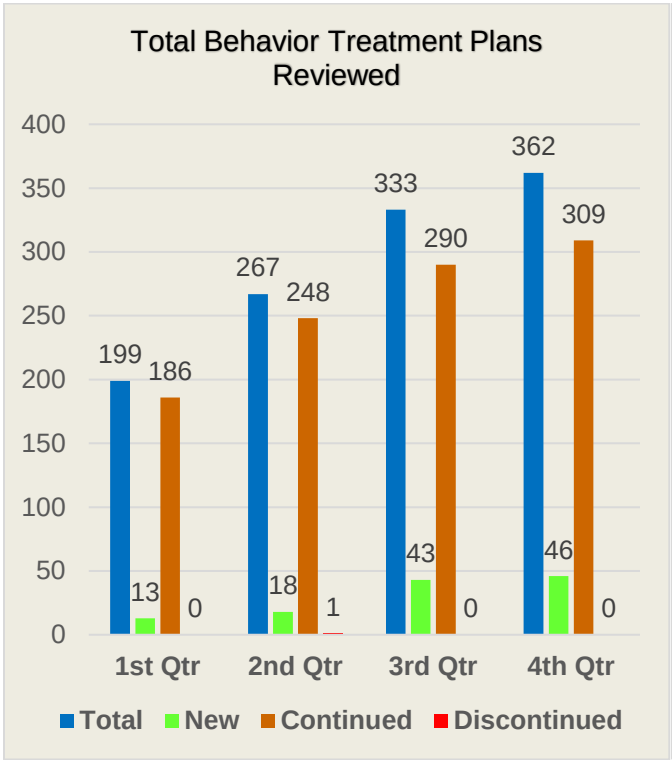
Behavioral Treatment Review

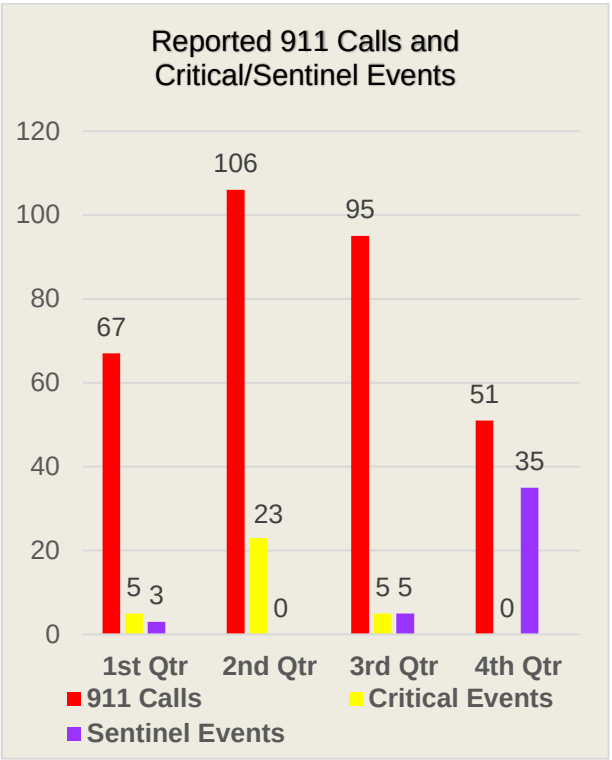
Activity Description

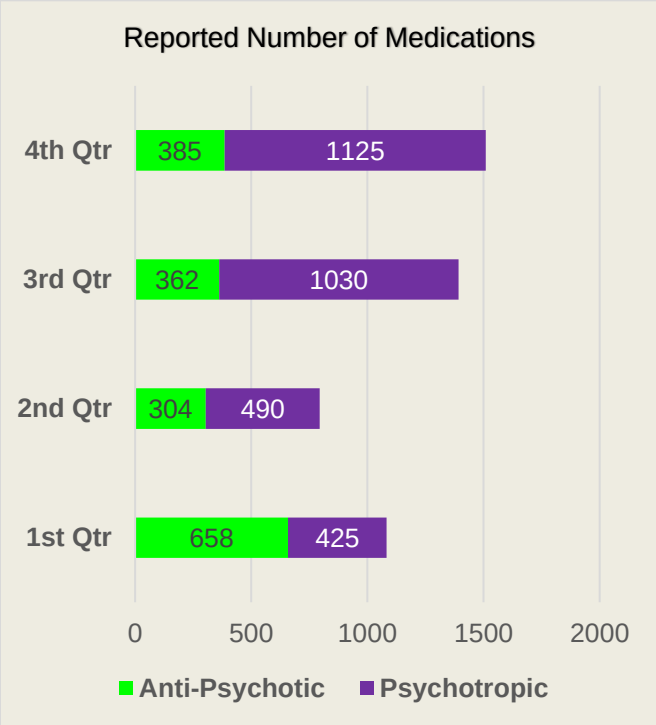
The QAPIP quarterly reviews analyses of data from the Behavior Treatment Review Committee (BTRC) where intrusive or restrictive techniques have been approved for use with members and where physical management has been used in an emergency. The data track and analyze the length of time of each intervention. The Committee also reviews the implementation of the BTRC procedures and evaluate each committee's overall effectiveness and corrective action as necessary. The Committee compares system-wide key indicators such as psychiatric hospitalization, behavior stabilization, reductions or increases in use of behavior treatment plans.

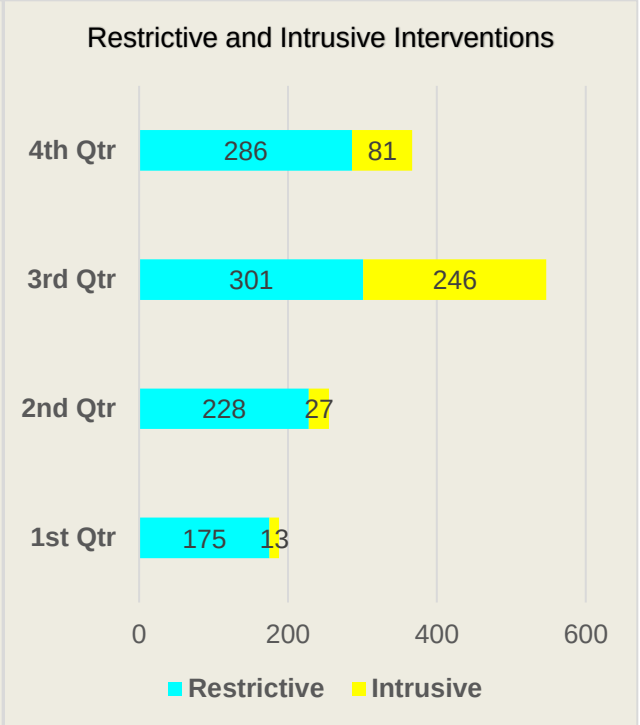
Quantitative Analysis and Trending of Measures

In FY21, DWIHN BTPRC reviewed 1,161 members on Behavior Treatment Plans which is a significant increase of 604 (108.43%) from the previous year. The data below depicts all the use of intrusive and restrictive techniques, 911 calls/critical events and use of medication per Individual receiving the intervention. The charts below illustrate the BTAC Summary of Data Analysis FY21.









Evaluation of Effectiveness

DWIHN prior year's performance goal was met. During FY21, DWIHN organized the two system-wide training events on the Technical Requirements of Behavior Treatment Plans (BTP). The first training event was for Habilitation Supports Waiver (HSW) providers on MDHHS requirements for the beneficiaries of HSW and BTP. DWIHN hosted the virtual technical assistance with MDHHS for network providers on the requirements of Behavior Treatment review and Occupational Therapy Evaluations, the event was attended by one hundred thirty-three (139) participants. With effect from October 1, 2020, DWIHN has delegated all contracted Mental Health (MH) Clinically Responsible Service Providers (CRSP) to have the BT review process in place. The BTPRC requirements are included in the CRSP written contract for FY 2020-2021. To date, DWIHN has a total of twenty (20) BTPRCs that are conducted at the MH CRSP. During FY20, there were a total of nine (9) BTPRCs at the MH CRSP, which demonstrate an overall increase of 122.2%. Behavior Treatment Category is now live in MH-WIN Critical and Sentinel Reporting Module to improve the systemic under-reporting of the four reportable sub- categories for the members on BTP: Death, Emergency Hospitalizations – including Emergency Medical Treatment; and Use of Physical Management. DWIHN continues submitting quarterly data analysis reports on system-wide trends of BTP to MDHHS. During FY 2020, the network providers presented the sixteen cases to the Behavior Treatment Advisory Committee for the case validation review process.

Barrier Analysis

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

Opportunities for Improvement

DWIHN has identified the following interventions and improvement efforts:

- Ensures the Supports Coordinator or Case Manager provide the Individual's IPOS and ancillary plans, before delivery of service at the service site.
- Ensures IPOS and Behavior Treatment Plans are specific, measurable, and are updated and revised per the policy/procedural guidelines.
- Conduct a training for network providers on the Technical Requirements of Behavior Treatment Plans.
- To implement a system-wide process for Behavior Treatment reviews.
- To improve the under-reporting of the required data of Behavior Treatment beneficiaries that includes 911 Calls, Deaths, Emergency Treatment, and Use of Physical Management.
- Case Validation Reviews of randomly selected cases as a step towards continuous quality improvement at PIHP level.

Performance Improvement Projects (PIPs)

Activity Description

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

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

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

Quantitative Analysis and Trending of Measures

DWIHN has seen a decrease of the HEDIS measurement for FY 2021. FY 20 rate 30.62 compared to FY 21 rate (29.57%) with a goal of (45%) for the 7 Day Follow – Up Appointment with a Mental Health Professional. This is a 1.05 percentage point decrease. For the 30-Day Follow – Up Appointment with a Mental Health Professional there is a decrease of the HEDIS measurement for FY 21. FY 20 rate (50.47%) compared to FY 21 (48.20%). This is a percentage point decease 2.27 percentage points with a goal of 75%. COVID 19 continues to be a barrier to care. DWIHN pivoted to telehealth to bridge the gap to care. The chart below illustrates the quantitative analysis of the HEDIS measurements and the interventions used to achieve improvement in quality of care.

Time Period	Measurement	Numerator	Denominator	Rate	Goal	Comparison to goal
1/1/2020-12/31/2020	Measurement 7 days	1290	4212	30.62	45%	14.38 percentage points
1/1/2020-12/31/2020	Measurement 30 days	2126	4212	50.47	75%	24.53 percentage points
1/1/2021-12/31/2021	Re-measurement 7 days	1793	6062	29.57	45%	15.43 percentage points
1/1/2021-1/31/2021	Re-measurement 30 days	2923	6062	48.2	75%	26.80 percentage points

Evaluation of Effectiveness

Detroit Wayne Integrated Health in 2020 changed its data collection tool to Vital Data. This Tool captures HEDIS data. Despite the decrease, the interventions initiated that are felt to be strong interventions and had significant outcomes and will continue are the following:

- Contracted hospitals contact DWIHN Access Center to schedule a 7-day follow-up appointment prior to member discharge. The DWIHN Access Center has access to open appointments for follow up appointments via MHWIN calendar. Hospital case managers encouraged to involve member/caregiver in discharge planning date and time preferences for appointments.
- In the first and second quarter of 2020 a total of 7207 7-day follow-up appointments were scheduled through the Access Center and 7207 30-day follow-up appointments were scheduled through the Access Center.
- Texting clients to remind them of their upcoming FUH appointment: For the first two quarters of 2020, 3877members were texted reminders and (62.22%) kept their appointments.
- DWIHN staff began make calls to members at least forty-eight hours prior to their appointment. These clients were not in the texting program. DWIHN discuss any barriers keeping them from the appointment. In 2020, 525 members were contacted and of those (58%) kept their appointment.
- COVID was a barrier.

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

Barrier Analysis

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

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

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

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

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

Opportunities for Improvement

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

Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Activity Description
This measure analyzes the percentage of members 19 to 64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least (80) percent of their treatment period.

Quantitative Analysis and Trending of Measures

Comparing the FY20 baseline data for Improving Adherence to Antipsychotic Medications for Individuals with Schizophrenia for re-measurement period of FY21, showed a decrease in this measure. FY20 rate (79.34%) compared to FY21 (46.42%). This is a (32.92) percentage point decrease. The (45%) goal was achieved. This decrease may be contributed to COVID 19 restrictions. DWIHN implemented the use of a new data collection system Vital data.

Time Period	Measurement	Numerator	Denominator	Rate	Goal	Comparison to goal
1/1/2020-12/31/2020	Measurement	4163	5247	79.34	45%	34.34 percentage points
1/1/2021-12/31/2021	Remeasurement	2462	5304	46.42	45%	1.42 percentage points

DWIHN meet its goal for both FY20 and FY21. DWIHN is performing below the Michigan health plan average for the HEDIS measures. It is important to provide regular follow up therapy to patients after they have been hospitalized for mental illness. An outpatient visit with a mental health practitioner is necessary to ensure that the patients transition to the home and work environment is supported and that gains made during hospitalization are not lost. A follow-up visit also helps healthcare providers detect early post-hospitalization reactions or medication problems, and demonstrates continuing care.

The key to improving performance in this area is managing the transition of care from the hospital to the ambulatory site. This can involve case management and systems that link scheduling of outpatient care within hospital discharge. Barriers to achieving objectives:

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

Evaluation of Effectiveness

The interventions that are felt to be strong interventions are the following:

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

Barrier Analysis

- Relationship with physician. (provider/practitioner knowledge)
- Lack of consistent treatment approach by physicians. (provider/practitioner knowledge)
- Stigma of the disease. (Member knowledge)
- Disorganized thinking/cognitive impairment. (Member knowledge)
- Enrollee/member's lack of insight about presence of illness or need to take to medication. (Member
- knowledge)
- Lack of family and social support. (Member knowledge)
- Medication side effects and/or lack of treatment benefits. (Member knowledge)
- Patients forget to take their medications. (Member knowledge)
- Patients forget to re-fill their medications. (Member knowledge)
- Lack of follow-up. (Member knowledge and provider/practitioner knowledge)
- Financial Problems. (Member knowledge and provider/practitioner knowledge)
- Opportunities for Improvement
- Improve the relationships with physician by providing member with key pre-appointment questions.
- Improve treatment approach by physician's by memo's sent to physicians quarterly regarding review of member's medication.
- Improve patient compliance with medication adherence.
- Improve patient adherence to medication refill.
- Improve patient follow up.

Improving Diabetes Monitoring for People with Schizophrenia and Bipolar Disorder

Activity Description

This measure analyzes the percentage of patients 18-64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening during the measurement year.

Quantitative Analysis and Trending of Measures

DWIHN saw a decrease in its HEDIS measure of Diabetes Screening for Schizophrenia and Bipolar Disorder members from (64.38%) in 2020 to (64.86%) in 2021 the first remeasurement period. This is a (0.48) percentage point increase. The 83.2% goal was not achieved.

Time Period	Measurement	Numerator	Denominator	Rate	Goal	Comparison to goal
1/1/2020-12/31/2020	Measurement	4891	7597	64.38	83.2%	18.82 percentage points
1/1/2021-12/31/2020	Remeasurement	5228	8061	64.86	83.2%	18.34 percentage points

Evaluation of Effectiveness

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

Barrier Analysis

- Lack of consistent practice among behavioral health (BH) and medical providers of the prevalence of
- diabetes in this population and the need for screening.
- Physician belief that diabetes prevalence is low in their practice.
- Lack of knowledge among behavioral health and medical providers of recommendations for screening for diabetes in members with schizophrenia and bipolar disorder.
- Lack of knowledge among behavioral health providers of which members have not been screened for
- diabetes.
- Lack of knowledge among provider support staff of HEDIS measure or DWIHN's HEDIS measure results.
- Behavioral Health and medical providers/practitioners not collaborating to address in an organized,
- consistent manner.
- Lack of knowledge by enrollee/members that they are at risk for diabetes if on atypical antipsychotic
- medication.
- Lack of follow-through by enrollee/members to have labs drawn when ordered.
- Lack of knowledge by enrollee/members on importance of healthy eating and exercise to help control any weight gain associated with antipsychotic medication.

Opportunities for Improvement

- Educate providers annually on post clinical practice guidelines on the DWHN website for
- Improving Diabetes Monitoring for People with Schizophrenia and Bipolar Disorder.
- Trainings to providers on MyStrength which is DWMHA's self-management tool vendor in which there are healthy eating and exercise modules.
- Quality Improvement Unit will continue to audit compliance with the Diabetes Screening clinical guidelines for Schizophrenic and/or Bipolar disorder enrollee/members on antipsychotic members. Providers that have compliance scores of < 95% are placed on Plans of Correction (POC) for monitoring.
- DWIHN has entered into a contract with Vital Data. This will allow the ability to provide a very detailed drill data in order to develop additional interventions. Providers will also have access to the data to identify their members requiring Diabetic Screening.

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

Care Coordination

Activity Description

Improving coordination of care is one of DWIHN's core strategies for delivering on our mission and the Triple Aim of improved health, experience, and affordability. Overall, continuity and coordination of care improvement initiatives promote efficient, effective and safe care for members when they are transitioning between levels of care or receiving care from multiple providers. More specifically, continuity and coordination of medical care is the facilitation across transitions and settings of care:

- Members getting the care or services they need.
- Practitioners or providers getting the information they need to provide member care.

Quantitative Analysis and Trending of Measures

Data shows that care coordination increases efficiency and improves clinical outcomes and member satisfaction with care. Through the provider self-monitoring for Coordination of Care providers scored, 82% with linking and coordinating with the Primary Care Physician (PCP), Natural and other Community Supports scored (84%), which is a decrease from the previous FY in which scores ranged from (95%) and (83%). This may be attributed to a shutdown of face to face services mandated except for the most critical services, in an effort to keep all persons safe from the virus. Tele-health services were provided to the persons that we served in an expedient and efficient manner. Staff were expected to provide these services from a home environment, with some limited staff continuing to provide crisis and/or medical services from the office, when it was impossible to do so via telehealth. Providers receiving evidence of requested documentation from the PCP, Natural and other Community Supports. Also, the results demonstrated a slight increase in the percentage of provider's participation from the previous year of 72%, compared to 71%, which is still considerably below the State Performance Measure goal of 95% set by the state of Michigan for the PIHP's for Continuity and Coordination of Care.

Evaluation of Effectiveness

DWIHN worked with the following health plans in FY21: AmeriHealth, Aetna, Michigan Complete, Molina and HAP Midwest. The Agency Profile within I-Dashboards indicates 5,864 MI Health Link members were enrolled with DWIHN in FY21, compared to the 5,271 members reported as enrolled last fiscal year. MI Health Link enrollees are a significantly small subset of DWIHN members (7%). There were 616 MI Health Link (MHL) members hospitalized during FY21. During FY20, DWIHN managed 560 community hospital admissions of MI-Health Link members. 92 MHL members were readmitted in FY20 and in FY21, there were 58 members who were readmitted within 30 days of discharge. The number of readmissions decreased by (47%) in FY21. Molina saw the highest number of admissions during FY21 at 251, (40%) of the DWIHN MHL admissions for FY20. AmeriHealth had the lowest number with 60 members admitted, followed by MI Complete, with 62 admissions.

Barrier Analysis

The COVID-19 pandemic continues to impact service delivery throughout the provider network by workforce shortages across disciplines, adjusting to the use of telehealth for the delivery of behavioral health services and limited resources. Providers reportedly experienced many barriers related to the COVID-19 pandemic, including but not limited to, staff turnover, adjusting to tele-health services, etc. It was noted that providers displayed a vast amount of adaptability and flexibility to ensure members received appropriate, high quality services throughout the pandemic.

Opportunities for Improvement

To improve continuity and coordination of care across DWIHN's health care network. DWIHN will continue to monitor the following aspects of continuity and coordination of medical care:

- All cause readmission rates (monitoring members getting care and services across transitions and settings of care).
- Provider satisfaction with the quality of information they receive from other providers.
- Low intensity emergency room utilization.
- Require providers to continue to document request and follow - up more than one time per year with the Primary Care Physician and or Community Supports.
- Continue training and technical assistance with our CRSP providers to help improve the effectiveness, efficiency, and sustainability of integrated services, which ultimately improves the health and wellness of individuals living with behavioral health disorders.

Workforce Pillar

Activity Description

To ensure a network of qualified practitioners, DWIHN provides effective and efficient workforce development training to the provider network and continuous support to the community through educational outreach and engagement while placing an emphasis on recovery and supporting resilience. Efforts continue to focus on maintaining and expanding a centralized training program for allied health professionals. Focusing on the development of new professionals is integral to achieving a collaborative integrated healthcare system.

Quantitative Analysis and Trending of Measures

In FY21, more than 60 mental health professionals engaged in interprofessional education to enhance competency in culturally responsive engagement, assessment, treatment planning, and intervention with individuals diagnosed with co-occurring disorders. By confirming that all Qualified Mental Health Professional (QMHP) and Child Mental Health Professional (CMHP) training and supplemental training, the professionals in the specialized training program were able to deliver services to individuals and increase the capacity of providers. The interprofessional training curriculum for social work, nursing, and psychiatry was converted to an online format to adjust to COVID-19 restrictions. In addition to the additional capacity to deliver services to the Wayne County community, the university partnerships have supported current staff professional development and retention in completing a certificate in integrated health and access to telehealth training.

The Trauma-Informed Care Project Initiative continues to strengthen and enhance professional development of clinicians and administrators through specific evidence-based practice trauma-informed care interventions. During FY 2021, DWIHN had been awarded a 2-year (2021-2022) grant from Michigan Department of Health and Human Services to build upon prior trauma training and supports and equip the provider workforce with a strong foundation for addressing the complexities of trauma among the individuals and families receiving services at participating provider agencies. Seven (7) provider partners had been awarded $15,000 to train and provide support for their respective staff to help them better understand how trauma contributes to a person's suffering and shapes a person's efforts to cope. Emphasis is placed on trauma screening, assessment tools and the use of evidence-based therapies and models.

During this first year of implementation, emphasis was placed on professional development. Three-hundred fifty (350) clinicians and administrators at the partnering provider agencies enhanced trauma-related competencies through various training and resources. These were SAMHSA's evidence-based trauma informed 101 curricula, understanding adverse childhood experiences, secondary trauma, and zero suicide prevention. Some staff received advance training in EMDR, CPT and PET. Thirty-five (35) clinicians were trained and certified to use TREM/MTREM. Organization leadership and clinicians received consultation from a national expert on the use of CAMS (Collaborative Assessment and Management of Suicidality), an EBP utilized in HHI's Suicide Prevention Care Path, and Zero Suicide consultants. DWIHN held a virtual 2-day Trauma-Informed Care Conference on February 18 -19, 2021, 267 clinicians attended. The conference equipped and effectively addressed post-traumatic stress symptoms, managing the risk of triggering individuals into episodes of mental illness symptoms or substance abuse relapse.

Evaluation of Effectiveness

During FY2021, staff supported 6,005 callers. Using the least restrictive methods to access services, callers that live, work, play, worship, and learn in Wayne County are able to access behavioral health support that is consistent with their current stage of change. As callers are often pre-contemplative, staff provided support and encouragement without requiring identifying information to receive services. The focus on engagement has led to a majority of individuals reporting an increased level of comfort in accessing services that positively affect their behavioral health. When callers demonstrate an ongoing need for services, staff provided a direct referral with a community mental health provider.

DWIHN hosted several events in recognition of suicide prevention and awareness month. There was a partnership event with the Wayne County Sherriff's Office that aimed to bring positive connections between the community, mental health, and law enforcement. COVID-19 vaccinations, COVID-19 testing, and behavioral health screening were offered. Over 400 meals were distributed and 1235 backpacks in partnership with various communities and organizations such as Detroit PAL, DABO, Center for Youth & Urban Family Development, etc. DWIHN also hosted a Suicidology Conference with 210 in attendance and a Self-Care Conference with 285 in attendance. The team director also participated in a panel for the Children's Center's Demystifying Suicide – Imperative for Black Boys and a panel for the Muskegon Suicide Prevention Coalition focusing on the increase in suicide rates in African American youth. In addition to partnerships with state and county organizations, community engagement has included hosting and participating in quarterly events that include representation from the provider network and sharing information and resources to community members at barbershops, hair salons, concerts, sporting events, and other events throughout Wayne County. By offering information, resources, screenings and immediate support, DWIHN has been introduced to thousands of Wayne County residents.

DWIHN's Veteran Navigator assisted 222 Veterans and their family members since during the fiscal year. On average there are 3 to 6 phone calls each day by Veterans, family members, and service providers requesting assistance over the phone. There has also been an increase in referrals via phone and email from service providers, detention centers, the hospitals, and the MVAA. There were over four dozen presentations/seminars provided to various veteran specific groups and audiences. Despite the challenges of the pandemic, the Veteran service community found new and creative ways to serve our veterans. The virtual approach was utilized to continue to inform and assist Veterans and their families with resources, education, therapy, medical assistance, and advocacy. The Workforce Training and Program Development completed 72 Live events, with 4454 Attendees across all of those events, meaning that our median attendance for all events combined is 61.8 attendees per event during FY21.

Barrier Analysis

Community engagement that includes awareness and education continues to be critical to the aims of DWIHN. Various community efforts were utilized to engage with individuals that are typically disengaged from community mental health resources. Building and maintaining relationships with allied systems within the Wayne County community continues to be a major component to increase accessibility to services while also gaining an awareness of the current needs of community members to ensure that clinical practices are relevant. Over the past three years, it has become evident that traditional methods of community engagement are not reaching the typical Wayne County resident.

Throughout FY 2021, partnering organizations identified common challenges related to the implementation practices, such as, the impact of COVID-19 global pandemic and workforce retention. They've informed that treatment services are modified to include telehealth beginning April 2020 – current. Also, staff turn-over increases once evidence-based trauma specific training is obtained, resulting in the need for new clinical staff to be trained and delay/interruption of treatment modalities. However, there is a commitment from all organizations to continue making an effective impact on the care of individuals, with an understanding that a trauma-informed approach is vital. The Attitudes Related to Trauma-Informed Care (ARTIC) Scale Sample Survey Version 1 was introduced to 65 clinicians. DWIHN has scheduled a consultation with the Trauma Stress Institute to further explore ways to best implement the tool and collect the data measures for FY 22.

Opportunities for Improvement

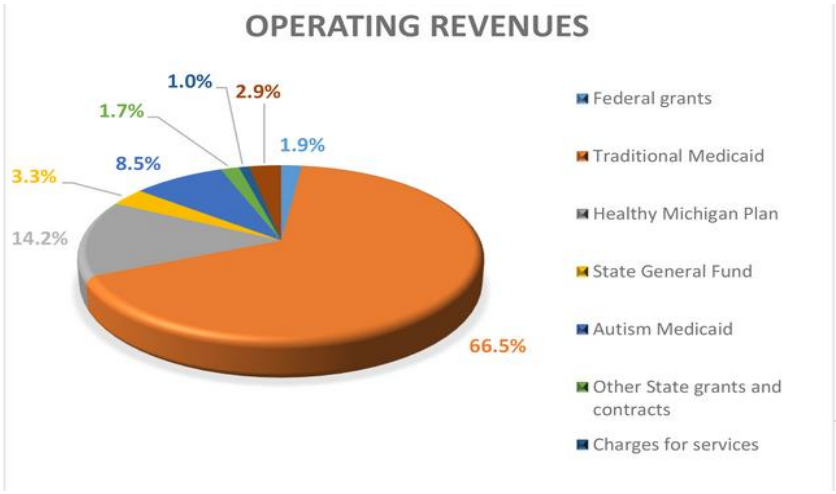
DWIHN plans to help build on the phases within DWIHN's System Transformation process. This momentum will assist and provide direct guidance on the measurable importance of holistic care. The network expansion will include technical assistance on the use of evidence-based screening and assessment tools, and interventions, in addition to learning the best method of tracking data, and integrating all elements of behavioral health, physical health, economic health, social well-being, and spiritual well-being.

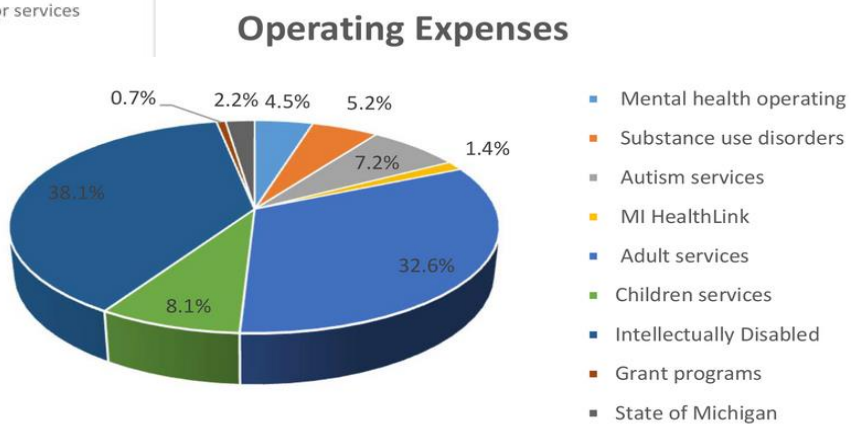
Finance Pillar

Verification of Services

Quantitative Analysis and Trending of Measures

The charts below indicate funding sources utilized to pay for an individual's service in FY20/21. It combines general Medicaid, Healthy Michigan, Habilitation Waiver and other waiver programs which are all Medicaid, accounting for (75%) of the funding source utilized. Block Grant and State Disability Assistance (SDA) which is used to pay for SUD and Room and Board with Substance Use Disorders is reflected as funding sources totaling (9%); decreased from (10%) last fiscal year. General Fund is reflected at 3.3% (a changed from 4.2% in FY19/20) and MI Health Link is at 1.4% (a change from 1.2% in FY19/20). The funding source mix is very similar to last year. Further analysis is required to determine if funding source impacts overall utilization.





Evaluation of Effectiveness

DWIHN analyzed trends in service delivery and health outcomes over time, including whether there have been improvements and barriers impacting in the quality of health care services for members as a result of the activities. In FY21, A total of 2,371 claims were randomly selected for verification. Of those claims 1,210 were reviewed and validated for 51.03%, which is a 13.3% increase from the previous fiscal year.

The COVID-19 Pandemic had a major impact on last year's review schedule and timeliness to complete the 1st and 2nd Quarter Reviews. This was for a variety of reasons, including but not limited to an inability to reach providers, providers being short staffed, building closures and program closures. To get back on schedule for FY 2020, it was decided that the focus of the 3rd and 4th Quarter reviews would include providers that had not been reviewed during the 1st and 2nd Quarters of FY 2020. In FY21, a total of 288 (23.8%) of the claims reviewed had scores <95% was required to complete a Plan of Correction. DWIHN failed to meet the minimum sampling standards established by the Office of Inspector General (OIG). This goal will continue.

Barrier Analysis

The Medicaid Claims review process continues to be impacted by the COVID 19 pandemic. Virtual reviews and desk audits continued, which created challenges for contracted providers and DWIHN staff. Providers experienced staffing shortages which hindered follow-up, some providers had difficulties displaying documentation virtually, and submitting documents through secured mail or electronic submission in MHWIN system.

Opportunities of Improvement

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

Advocacy Pillar

Home Community-Based Services (HCBS)

Activity Description

The goal is to monitor network implementation of the Home and Community Based Services transition to ensure quality of clinical care and service. In FY21, DWIHN Quality performed fifty-two (52) residential treatment provider reviews and forty (40) Heightened Scrutiny reviews, which is a slight increase from the previous year. The Covid 19 Global Pandemic adversely impacted this project in FY20. This project will continue until complete. Completion date is expected to be March 17, 2023.

Evaluation of Effectiveness

DWIHN has developed a policy for HCBS describing the requirements under the HCBS Final Rule. These requirements aim to improve the quality of the lives of beneficiaries and allow them to live and receive services in the least restrictive setting possible with full integration in the community. DWIHN maintains a list of all contracted service providers that are HCBS compliant within the DWIHN's network. This information can be found on DWIHN's website under for Providers/Provider Resources tab.

Barrier Analysis

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

Opportunities for Improvement:

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

Community Outreach

DWIHN distributed over 110,000 PPE items to the Provider network to assist them in their places of business and with the people we serve throughout this pandemic. DWIHN social media accounts are growing with an increase in impressions across all four channels. DWIHN content is trending upward. Posts that generated the greatest reach on DWIHN social media channels were posts acknowledging DWIHN Board Chair, Angelo Glenn for receiving a Men of Excellence award from the Michigan Chronicle newspaper. Another post that did very well was a Mental Health Care-No Child Left behind billboard post.

DWIHN's Chief Medical Officer Dr. Shama Faheem continues to educate the public with her bimonthly newsletter containing information about COVID-19, vaccinations and answers to questions that are sent in by staff, people we serve, etc. This publication is sent to Providers, stakeholders and posted on the DWIHN website and social media. The Communications Team has also moved the newsletter to a digital format visit AskTheDoc@dwihn.org.

DWIHN Website

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

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

Find a Provider

https://www.dwihn.org

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

Sharing of Information

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

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

DWIHN Accreditation

DWIHN has been accredited for three years through the National Committee for Quality Assurance (NCQA). DWIHN received high marks and perfect scores in several critical areas including Member Experience, Self-Management Tools, Clinical Practice Guidelines, Clinical Measurement Activities, Coordination of Behavioral Healthcare and Collaboration between Behavioral Health and Medical Care. DWIHN scored 92.49 out of a possible 100 points. This goal will continue.

External Quality Reviews

The PIHP is subject to external quality reviews through Health Services Advisory Group (HSAG) to ensure compliance with all regulatory requirements in accordance with the contractual requirements with MDHHS. All findings that require opportunities for improvement are incorporated into the QAPIP Work Plan for the following year. HSAG completes three separate reviews annually: Performance Improvement Project (PIP), Performance Measure Validation (PMV) and the Compliance Monitoring review.

Quantitative Analysis and Trending of Measures

During FY21 validation period, DWIHN continued its state mandated PIP topic: Improving Diabetes Screening Rates for People with Schizophrenia or Bipolar Who Are Using Antipsychotic Medications. The PIP topic selected addressed Centers for Medicare & Medicaid Services (CMS) requirements related to quality outcomes—specifically, the quality, timeliness, and accessibility of care and services. The goal of statistically significant improvement over the baseline rate was not achieved during the second remeasurement. The study indicator demonstrated a statistically significant decrease (21.03%) over the baseline and did not achieve the plan-selected goal (target 80%). As displayed in the table below, the goal did not represent a statistically increase over the baseline performance for Remeasurement 1 and Remeasurement 2 reporting data.

PIP Topic	Validation Status	Study Indicator	Study Indicator Results			
			Baseline	R1	R2	Goal
Improving Diabetes Screening Rates for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	*Not Met*	The percentage of diabetes screenings completed during the measurement year for members with schizophrenia or bipolar disorder taking an antipsychotic medication.	81.4%	76.9% ↓	64.28 ↓	80.0 %

Evaluation of Effectiveness

The goal is to increase diabetes screening for members with schizophrenia or bipolar disorder who are dispensed atypical antipsychotic medications. For the first remeasurement period, DWIHN reported that 76.9% of people with schizophrenia and bipolar disorder who were dispensed atypical antipsychotic medications had a diabetes screening. In FY20, the Remeasurement 1 plan-selected goal was revised from 85% to 80%, and the overall goal of the PIP was to achieve statistically significant improvement over the baseline rate 81.4%. The study indicator did not achieve the goals during the remeasurement period, demonstrating a statistically significant decrease over the baseline rate. In FY21, for the second remeasurement period, DWIHN reported that 64.3% of people with schizophrenia and bipolar disorder who were dispensed atypical antipsychotic medications had a diabetes screening. The study indicator did not achieve the goals during the remeasurement period, demonstrating a statistically significant decrease over the baseline rate. The restrictions related COVID-19 pandemic, which occurred during the second remeasurement period, impacted members' ability to obtain face-to-face services, including the completion of lab draws, and interrupted DWIHN's ability to conduct some interventions.

Barrier Analysis

DWIHN 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 members to have labs drawn when ordered.
- Restrictions related COVID-19 pandemic.

Opportunities for Improvement

To address these barriers, DWIHN initiated the following interventions:

- Monitor compliance with diabetes screening through clinical treatment chart audits.
- Measure and monitor compliance with having labs ordered and drawn no less than quarterly through review of the HEDIS-like data in Vital Data.
- Educate members on the importance of having labs completed through community outreach initiatives and training.
- Provide education on the Clinical Guidelines Procedures to service providers, practitioners, and DWIHN Detroit staff members through the Quality Operations Workgroup, Quality Improvement Steering Committee, and Improvement Practices Leadership meetings.
- Educate the provider network through community outreach initiatives and training on the importance of diabetes screening.
- Conduct monthly care coordination meetings with Medicaid health plans to develop care plans for members, including those diagnosed with diabetes who have been prescribed atypical antipsychotic mediations. The focus is on effective planning and communication for the care coordination of physical health conditions and behavioral health.

Performance Measures Validation (PMV)

Activity Description

The validation of performance measures is one of the mandatory external quality review activities that the Balanced Budget Act requires state Medicaid agencies to perform. The purpose of the PMV is to validate the data collection and reporting processes used to calculate the performance measure rates. Outcomes from the review was reported to Program Compliance and other appropriate committees as required.

Quantitative Analysis and Trending of Measures

In FY21, HSAG reviewed DWIHN's performance indicators reporting data for validation. The reporting cycle and measurement period was from October 1, 2020 through December 31, 2020. DWIHN received a full compliance score of 100% with no Plan of Correction (POC), which represents a 14.9% increase compared to last fiscal year (87.65%).

Evaluation of Effectiveness

DWIHN continues to monitor opportunities to improve transition of care services and supports for adult members to reduce the likeliness of readmissions. Though DWIHN's Recidivism Task Force which include the Clinically Responsible Service Providers (CRSPs) led by DWIHN Crisis/Access team these efforts have decreased the adult recidivism from 20.41% during Quarter 1 of FY 2019-2020 to 15.01% for Quarter 1 of FY 2020-2021. The efforts from this group produced a 26.45% drop in Indicator 10 as of Q1FY 2020-2021.

Barrier Analysis

Beginning Q3 of FY 2020, separate indicators were developed for PI#2a new persons receiving a completed Biopsychosocial Assessment within 14 calendar days of a non-emergency request for service, PI#2b SUD Services and indicator #3 new persons starting any medically necessary on-going covered service within 14 days of completing a non-emergent Biopsychosocial Assessment. There is no established standard set by MDHHS for these indicators. The indicators are for persons with mental illness, developmental disabilities and substance use disorder. During FY21, the total compliance rates ranged from (36.02%-50.12%) for 2a, (86.10%-89.81%) for 2b and (84.84%-88.4%) for #3. DWIHN is underperforming on PI2a performance measure compared to the other PIHPs in the state. DWIHN is lowest in in the state at 50.12%, the state average is (65.47%).

Opportunities for Improvement

DWIHN identified the following improvement efforts:

- Initiate a Value Based Performance Indicator 2a Incentive if Service Provider receives a metric of 80% or more for Performance Indicator 2a.
- Continue with existing provider and internal workgroups to regularly review progress on improving performance measure rates and data collection processes.
- Continue to monitor performance trends and targeting low performing areas, including an assessment of performance at the individual provider level, as well as within core member demographics, to identify systemic patterns of performance.
- Continue to use existing workgroups to identify root causes for low performance and disseminate best practices.

Compliance Review

Activity Description

To comply with the federal requirements, MDHHS contracts with HSAG, to conduct compliance reviews of its contracted PIHPs responsible for the delivery of comprehensive mental health and developmental disability services, as well as certain covered substance use services under the State's Medicaid managed care program. The new cycle of compliance reviews for DWIHN begin in FY21. The review focused on 13 performance areas. HSAG reviews ½ of the standards in year one (FY 2021) and the remaining ½ of the standards in year two (FY 2022). If applicable, in year three (FY 2023), HSAG will review the corrective plan for each element that did not achieve full compliance.

Quantitative Analysis and Trending of Measures

In FY 2018-2020 reporting cycle, DWIHN successfully addressed all prior recommendations and achieved full compliance on all standards, for an overall compliance score of 98%. In FY21 of the new reporting cycle (2021-2023), DWIHN received an overall compliance score of 77% with a corrective action plan. Below are the overall percentage of compliance scores across all six standards reviewed.

	Standards Reviewed	Number of Standards	Met	Not Met	Total Compliance Score
I	Member Rights and Member Information	19	16	3	84%
II	Emergency and Post stabilization	10	10		100%
III	Availability of Services	7	6	1	86%
IV	Assurances of Adequate Capacity and Services	4	0	4	0%
V	Coordination and Continuity of Care	14	11	3	79%
VI	Coverage and Authorization of Service	11	7	4	64%
	Total	65	50	15	**77%**

Evaluation of Effectiveness

DWIHN received a total compliance score of (77%) across all standards reviewed during the FY 2021 compliance monitoring review. DWIHN's performance measure (Emergency and Post stabilization) is above the MDHHS standard of 95% indicating strengths in this area.

Barrier Analysis

DWIHN's performance measure (Assurances of Adequate Capacity and Services) scored below the MDHHS standard of 95% indicating opportunities for improvement in this area.

Opportunities for Improvement

To address the areas requiring improvement, DWIHN will prioritize areas of low performance and develop a comprehensive and effective plan of action to mitigate any deficiencies identified during the 2020–2021 compliance monitoring review.

Utilization Management

The Annual Utilization Management (UM) Program Executive Summary is under a separate cover for FY 2021. It is the responsibility of DWIHN to ensure that the UM Program meets applicable federal and state laws and contractual requirements and is a part of the QAPIP. DWIHN is required to have a written Utilization Management Program Description which includes procedures to evaluate medical necessity criteria, and the processes used to review and approve the provision of mental health and substance abuse services. DWIHN is also required to have an Annual Utilization Management Program Evaluation report in order to:

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

Adequacy of Quality Improvement Resources

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

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

Title	Department	Percent of time per week devoted to QI
Medical Director	Administration	100%
Director of Quality Improvement	Quality Improvement	100%
Quality Improvement Administrator	Quality Improvement	100%
Director of Utilization Management	Utilization Management	50%
Clinical Officer	Clinical Practice Improvement	50%
Director of Customer Service	Customer Service	50%
Director of Integrated Health Care	Integrated Health Care	60%
Director of Managed Care Operations	Managed Care Operations	10%
Strategic Planning Manager	Compliance	0%
Information Technology	Information Technology	0%
Practitioner Participation	Provider Network	100%

Overall Effectiveness

An evaluation of DWIHN's QI Work Plan for FY2021 has been conducted. This evaluation included review of trended results for QI measures over time, comparison against performance objectives, quantitative and qualitative analyses for completed and ongoing QI activities. Overall, improvements were achieved in planned QI initiatives, both clinical and service. In addition, programs that address member safety were implemented. The Quality Improvement Steering Committee (QISC) and the Program Compliance Committee (PCC) Board reviewed and approved the 2021 QAPIP Evaluation and FY2021 Work Plan (Attachment A). The 2021 QI Work Plan was implemented in accordance with the plan. The indicators measured cover a broad spectrum, including quality of clinical care, quality of service and safe clinical practices. The QI initiatives are relevant to the needs of the residents of Wayne County and in alignment with DWIHN's mission and vision. DWIHN's organizational structure and resources are adequate and supportive of the QI process.

The quality resource needs are determined based on the percentage of key activities completed and associated goals attained. After evaluating the performance of the Quality Program, DWIHN has determined there are adequate staffing resources to meet the current program goals and include highly educated and trained staff. DWIHN evaluated data, staff, resources, and software to ensure our health information system that collects, analyzes and integrates the data necessary to implement the QI program is adequate. DWIHN IT has successfully designed, tested and deployed the Provider Risk Matrix dashboard that is built upon scientific measurable goals for CRSP providers and implemented a new Business Intelligence platform built on Microsoft's world leader PowerBI platform which allows DWIHN to easily connect its data sources and share with staff and providers so they can focus on what's important to deliver quality care. IT also deployed a nationwide NCQA accredited Care Coordination platform that supports the calculation of HEDIS measures and enables us to partner with Health Plans to manage Behavioral and Physical Health services. As part of the 21st Century Cures Act, the Centers for Medicare & Medicaid Services (CMS) is requiring states to implement an Electronic Visit Verification (EVV) system, during FY' 2021 DWIHN finalized testing that integrates with our main MHWIN system for timely and accurate data delivery.

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

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

Analysis

DWIHN believes there are adequate practitioner involvement and consultation to meet the objectives of the Quality Program. No changes are anticipated for FY 2022.

Committee Structure

After evaluating the QI program committee structure, DWIHN committee involvement is adequate and all committee members regularly attend and actively participate in QISC committee meetings. DWIHN's commitment to quality is strong and shared across all levels of the organization. DWIHN believes the structure supports effective governance and align key strategic initiatives to ensure adequate guidance to help DWIHN reach goals and objectives. No changes are anticipated for FY 2022.

Practitioner Participation

DWIHN continues to have substantial practitioner participation in our QISC committees, Quality Operations Workgroup and adhoc provider advisory workgroups as needed. This represents input from the provider network and practitioner leadership. The practitioners actively participate in the planning, design, implementation and program evaluation, through data collection and analysis. Their activities ensure program alignment with evidence-based care and overall population management between the health plan, care delivery systems and community partners. In addition to serving on the QISC committee, DWIHN enlists practitioner input regarding key initiatives. After evaluating the practitioner participation, DWIHN believes there are adequate practitioner involvement and consultation to meet the objectives of the Quality Program. No changes are anticipated for FY 2022.

QI Program Effectiveness

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

DWIHN's commitment to continuous improvement is integral to achieving excellent health outcomes and an excellent overall member experience. In 2022, DWIHN will continue to address identified opportunities for improvement to ensure optimal member experience.

2022 Work Plan Goals and Objectives

In FY 2022, the QAPIP work plan will be reviewing these areas to achieve continuous quality improvement in the quality and safety of clinical care, quality of service and member experience.

- Maintain NCQA accreditation.
- Continue coordinated regional response to COVID-19 pandemic, including expansion of the use of telehealth for a broad array of supports/services.
- Establish an effective Crisis Response System and Call Center.
- Continuously improve the quality, appropriateness, availability, accessibility, coordination and continuity of health care services to members across the continuum of care.
- Continue implementation transition of Home and Community Based Services Waiver.
- Improve member and provider satisfaction.
- Conduct reviews through virtual monitoring to ensure that telehealth services are compliant in accordance with regulatory standards.
- Ensure a high-quality network through credentialing, peer review and contracting processes. •
- Establish and revised/improved regional standardized contract and provider performance monitoring protocols for autism service providers, fiscal intermediary services, specialized residential providers

and inpatient psychiatric units.

- Continue to collaborate with providers to share ideas and implement strategies to improve care coordination and quality of service.
- Improve and manage member outcomes, satisfaction and safety.
- Maintain excellent compliance with state and federal regulatory requirements, and accreditation standards.
- Ensure DWIHN's organizational initiatives related to cultural competency and diversity for members and providers meet the needs of DWIHN members.
- Address regional role in statewide training and provider performance monitoring reciprocity activities.
- Continue efforts to participate in children/family outreach by attending community events, schools, and working with children service providers to increase mental health awareness, information, and access to services.
- Continue efforts on children services. In 2022, DWIHN will begin a campaign/initiative called "***Mental Health Care-Putting Children First***". DWIHN is going to extend our scope and resources to reach the over 285,000 school-aged kids we have in Wayne County.
- Support DWIHN in establishing improved performance metrics for services and supports and for MDHHS incentive payment metrics (including follow-up after hospitalization for mental illnesses, follow-up to persons with a SUD diagnosis following contact with an Emergency Room; identification and follow up activities related to health disparities; better support for veterans and expanded population health and performance monitoring metric.
- Demonstrate and communicate DWIHN's commitment to improving progress toward influencing network-wide safe clinical practices.
- Support DWIHN strategic planning efforts related to becoming a Certified Community Behavioral Health Home (CCBHC), Behavioral Health Homes (BHH) and increase Opioid Health Home (OHH) provider services.
- Continue to increase the training of providers, health care workers, jail staff, drug court staff, community organizations and members of our region on how to use Naloxone to reverse opioid overdose.

Work Plan Summary and Work Plan FY2021-2022

DWIHN Quality Improvement goals are integrated and communicated throughout the organization with a structure Work Plan, with identified goals objectives that are owned at the departmental level. DWIHN's organizational monitoring activities, reports and documented processes are reviewed throughout the year by the Quality Improvement Steering Committee (QISC) and Program Compliance Committee (PCC) no less than quarterly to identify opportunities for improvements. These activities, in addition to ongoing Performance Improvement Projects (PIPs), form the basis of the organization's Work Plan and support all services offered by DWIHN. The Behavioral Healthcare landscape, COVID-19, key strengths and opportunities for improvement guided DWIHN's overall quality-related efforts in FY2021.

QAPIP Work Plan
FY 2020-2021

Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Responsible Department	Timeframe for Each Activity's Completion	Monitoring of Previously Identified Issues	Evaluation	Outcomes	Oversight of QI Activities by Committee
	Customer Pillar						
Goal I	**Improve Members Experience with Services**						
I.1	ECHO Satisfaction Surveys (Adult and Children)	Customer Service	FY 2020-2021	The goal is to increase each score by 10% or higher. Increase response rates and improve member access to behavioral health services for the reporting measures scoring < 50%;Treatment after benefits are used up, Counseling and Treatment, Getting Treatment Quickly, Office Wait and Access, and Perceived Improvement.	Provider Survey, Consumer Satisfaction Survey and other assessments related to member experiences.	**Met:** Targeted goal met in FY21. Getting treatment quickly overall satisfaction rate for FY 21 was 46%, which is a 3% increase when compared to the last fiscal year (43%). There were two measures with scores of higher than (50%): Treatment after benefits used up (56%) and Counseling and Treatment (51%). The score for Perceived Improvement has remained stagnant in the low 30's since 2017. Goal will be continued in FY2022.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
I.2	National Core Indicator Survey (NCI)	Customer Service	FY 2020-2021	The goal is to increase members participation by 25%. Increase response rate to complete the survey to provide feedback regarding members experience access to service and quality of care.	Review and evaluate the results of the NCI survey for system enhancement to improve access to service and quality of care through the response rate from the NCI Survey.	**Not Met:** Due to the ongoing COVID-19 issues MDHHS has delayed the operation of the survey process until FY22. Goal will be continued in FY2022.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
I.3	Provider/Practitioner Surveys	Customer Service	FY 2020-2021	The goal is to increase Provider Practitioner Survey responses rate 50-60%. Increase the number of provider organizations and practitioners participation to complete the survey.	Review Provider and Practitioner Satisfaction Surveys results related to service access and other assessments related to member experiences.	**Not Met**: The total number of actual respondents for FY 21 from provider organizations was 140 out of 529, which is a decrease of 180 out of 354 from FY20. Percentage wise the provider and individual practitioner's response rates were 26% and 23%, respectively. Goal will be continued in FY2022.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
I.4	Grievance/Appeals	Customer Service	FY 2020-2021	Improve outcomes by decreasing grievance by 5% in the areas of Delivery of Service, Access to Staff and Customer Service.	Review Grievances, Appeals, Recipient Rights and Sentinel Events data and other initiatives to determine priority actions and improvements to better engage members and stakeholders.	**Met:** FY21, there were 60 grievances reported in which there were 96 issues identified. Delivery of Service and Customer Services were consistently high over each of the three years. Interpersonal relations came in third with a total of 46 complaints. There was a decline in the number of grievances in the following categories Quality of Care, Program Issues and Environmental. Goal will be continued in FY2022.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
I.5	Timeliness of Utilization Management Decisions	Utilization Management	FY 2020-2021	The goal is to meet performance measure set by the state for timely UM decisions making, timeframes and notification. Threshold 90% .	The Timeliness of UM Decisions Making and UM Notification is reported on a quarterly basis during the Utilization Management Committee meeting.	**Met:** Standard met for timeliness of urgent pre-service decision making during FY 21. Goal will be continued in FY2022.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
I.6	Cultural and Linguistic Needs	Customer Service, Managed Care Operations, Quality Improvement and Information Technology	FY 2020-2021	Target goal 95% or higher to Improve through member accessibility reporting for advancing health equity, improve quality, and help eliminate health care disparities by implementing culturally and linguistically appropriate services.	Review data collection to document cultural linguistic competency need, include cultural linguistic competency in staff evaluations and creating recruitment strategies for bilingual and diverse staff.	**Met:** DWIHN adopted the Culturally and Linguistically Appropriate Services (CLAS) standards to advance health equity, improve quality, and help eliminate healthcare disparities. These standards provide a blueprint for individuals and healthcare organizations to implement culturally and linguistically appropriate services. Goal will be continued in FY2022.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.

Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Responsible Department	Timeframe for Each Activity's Completion	Monitoring of Previously Identified Issues	Evaluation	Outcomes	Oversight of QI Activities by Committee
	Access Pillar						
Goal II.	**Improve members Access to Services, Quality of Clinical Care, Health and Safety**						
	Michigan Mission Based Performance Indicators (MMBPI)						
II.1	Indicator 1(a) and 1(b) - Percentage of pre-admission screenings for psychiatric inpatient care (Children and Adults) for whom disposition was completed within three hours	Quality Improvement	FY 2020-2021	The goal is to meet or exceed performance standards for indicator 1(a) and 1(b) as set by MDHHS. Threshold (95%) for each quarter.	Performance is monitored monthly. When performance standards are not met, providers submit a POC identifying causal factors, interventions, implementation timelines, and any other actions they will take to correct undesirable variation. Regional trends are identified and discussed at the QISC for planning efforts and coordination. The effectiveness of the action plan will be monitored based on the re-measurement period identified.	**Partially Met:** Standard met for Children. Standard not met for Adult for Q2 (92.74%), Q3 (93.58%) and Q4 (94.82). Threshold (95%) for each quarter.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
II.2	Indicator 2(a) and 2(b) - Percentage of persons (Children and Adults) receiving a face to face meeting with a professional within 14 calendar days of a non-emergency request for service.	Quality Improvement	FY 2020-2021	Performance goal is to achieve comparable score to the statewide average. No standard/benchmark for indicator 2 has been set by MDHHS. There are no exceptions allowed for indicator 2.	Indicator 2 is baseline data collection, improvements will be focused on ensuring valid, reliable, and actionable data is being collected and ensure categories for "out of compliance" events, appointments scheduled outside 14 days, no showed/canceled and rescheduled be documented, reviewed and analyzed.	**Not Met:** DWIHN demonstrated a (45.14%) performance rate for all population categories for Indicator 2 during FY2021. The statewide average is (63%).	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
II.3	Indicator 3(a) and 3(b) - Percentage of persons (Children and Adults) needed on-going service within 14 days of a non-emergent assessment with a professional.	Quality Improvement	FY 2020-2021	Performance goal is to achieve comparable score to the statewide average. No standard/benchmark for indicator 3 has been set by MDHHS. There are no exceptions allowed for indicator 3.	Indicator 3 is baseline data collection, improvements will be focused on ensuring valid, reliable, and actionable data is being collected.	**Met:** DWIHN demonstrated a (86.49%) performance rate for all population categories for Indicator 3 during FY2021. The statewide average is (79.03%).	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
II.4	Indicator 4a and 4a - Percentage of discharges from a psychiatric inpatient unit (Children and Adults) who are seen for follow up care within 7 days.	Quality Improvement	FY 2020-2021	The goal is to meet or exceed performance standard for indicators 4(a) Children and 4(a) Adult as set by MDHHS. Threshold (95%) for each quarter.	Performance is monitored monthly. When performance standards are not met, providers submit a POC identifying causal factors, interventions, implementation timelines, and any other actions they will take to correct undesirable variation. Regional trends are identified and discussed at the QISC for planning efforts and coordination. The effectiveness of the action plan will be monitored based on the re-measurement period identified.	**Partially Met**: Standard met for Adult. Standard not met for Children for Q1 (92.75%), Q2 (94.83%) and Q3 (91.23%). Threshold (95%) for each quarter.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
II.5	Indicator 4b - Percentage of discharges from a Substance Abuse Detox Unit who are seen for follow-up care within 7 days.	Quality Improvement	FY 2020-2021	The goal is to meet or exceed performance standard Indicator 4(b) as set by MDHHS. Threshold (95%) for each quarter.	Performance is monitored monthly. When performance standards are not met, providers submit a POC identifying causal factors, interventions, implementation timelines, and any other actions they will take to correct undesirable variation. Regional trends are identified and discussed at the QISC for planning efforts and coordination. The effectiveness of the action plan will be monitored based on the re-measurement period identified.	**Met**: Standard met for all 4 quarters during FY2021 Q1 (100%) Q2 (99.47%) Q3 (99.57%) Q4 (98.33%). Threshold (95%) for each quarter.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.

Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Responsible Department	Timeframe for Each Activity's Completion	Monitoring of Previously Identified Issues	Evaluation	Outcomes	Oversight of QI Activities by Committee
II.6	Indicator 10 (a) and 10 (b) - Percentage of readmissions (Children and Adults) to inpatient psychiatric unit within 30 days of discharge.	Quality Improvement	FY 2020-2021	The goal is to meet or exceed performance standard for indicators 10(a) and 10(b) as set by MDHHS. Threshold (15% or less) for each quarter.	Performance is monitored monthly. When performance standards are not met, providers submit a POC identifying causal factors, interventions, implementation timelines, and any other actions they will take to correct undesirable variation. Regional trends are identified and discussed at the QISC for planning efforts and coordination. The effectiveness of the action plan will be monitored based on the re-measurement period identified.	**Partially Met:** Standard met for the children population for all quarters. Standard not met for the adult population for all quarters Q1 (17.34%) Q2 (17.34%) Q3 (17.03%) Q4 (15.01).Threshold (95%) for each quarter.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
II.7	Complex Case Management	Integrated Health Care	FY 2020-2021	The goal is to receive 50% or greater member satisfaction scores. Improve members optimum health, improved functional capability, and a better quality of life by focusing on their own health goals. CCM will be measured against the following benchmark for participating members.	Review and analyzed member Admission, Discharge and Transfer (ADT) alerts and DWIHN claims data to measure utilization of Emergency Department and Hospital Admissions 90 days prior to participating in CCM services and 90 days after starting CCM services.	**Not Met**: Member satisfaction and the experience continues to remain relatively the same from one year to the next (FY21 to FY20 48%) respectively. Targeted goal is to increase the return rate to 55% in FY22.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
II.8	Crisis Intervention	Utilization Management	FY 2020-2021	The goal is to decrease number of re-hospitalization within 30 days of discharge to 15% or lower.	Analyze the expansion of Med Drop program to incorporate more providers and target recidivistic individuals, with goals to decrease need for higher level of care such as Assertive Community Treatment and inpatient hospitalizations.	**Not Met**: Standard not met for the adult population for all quarters Q1 (17.34%) Q2 (17.34%) Q3 (17.03%) Q4 (15.01).Threshold (95%) for each quarter.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
	Workforce Pillar						
Goal III.	**Develop and maintain a Competent Workforce through the Credentialing and Re-Credentialing Process**						
III.1	Maintain Competent Workforce	Workforce Development, Credentialing, Quality Improvement, Clinical Practices Improvement and Managed Care Operations	FY 2020-2021	The goal is to focus on maintaining and expanding a centralized training program for allied health professionals. Focusing on the development of new professionals is integral to achieving a collaborative integrated healthcare system. The Health Resources and Service Administration have recognized the innovative university and community partnership model nationally and regionally.	Primary focus Workforce Development and Retention, Suicide Prevention, Community Collaboration, Public Safety Partnerships, and Program Expansion.	**Met:** In FY21, DWIHN completed verification for 913 practitioner files for credentialing and 73 providers, which is a significant increase compared to last fiscal year of 537. All files were clean, had appropriate checks done, and had no issues or concerns. Workforce Training and Program Development completed 72 Live events, with 4454 Attendees across all of those events, meaning that our median attendance for all events combined is 61.8 attendees per event. More than 60 mental health professionals engaged in interprofessional education to enhance competency in culturally responsive engagement, assessment, treatment planning, and intervention with individuals diagnosed with co-occurring disorders. Goal will be continued in FY2022.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
	Finance Pillar						

Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Responsible Department	Timeframe for Each Activity's Completion	Monitoring of Previously Identified Issues	Evaluation	Outcomes	Oversight of QI Activities by Committee
Goal IV	**Maximize Efficiencies and Control Costs**						
IV.1	Verification of Services	Quality Improvement, Compliance and Finance	FY 2020-2021	The goal is to review 100% randomly selected Pool of Paid Encounters/Claims to eliminate Fraud, Waste and Abuse in the network by identifying patterns and trends of behavioral health service utilization by funding source.	Review the sample size that is randomly selected through DWIHN Information Technology Unit generates a statistically sound random sample, obtained from a Pool Of Paid Encounters/Claims.	**Not Met:** A total of 2,371 claims were randomly selected for verification FY21. Of those claims 1,210 were reviewed and validated for 51.03%, which is a slight increase from the previous Fiscal Year (40%). This goal will be continued in FY22.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
	Quality Pillar						
Goal V.	**Improve Quality Performance, Member Safety and Member Rights system-wide**						
V.1	Provider Network Performance Monitoring - Clinically Responsible Service Provider (CRSP)	Quality Improvement	FY 2020-2021	The goal is to increase number of reviewed providers by 15%. Improve performance rates on regulatory audits (acute care discharge, IPOS and crisis and response planning). Measurement will include the number of providers reviewed during FY21 with reported outcomes.	Review the quality and data practices within the network.	**Met:** In FY21, DWIHN saw an increase in audits performed compared to FY20 through virtual monitoring. The reviews include the Clinically Responsible Service Provider (CRSP), Autism, SUD, MI Health Link and Residential Treatment Providers. The average scores of these reviews ranged from 77% being the lowest and 96% being the highest. Those providers who scored below 95% were placed on a corrective action plan. Goal will be continued in FY2022.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
V.2	Residential Treatment Providers	Quality Improvement	FY 2020-2021	The goal is to review 60% of the Residential Treatment Providers to ensure services and supports received are set forth in the member's treatment/service plan.	Review the quality and data practices within the Network.	**Not Met**: Targeted goal not met. Goal will be continued in FY2022.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
V.3	Provider Network Self Monitoring (Inter-Rater Reliability)	Quality Improvement	FY 2020-2021	The goal is to increase Provider's participation in Self Monitoring from the previous year by 10%.	Providers inter-rater reliability analysis to objectively assess the level of consistency within the Provider network. The provider self-monitoring reviews is a multilevel approach, which begins at the service provider level.	**Met**: Targeted goal met; increased numbers of self reviewed cases by 20% in FY21. Goal will be continued in FY22.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
V.4	Autism Services	Quality Improvement and Children's Initiatives	FY 2020-2021	The goal is to increase clinical record reviews by 10%.	Monitor and bring system-wide improvement to the ABA program.	**Met:** Reviewed 100% of the Autism Providers in FY21. The average scores of these reviews ranged from 77% being the lowest and 91% being the highest. Goal will be continued in FY2022.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.

Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Responsible Department	Timeframe for Each Activity's Completion	Monitoring of Previously Identified Issues	Evaluation	Outcomes	Oversight of QI Activities by Committee
V.5	Critical/Sentinel/Unexpected Death and Risk Reporting	Quality Improvement and Information Technology	FY 2020-2021	The goal is to improve reporting requirements and monitor the safety of clinical care of members. .	Review critical incidents, to ensure adherence to data and reporting standards and to monitor for trends, to improve systems of care; Monitor sentinel event review processes and ensure follow-up as deemed necessary; Monitor unexpected deaths review processes and ensure follow-up as deemed necessary.	**Met**: In FY21, processed 3158 Critical/Sentinel Events, which is a decrease of (29.19%) in FY20;Of those incidents, the SERC reviewed and analyzed over eight-hundred and thirty (830) critical incidents. the highest category being reported Physical Illness Requiring Emergency Room (975); the next top category is Serious Challenging Behavior (609); and the lowest number of critical incidents is Medication Error (16).	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
V.6	Behavioral Treatment Review	Quality Improvement and Medical Director	FY 2020-2021	The goal is to meet performance standard on required BTPRCs requirements set by MDHHS. Threshold 95%.	Review quarterly data on BTPRC outcomes submitted by the Clinically Responsible Service Providers (CRSP) providers to ensure BTP restrictions are appropriately used and time limited.	**Met**: In FY21, DWIHN organized the two system-wide training events on the Technical Requirements of Behavior Treatment Plans (BTP). The first training event was for Habilitation Supports Waiver (HSW) providers on MDHHS requirements for the beneficiaries of HSW and BTP. DWIHN hosted the virtual technical assistance with MDHHS for network providers on the requirements of Behavior Treatment review and Occupational Therapy Evaluations, the event was attended by 139 participants. DWIHN has also delegated all contracted Mental Health (MH) CRSP to have the BT review process in place. The BTPRC requirements are included in the CRSP written contract for FY21. DWIHN has a total of twenty (20) BTPRCs that are conducted at the MH CRSP, which is an increase of 122.2%. Goal will continue in FY2022.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
	Performance Improvement Projects (PIPs)						
V.7a	Improving the availability of a follow up appointment with a Mental Health Professional with-in 7 days after Hospitalization for Mental Illness.	Integrated Health Care and Quality Improvement	FY 2020-2021	The goal is 45% or higher in improving the availability of a follow up appointment with a Mental Health Professional with-in 7 and 30 days after Hospitalization for Mental Illness.	Focused on follow up after hospitalization within 7 or 30 days. This measure has the potential to improve the health of members with mental illness and reduce readmissions through increasing appropriate follow up care.	**Not Met**: Targeted goal not met of 45%. FY 21 rate (29.57%) with a goal of (45%) for the 7 Day Follow – Up Appointment with a Mental Health Professional. For the 30-Day Follow – Up Appointment with a Mental Health Professional there is a decrease of the HEDIS measurement for FY 21. FY 20 rate (50.47%) compared to FY 21 (48.20%). This is a percentage point decease 2.27 percentage points with a goal of 75%.Goal will continue in FY2022.	Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.
V.7b	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Integrated Health Care and Quality Improvement	FY 2020-2021	The goal is 45% or higher. This measure analyzes the percentage of members 19 to 64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least (80) percent of their treatment period.	Improve members with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.	**Met:** Targeted goal was achieved of 45%. Comparing the FY20 baseline data for Improving Adherence to Antipsychotic Medications for Individuals with Schizophrenia for re-measurement period of FY21, showed a decrease in this measure. FY20 rate (79.34%) compared to FY21 (46.42%). This is a (32.92) percentage point decrease**.** Goal will continue in FY2022**.**	Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.
V.7c	Antidepressant Medication Management for People with a New Episode of Major Depression	Integrated Health Care and Quality Improvement	FY 2020-2021	The goal is 51% or higher. Improve the importance of a good clinician/ patient relationship in addressing the importance of disease management and member's fear of taking medication as well as the risks and benefits of taking the medication.	Improve measurement-medication Compliance for Members 18 years or Older with a Diagnosis of Major Depression on Antidepressant Medication for at least 84 Days (12 weeks).	**Met:** Targeted goal not met of 51%. The goal for FY 2021 (46.42%). Goal will be continued in FY2022.	Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.

Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Responsible Department	Timeframe for Each Activity's Completion	Monitoring of Previously Identified Issues	Evaluation	Outcomes	Oversight of QI Activities by Committee
V.7d	Improving Diabetes Monitoring for People with Schizophrenia and Bipolar Disorder	Integrated Health Care and Quality Improvement	FY 2020-2021	The goal is 80% or higher. This measure analyzes the percentage of patients 18-64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening during the measurement year.	Increase Diabetes Screening for people with Schizophrenia and/or Bipolar Disorder measures for percentage of patients 18-64 years of age.	**Not Met:** Targeted goal not met of 80%. The goal did not represent a statistically increase over the baseline performance at 64.28%. Goal will be continued in FY2022.	Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.
V.7e	Coordination of Care	Integrated Health Care, Utilization Management and Quality Improvement	FY 2020-2021	The goal is 95% or higher for review of randomly selected cases through the performance monitoring process for compliance.	Collect and analyze data to identify opportunities for improvement of coordination between behavioral healthcare in the following areas: Exchange of information; Appropriate diagnosis, treatment and referral of behavioral disorders commonly seen in Primary Care.	**Not Met:** Targeted goal not met. The percentage of provider's participation for FY21 (71%), which is considerably below the State Performance Measure goal of 95% set by the state of Michigan for the PIHP's for Continuity and Coordination of Care. Goal will be continued in FY2022.	Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.
V.7f	Case Finding for Opiate Treatment	Substance Use Disorder	FY 2020-2021	The goal is 79% or higher.	Increase the Number of Persons revived with provided Naloxone Kits in Wayne County MI (Naloxone Project). Distribution of Naloxone kits to promote the use of overdose-reversing drugs.	**Not Met:** Targeted goal not met. Goal will be continued in FY2022.	Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.
V.7h	PHQ-9 Implementation	Clinical Practice Improvement	FY 2020-2021	The goal is 95% or higher.	Reduce the suicide rate for enrolled members which includes determining if the PHQ-9 could be a value added screener for its service population, DWIHN reviewed its population data/Agency Profile to determine the prevalence of depression among the enrolled members within the service delivery system	**Not Met:** Targeted goal not met 75%. Goal will be continued in FY2022.	Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.
V.7i	PHQ-A Implementation	Children's Initiative	FY 2020-2021	Target goal is 95% or higher.	Improve the health of the pediatric community through a grant to implement the Integrated Care for Kids Model. The Model outlined a child-centered local service delivery and state payment model that aims to improve the quality of care for children under 21 years of age covered by Medicaid through prevention, early identification, and treatment of behavioral and physical health needs. DWIHN in collaboration with providers and practitioners within the contracted provider network determined that youth members ages 11-17 will be assessed for the symptoms of depression via the PHQ-A screening tool.	**Partially Met**: Targeted goal partially met. 98.3% of PHQ-A assessments were completed at intake. 62.9% of the cases had a follow-up with the provider when the PHQ-A score was greater than 10. Goal will be continued in FY2022.	Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.
V.7l	Decreasing Wait for Autism Services	Children's Initiative	FY 2020-2021	Target goal is 95% or higher.	Improve efficiency in processing denials and appeals. Reducing the number of delegated functions is not only cost effective, but positions DWIHN as a leader in integrated care.	**Not Met**: Targeted goal not met for FY 2021 (90%). Goal will continue in FY2022.	Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.
	Advocacy Pillar						
Goal VI.	**Increase Community Inclusion and Integration**						

Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Responsible Department	Timeframe for Each Activity's Completion	Monitoring of Previously Identified Issues	Evaluation	Outcomes	Oversight of QI Activities by Committee
VI.1	Home and Community Based Services (HCBS)	Quality Improvement	FY 2020-2021	The goal is 100% compliance of the Network with the HCBS requirements.	Activities include completing survey process, review of data collected from survey, notifying providers of corrective action, collecting corrective action, approving corrective action and resurveying to assure both initial and ongoing compliance.	**Not Met:** Targeted goal not met for FY21 (45%) Goal will be continued in FY2022.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
Goal VII	**External Quality Reviews**						
VII.1	MDHHS Annual 1915 (c) Review	QI, MCO, CS, ORR, Finance, Workforce, Credentialing, IHC and Administration	FY 2020-2021	The goal is to achieve 95% or higher compliance for all standards of Annual MDHHS Review.	Monitor and address activities pertaining to the Waiver Programs (HSW, CWP, SEDW) by the DWIHN network to ensure compliance with the MDHHS HSW, CWP, and SEDW requirements.	**Met:** In FY21, DWIHN's initial review resulted in a Plan of Correction (POC). All matters were adequately remediated.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
VII.2	NCQA Accreditation	QI, MCO, CS, ORR, Finance, Workforce, Credentialing, IHC and Administration	FY 2020-2021	The goal is 89% or higher.	DWIHN received high marks and perfect scores in several critical areas including Member Experience, Self-Management Tools, Clinical Practice Guidelines, Clinical Measurement Activities, Coordination of Behavioral Healthcare and Collaboration between Behavioral Health and Medical Care.	**Met**: DWIHN scored 92.49 out of a possible 100 points. This goal will continue in FY22.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
VII.3	Health Services Advisory Group (HSAG)	QI, MCO, CS, ORR, Finance, Workforce, Credentialing and IHC	FY 2020-2021	The goal is to ensure compliance with all regulatory requirements in accordance with the contractual requirements with MDHHS.	HSAG completes three separate reviews annually: Performance Improvement Project (PIP), Performance Measure Validation (PMV) and the Compliance Monitoring review.	**Partially Met**: The PIP did not achieve the plan-selected goal (target 80%); For the PMV review, DWIHN met all the reportable standards. No plan of correction required. DWIHN received an overall compliance score of 77% with a corrective action plan for the compliance review. Goals will continue in FY22.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
VII.4	Annual Needs Assessment	QI, MCO, CS, ORR, Finance, Workforce, Credentialing and IHC	FY 2020-2021	Targeted and prioritized planned actions identified in Needs Assessment through meaningful feedback from providers meetings, focus groups and members.	Implement targeted and prioritized planned actions identified in Needs Assessment through meaningful feedback from providers meetings, focus groups and members.	**Partially Met:**DWIHN's integrated services continues to grow, beginning with our emphasis on opioid health homes. We have increased the number of enrollees to 137, which is a 10% increase from July. Moreover, DWIHN is on target to become a Lead Entity as a Behavioral Health Home (BHH) once the proposed State Plan Amendment is approved. DWIHN has taken a significant step in improving the technology infrastructure of our residential and children's providers. The IT department has distributed over 230 iPad, 68 laptops and 16 prepaid internet connections**.** Goal will continue in FY2020.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.