Quality Assurance Performance Improvement Plan (QAPIP)

FY 2021-2022 Work Plan Evaluation

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Approved:

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Executive Summary

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 FY2022.

Description of Service Area

Wayne County is the most populous county in the State of Michigan. Wayne County is comprised of 34 cities and 9 townships covering roughly 673 miles. The municipality of Detroit had a 2021 estimated population of 632,464 which is a noted decrease of 37,567 from the previous fiscal year (670,031). 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

Demographics

DWIHN provided services to an unduplicated count of 75,873 members during FY2022, which is an increase of 2,465 (3.35%). Of those served 47,526 (62.64%) received services through Medicaid funding, 18,893 (24.90%) received services through Healthy Michigan Plan funding, 7,025 (9.26%) received services through General Fund, 6,057 (7.98%) through SUD Block Grant, 6,084 (8.02%) through MI Health Link, 1,393 (1.84%) through State Disability Assistance (SDA) and 1,035 (1.36%) through Habilitation Supports Waiver. The percent of adults who reported having an SMI in FY22 was 44,349 (58.45%), demonstrating an increase of (2.64%) from the previous year. Followed by 11,222 (14.79%) (SED), 12,952 (17.07%) (IDD), 1,343 (4.92%) (SUD), 1,925 (2.54%) (MI), 2,387 (Co-Occurring, and 303 (0.40%) unreported, which is a substantial decrease of unreported disability designation from the previous year. Of those served 41,633 (54.87%) were of African American descent. The Caucasian count was 23,428 (30.88%). The remaining (14.25%) 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 33,662 (44.37%). Followed by the age group of 0-17 years-old,16,923 (22.30%), and the age group of 51-64 years-old, 15,424 (20.33%). The growth of persons served 65 and over continues to increase by (6.31%) from the previous year. *Data was extracted for this report on January 9, 2023.

Data has also been added to include information regarding LGBTQ+ members. According to the UCLA Williams Institute 2020 data, there is an estimated 311,000 LGBTQ+ members in Michigan. Although the full range of LGBTQ+ identities is not commonly included in large-scale studies of mental health, there is strong evidence from recent research that members of this community are at a higher risk for experiencing mental health conditions especially depression and anxiety disorders. In future reporting, DWIHN will include LGBTQ+ identifiers in our demographic data to reflect the growing population of members that we serve.

Customer Pillar

Member Experience with Services

DWIHN manages an annual Member Experience Survey offered to random participants who receive adult services, and to families of children receiving services from our system. Wayne State University School of Urban Planning administers the Experience of Care & Health Outcomes (ECHO®) Survey a comprehensive member experience outcome tool developed by Consumer Assessments of Healthcare Providers and Systems (CAHPS), for the purpose of understanding patient experience in behavioral health services while utilizing a scientific approach. DWIHN has used the tool for adults in 2017, 2020, 2021 and children in 2020 and 2021. DWIHN is in process of administering the survey for the look back period for both children and adult populations for 2022. Data sources also include grievances and appeals, and member feedback received directly from customer service.

Quantitative Analysis and Trending of Measures

Over the years in utilizing ECHO®, DWIHN's team has made recommendations for Quality Improvement that focuses on the implications of care including but not exclusive of Treatment of Care, Timeliness and Appropriateness of Care, Perception of Improvement of Health, Competency and Care of Practitioner's including Cultural Competency, and Access to care. DWIHN has seen slight improvements in both populations since establishing the baseline, recommendations and policy focused solutions have been implemented through the QAPIP process to ensure systemic change and the opportunity for better health outcomes for participating members. DWIHN uses a blind anonymous study as recommended by NCQA accrediting body. While thresholds demonstrate that a sampling of 600 participants in the adult survey proves scientifically adequate, DWIHN has over performed by surveying closer to 900 adults and over 1,000 for the children population during FY2021.

DWIHN reviews the Member Experience ECHO® results along with other collected data that captures member experience data. The comprehensive report provides an accurate assessment of the quality of care and services that are essential to our member's recovery and to assist with engaging them in their health care journey. The 2022 (look back) ECHO® Survey is underway, a preliminary report will be available in late April and a Final Report will be available in June 2023.

Evaluation of Effectiveness

During FY21, DWIHN scored well on several measures, notably parents/guardians reporting receiving information on patient rights (95%), confidence in the privacy of their information (93%), and completely discussing the goals of their child's treatment (93%). 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%). There was variation in the overall rating during FY2020 compared to FY2021, "Perceived improvement" (28% compared to 29%); How Well Clinicians Communicate" (73% compared to 68%); and rating of counseling and treatment (54% compared to51%). DWIHN will complete an analysis on the comparison of data for FY2021 and FY2022 once the final report is available in June of 2023.

Identified Barriers

The noted barrier is that the preliminary report will not be available until late April. The Final Report will be available in June 2023 for analysis on the comparison of data for FY2021 and FY2022.

Opportunities for Improvement

DWIHN will continue to focus on access to care for behavioral health services based on the 2021 survey results and will incorporate the 2022 survey results once available. 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 and potential improvements that would support members being seen within 15 minutes of appointment time.
- Service providers and members to identify barriers for 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 I/DD or SUD, are confident in the privacy of their information and that those with guardians feel clinicians listen carefully to their needs.
- Review the provider network for access to behavioral health services, especially in more urban counties and reducing the number 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 about 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 are offered via the ECHO survey, particularly for those providers given lower scores on members' experience.

National Core Indicators (NCI) Survey

On an annual basis, DWIHN participates in the National Core Indicator (NCI) Survey. The 2021 survey is reported in a collective summary which is conducted by Wayne State University Developmental Disabilities Institute, (WSU/DDI) on behalf of MDDHS. WSU/DDI aggregates the data of all participating PIHP's within the State of Michigan. Each year the survey commences around November and pre-survey data is collected from providers on behalf of consenting (participating) members. These members are identified by a list provided by the State prior to the survey's release. The 2022 NCI Survey is underway with the pre-survey background being completed for selected members. WSU/DDI arranges and administers the in-person surveys to the identified persons between February and May of 2023. The Summary will be completed in September and will be offered for a preview by MDHHS and WSU/DDI at such time. DWIHN does not control or participate in the completion of this report.

Quantitative Analysis and Trending of Measures

During FY2022, over 250 participants from Wayne County were asked to participate in the NCI Survey. The results of NCI Survey include the total response of about 620 persons state-wide, therefore Wayne County plays a significant role in providing to MDHHS an overview of care related to IDD/DD Indicators to help align programming with strategies to improve overall care. While the actual survey summary does not drill down to the individual or (back) to DWIHN as a PHIP in 2023, DWIHN is looking at how consenting NCI participants can identify their terms of satisfaction by focusing on a research study of persons who receive IDD Services and their involvement in the decision making of their Individual Plan of Service (IPOS)/Person Centered Plan (PCP). The State does not and has declined request to provide data of the actual survey from individual PIHP's or Counties.

Identified Barriers

The noted barrier is that the actual survey summary does not drill down to the individual or (back) to DWIHN as a PIHP. Also, DWIHN does not control or participate in the completion of this survey. The NCI survey does not deliver outcome scores which provides a basis for satisfaction or dissatisfaction. The data that is collected at the PIHP level is demographic and background history only. In addition, the group that is surveyed is not a representative sampling of our members in our IDD Community and the data is not aggregated in qualitative measure. Therefore, this goal will be discontinued during FY2023.

Opportunities for Improvement

DWIHN will continue to focus on participants to identify their terms of satisfaction by reviewing and analyzing research studies of persons who receive I/DD Services and their involvement in the decision making of their IPOS/ PCP.

Long-Term Services and Supports (LTSS)

The DWIHN Member Experience unit also coordinated and administered a Baseline LTSS survey to look at the overall satisfaction with LTSS, particularly in the skills-building workshop environment. The survey looked at a sample of members who identified as receiving services during a specified 12-month look-back period in 2021 and 2022. Approximately 340 members participated and while nearly 80% of the respondents shared that they were satisfied overall with their services the data revealed potential opportunities to improve the correlation between member involvement in understanding their IPOS/PCP better to assist with enhancing a better overall experience with their services, specifically with their LTSS Services.

An overall review of persons with Long Term Support Services including a study on persons engaged in NCI survey will be asked to participate in a demonstration PIP commencing in April 2023 through November 2023. This endeavor will help DWIHN to better assist persons on an individual basis to provide feedback toward their level of satisfaction, offer supports to those persons which will include training and programming with the assistance of peers and other staff to better improve outcomes and improve outcomes of their desired goals around inclusion, choice of residential preferences and perceived health improvement.

Opportunities for Improvement

- Drill down the data to identify persons who expressed dissatisfaction with their Skills Building (LTSS) service.
- Utilize that dissatisfied group and build a demonstration project/PIP to include a minimum of 30 persons and a maximum of 50 persons (still receiving LTSS) treatment to study if there is any correlation between their dissatisfaction and the lack of understanding or development of a strongly crafted IPOS by supporting intensive work/training with the individual member and intensive training/supports to individuals.
- Pre- Survey the study group about their dissatisfaction of LTSS focusing on their understanding of their IPOS and their decision- making ability related to their personal goals, their goal focus and expectations for progress related to their personal goals and independence, their perceived clinical support, their perceived natural supports, their spiritual goals their socialization goals and their residential preference goals.
- Trained peers to assist the member in self-determined education about their IPOS and assist in crafting goals in the person's own voice about improving and meeting goals determined through the LTSS treatment.
- Assigned peers to train through a cooperative effort between Quality, WDF, and Clinical Services- EBP and work with the study group throughout the project.
- After independent individual work with the member and second post-survey will be conducted by Member Experience to determine if the peer intervention provided a substantial increase in satisfaction.
- Additional post-satisfaction surveys addressing the same focus will be administered by Member Experience with preliminary data, after 90 days, and after 150 days, analysis of the data will be reviewed by the Quality unit to establish systemic policy or changes necessary to implement peer intervention in the IPOS process to improve satisfaction.
- determine if peer intervention effectively impacts expectations and increased satisfaction and outcomes in LTSS participants.
- Establish a study group of guardians of about 30 participants who by a newly created baseline survey describe dissatisfaction in the LTSS treatment, and study whether similar peer interventions with guardian interface could also impact and increase satisfaction toward obtaining the level of accomplishment and or expectations that the guardian anticipates should be available to their love one.

Member Grievance and Appeals

DWIHN's Customer Service completes an analysis of member experience trends and occurrences through a review of Grievance data. DWIHN uses this data and other initiatives to determine priority actions and improvements to better engage members and stakeholders. Analyzing the data helps to forecast the direction and future of DWIHN's public behavioral health system by enhancing and developing policy, initiating process improvement plans, and 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 services within the DWIHN system.

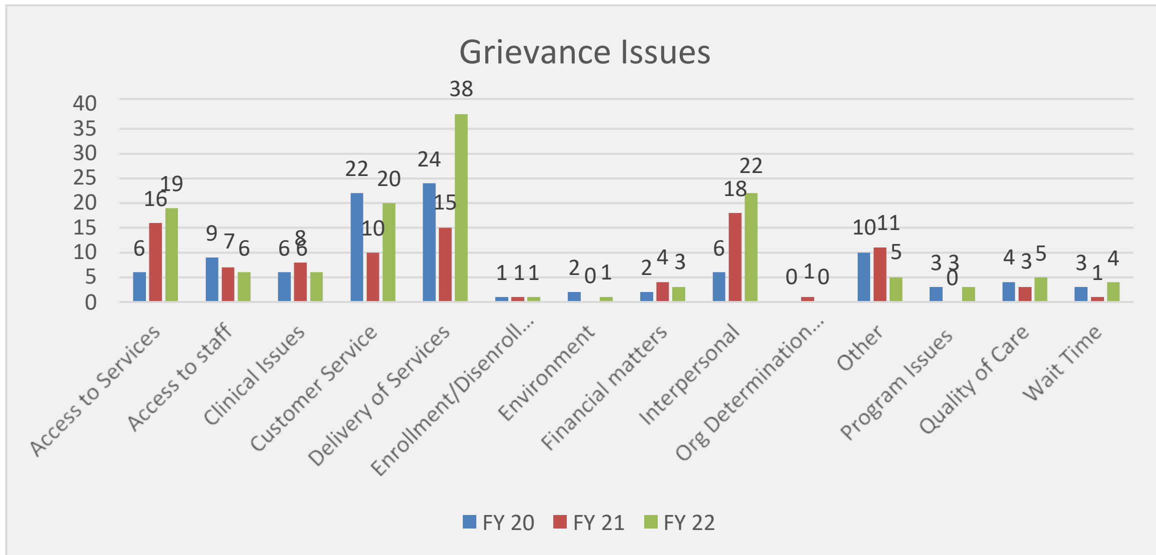
DWIHN's goal is to educate members as well as providers on the importance of promoting expressions of member dissatisfaction as a means of identifying continuous quality improvements in our delivery of behavioral health care services. It promotes members' access to medically necessary, high-quality, member-centered integrated health services by responding to member concerns in a sensitive and timely manner. This process supports recovery and assures that people are heard. It empowers individuals receiving services to become self-advocates and provides input for making the system better for everyone.

Quantitative Analysis and Trending of Measures

In FY2021/2022, Customer Service's effort to assist members with their due process rights of grievances and appeals resulted in the processing of 788 grievance related communications (emails and calls) compared to 324 calls from the previous year. Grievances received were 92 for the current fiscal year, a slight decrease from FY2021. Numerous member educational venues and provider trainings to address grievance and appeals updates and technical assistance were also a key focus. In the area of appeals, increases were seen as the unit processed 595 appeals related correspondence (emails/calls). Actual appeal cases increased with a total of 38 related appeal cases being addressed. State Fair Hearings conducted this fiscal year showed a modest increase by 3.

The monitoring of 15,845 Mental Health based Adequate and Advance Adverse Benefit Determination Notices sent in FY2021/2022, compared to 17,039 the previous year, showed a significant decrease. This is an increase noted with 1,555 Autism related Applied Behavioral Analysis notices being sent out in comparison to 1,262 the previous year. In the area of SUD notices, there was an increase, 945 compared to 725 and 2,899 IDD related notices compared to 1,826 from the previous year.

DWIHN has a network of approximately 1,558 providers. Grievances were not reported against every provider. DWIHN identifies grievance categories in alignment with MDHHS requirements as illustrated in the graph below. During FY2020, there were 53 grievances reported in which 97 issues were identified. During FY2021, there were 60 grievances reported of which there were 96 issues identified. FY2022 had a total of 92 grievances with 146 issues. FY2022 numbers indicated Delivery of Service (38), Interpersonal (22) and Customer Services (20) issues remain the top three issues consistently over the three-year span. There was a consistent decline in the number of grievances in the Access to Staff category over the past three fiscal years. Enrollment/Disenrollment issues remain consistent over the last 3 fiscal years with 1 issue being reported.



A total of 13 grievances were reported for the five ICOs over the last three fiscal years. Molina has consistently had the highest number of grievances reported. There were three grievances in FY2022, six in FY2021, and four in FY2020. The 13 grievances are included in the total number of grievances reported for each year and the same for the grievance categories. Medicaid grievances are required to be resolved within ninety (90) calendar days, non-Medicaid grievances must be resolved within sixty (60) calendar days and MI Health Link grievances must be resolved within thirty (30) calendar days. Grievances were resolved within the average number of 36.5 days for FY2022, 27 days in FY2021, and 37 days in FY2020.

All MI Health Link grievances were resolved within the 30-calendar day timeframe. Of the 205 grievances reported over the last three fiscal years, 94% were resolved within the Customer Service unit at either the Service Provider or DWIHN. Those grievances were usually coordinated with other departments for resolution. There were 13 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 which accounts for 6%.

Evaluation of Effectiveness
There were 205 grievances reported over the last three fiscal years (FY2020, FY2021, and FY2022). Over half of the grievances were resolved satisfactorily (130). 29 grievances were marked unsatisfied with the outcome of their complaint. Unable to determine the satisfaction disposition for the remainder of the grievances due to either not responding to contact attempts or other factors.

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.

Identified Barriers
The noted barrier is the underreporting throughout the system based on the monitoring and review of Quality Performance Improvement findings. The reporting represents only those events entered the DWIHN system.

Opportunities for 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 members 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 and Practitioner Satisfaction Survey

In FY2021-2022, DWHIN established an Ad-Hoc Committee to review the DWIHN Provider Satisfaction Survey. The Committee's goal was to increase the survey response rate from the previous year and locate areas for improvement.

Quantitative Analysis and Trending of Measures

DWIHN administered the Provider Satisfaction Survey for FY2022 during the months of September and October to measure provider experience with service access, service provision, treatment experiences and outcomes. Approximately 247 provider organization participated which resulted in a 3% increase in the response rate. The following metrics were utilized to determine favorability: questions that received "Excellent", "Very Good", and "Good" results with a combined score of over 78% were considered favorable. Conversely, questions that received "Excellent", "Very Good", and "Good" results with a combined score of less than 65% were considered unfavorable. The Practitioner Satisfaction Survey was not administered during FY2022 and will be sent out in Q2 (January-March) of FY2023, results will be completed later this year.

Evaluation of Effectiveness

DWIHN found that the main reason for the low completion rate was the length of the surveys, so revisions were made to reduce the number of questions from 76 to 37, which included clarifying unclear questions and recrafting questions when necessary. Both the Provider and Practitioner Satisfaction surveys asked 34 questions, covering all areas of DWIHN Departments including Utilization Management, Claims, Managed Care Operations, Quality Improvement, and Credentialing. The survey is comprised of 5 components:

1. Measured DWIHN's effectiveness in meeting contractual provider obligations.
2. Measured support of providers in meeting the needs of members
3. Measure DWIHNs provider responsiveness
4. Uncover gaps and/or deficiencies in DWIHN's operation.
5. Identify opportunities for improvement and /or for corrective actions needed.

Causal Analysis of Provider Survey Results

Staff Availability

Three departments received high scores for staff availability: Integrated Healthcare, Office of Recipient's Rights, and Quality Improvement. However, Workforce Development and Community Outreach of Psychiatric Emergencies received lower scores.

Timeliness of Response

Two departments received positive scores for timeliness: Office of Recipient's Rights, and substance use disorder. However, Access Call Center, Credentialing, and Workforce Development received low scores.

Ease of Reach

The following departments received high scores in regard to ease of reach, Integrated Healthcare, Quality Improvement, Substance Use Disorder, and Children's Initiative. However, Access Call Center, Administration, Clinical Practice Improvement, and Community Outreach on Psychiatric Emergencies received lower scores.

Knowledge of Staff to Answer Questions and Resolve Issues

The Access Call Center scored low in this section (62% favorable). All other departments scored above 65% favorability.

MI Health Link

All 8 questions pertaining to MI Health Link received a favorable response rate of greater than 80%.

Credentialing

When asked about the Credentialing Process, only 50% of respondents selected a favorable response.
The Credentialing process is a very key and critical process. 50% of the providers rated DWIHN's Credentialing process favorably. A committee was established to evaluate DWIHN's Credentialing process. Aspects of the process requiring improvement have been identified and an Action Plan has been established. Additionally, there were aspects of DWIHN's operation in which scores of favorable and unfavorable varied amongst departments. Focused initiatives will occur in the departments which scored unfavorably.

Identified Barriers

The Practitioner Satisfaction Survey was not administered during FY2022 and will be sent out in Q2 (January-March) of FY2023, results will be completed later this year. Given the change in the Provider Survey Tool, a comparison could not be made. The same survey tool will be administered in 2023 at which time a comparison between 2022 and 2023 will be conducted.

Opportunities for Improvement

Based upon the Provider Survey results DWHIN will:

- Distribute survey results to relevant departments to acknowledge outcomes and develop an action plan (if necessary).
- Develop interventions within DWIHN to address unfavorable responses.
- Communicate results with providers and share planned interventions to address unfavorable responses.
- Revision of DWIHN's Credentialing process

Cultural and Linguistic Needs

DWIHN and its Provider Network demonstrates an ongoing commitment to linguistic and cultural competence that ensures access and meaningful participation for all people in the service area. Such commitment includes acceptance and respect for the cultural values, beliefs, and practices of the community, as well as the ability to apply an understanding of the relationships of language and culture to the delivery of supports and services. Competence includes a general awareness of the cultural diversity of the service area including race, culture, religious beliefs, regional influences in addition to the more typical social factors such as gender, gender identification, sexual orientation, marital status, education, employment, and economic factors.

DWIHN has hired a Diversity Equity and Inclusion (DEI) Administrator whose primary responsibility is to recognize, create and implement plans to promote diversity within DWIHN & promote and develop training programs to enhance Employee & Provider understanding of inclusion issues. In addition, the DEI Committee rotates on a biennial basis and is comprised of a diverse group of employees whose mission is to promote values of inclusion, transparency, and fairness throughout DWIHN. This dedicated team works diligently to develop inclusive actions that clearly demonstrate DWIHN's commitment to eliminating systemic inequities and promote diversity, equity, and inclusion.

Evaluation of Effectiveness

Diversity, Equity, and Inclusion

Earlier this year, a group of local partners, with the support of National Disability Institute (NDI) and JPMorgan Chase, held a virtual meeting convening on financial equity for people with disabilities who live at the intersection of disability, race/ethnicity, and poverty. The goals for these roundtables were to highlight the importance of having this conversation on intersectionality and to promote an ecosystem of collaboration between three key stakeholder groups, organizations serving individuals with a disability, organizations offering financial empowerment services and organizations serving communities of color. At the end of the convening, a brief was developed that summarized the discussion and most importantly, noted the list of concrete actions and opportunities that participating organizations can jointly take to address some of the barriers to financial stability and financial resilience that contribute to the significant wealth gap faced by communities of color with a disability.

A steering Committee was formed to continue to build capacity, expand awareness, provide training and technical assistance, and explore raising funds to sustain the commitment to financial inclusion and continue laying the foundation for this work.

Additionally, DWIHN is seeking to expand its scope of activity beyond cultural competence with an added focus on actively seeking to address implicit bias and to reduce health disparities. The analysis of the data has revealed a racial disparity with the African American population as compared to the White population served. The data demonstrates that there is a 4.51 percentage point difference in racial and ethnic disparity for African American members keeping their 7-day follow up appointment for inpatient psychiatric as compared to the White population served. DWIHN understands the importance of recently psychiatrically hospitalized members continuing outpatient care to improve their health outcomes. During 2021, African Americans were the population with the highest number of hospitalization events for DWIHN and accounted for more than double the events than White individuals, making up most of these hospitalization events. Follow-up after inpatient discharge is important in continuity of care between treatment settings and in ensuring that members receive care and services. Members receiving appropriate follow-up care with a mental health practitioner can reduce risk of repeat hospitalization.

DWIHN has been closely monitoring its hospitalizations as well as working to reduce the number of members needing hospitalization services. DWIHN recognizes that providing follow-up care to patients after psychiatric hospitalization can improve patient outcomes, decrease the likelihood of re-hospitalization and the overall cost of outpatient care. Data has also proven that poor integration of follow-up treatment in the continuum of psychiatric care leaves many individuals, particularly African Americans, with poor-quality of ongoing treatment. Based on a Michigan Health Endowment study, disparities in quality of care exist in all counties and PIHP regions, for most measures. The appropriate and additional interventions that link these individuals in inpatient settings to outpatient follow-up are needed for the reduction of racial disparities with outpatient mental health treatment following psychiatric inpatient admissions. Once these interventions are designed, implemented, examined and improved, DWIHN hopes to improve the health care disparities by implementing culturally and linguistically appropriate services.

Identified Barriers

DWIHN continues to identify challenges in the process and improve outcomes for its members. Identified barriers include the following building blocks of belonging:

- The five crucial building blocks of a sustainable DEI strategy
- The value of training in creating a common language and shared vocabulary
- Strategies for cultivating inclusive leaders.
- How to measure the effectiveness of your efforts

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.

- DWIHN and Clinical Responsible Service Provider (CRSP) collaborate to increase appointment access availability.
- DWIHN and CRSPs working together to improve engagement and utilize creative solutions.
- DWIHN's Crisis Providers and Outpatient providers improving communication and practices to ensure seamless transitions for members transferring levels of care.
- Increase resources and solutions to assist members to get to their appointments.
- Creation of educational materials, advertising resources and increase communication with members.

Practice Guidelines

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

Evaluation of Effectiveness

Clinical Practice Guidelines are intended to provide guidance to practitioners on common behavior health disorders. The purpose is to provide evidence-based recommendations to assist clinicians in ensuring that individuals served receive appropriate screening, assessment, treatment, and care for common psychiatric and behavioral health disorders. This includes appropriate diagnosis; treatment recommendations and services appropriate to meet the individuals need. These guidelines are intended to be used as guidance and should not replace clinical judgment.

DWIHN will ensure that guidelines are followed by monitoring its provider network through clinical, quality, compliance, and utilization management oversight to ensure that no harm is caused to the person served when implementing clinical practice guidelines. DWIHN will also ensure that use of these guidelines be based on medical necessity criteria, clinical appropriateness, and utilized in the least restrictive setting when and where appropriate.

Identified Barriers

The noted barriers to implementing clinical practice guidelines is the time it takes to review the material of the guidelines. Practitioners may lack time to review practice guidelines based on high caseloads, documentation requirements other organizational level training requirements. An opportunity to improve this barrier, would be for each organization to adopt one to two guidelines and research the latest publication by a credible source. This will not only support the requirement that the PIHP show evidence that guidelines were developed with provider feedback, but it will also give the practitioner an opportunity to research evidence-based practices that are beneficial to service delivery.

Opportunities for Improvement

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

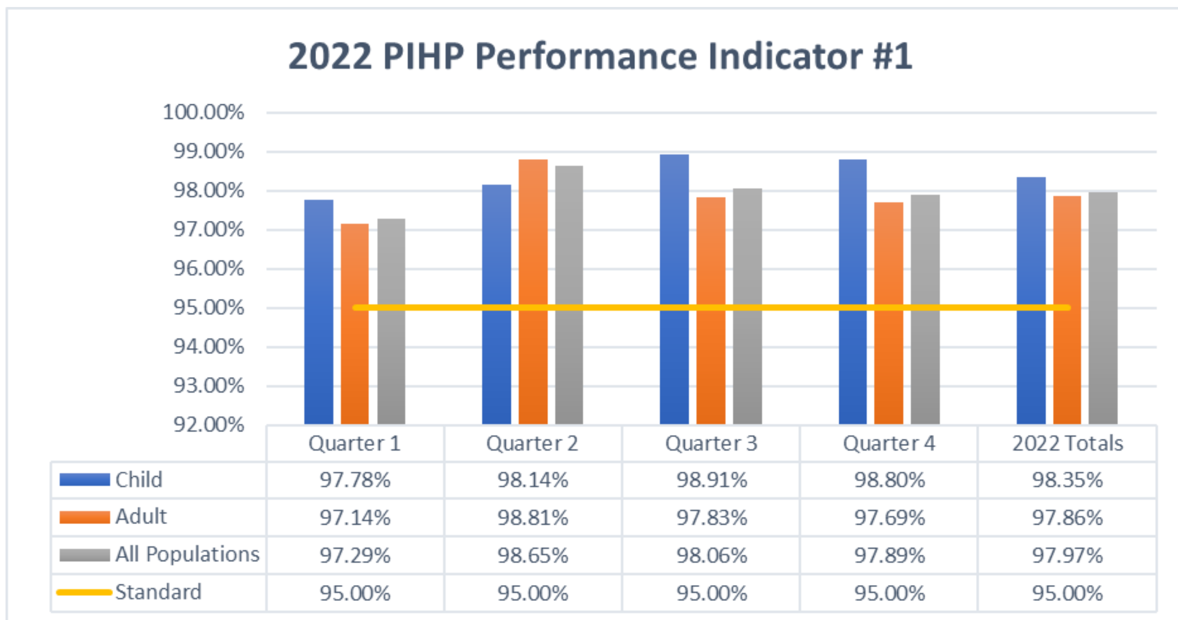
Access Pillar

The Michigan Mission Based Performance Indicators data are a way of measuring how well DWIHN is helping the people we serve by meeting standards of care like timeliness; by reducing problems like hospitalizations; or by helping people improve their lives in other ways. There are five indicators that have been established by Michigan Department of Health and Human Services (MDHHS) that are the responsibility of the Pre-Paid Inpatient Health Plan (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 indicators in which there are no established standard/benchmark set by MDHHS.

Mission Michigan Based Performance Indictors (MMBPI)

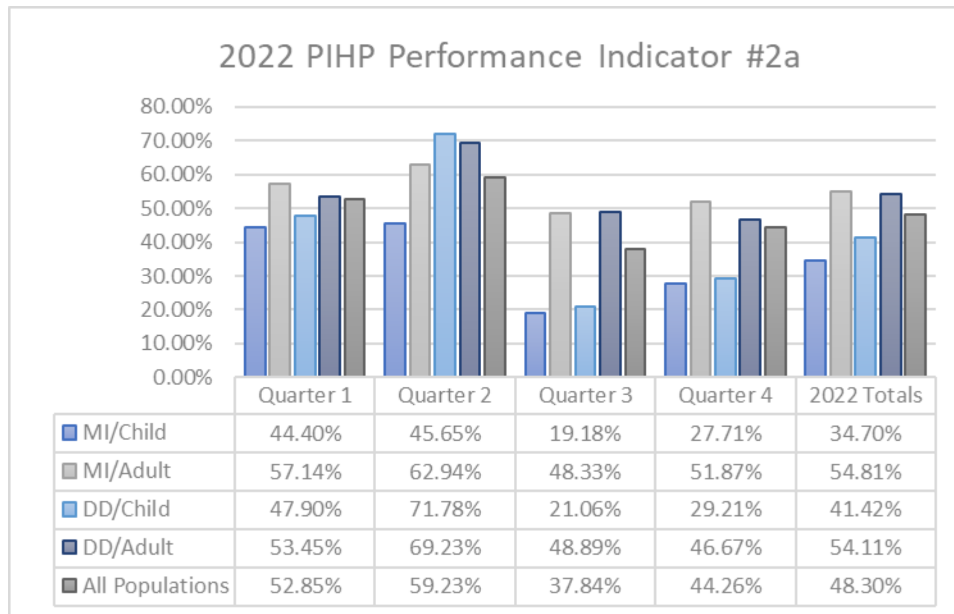
Qualitative Analysis and Trending of Measures

The percentage of persons during 2022 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:** FY2022 standard met for all populations. Total population rate (97.97%).



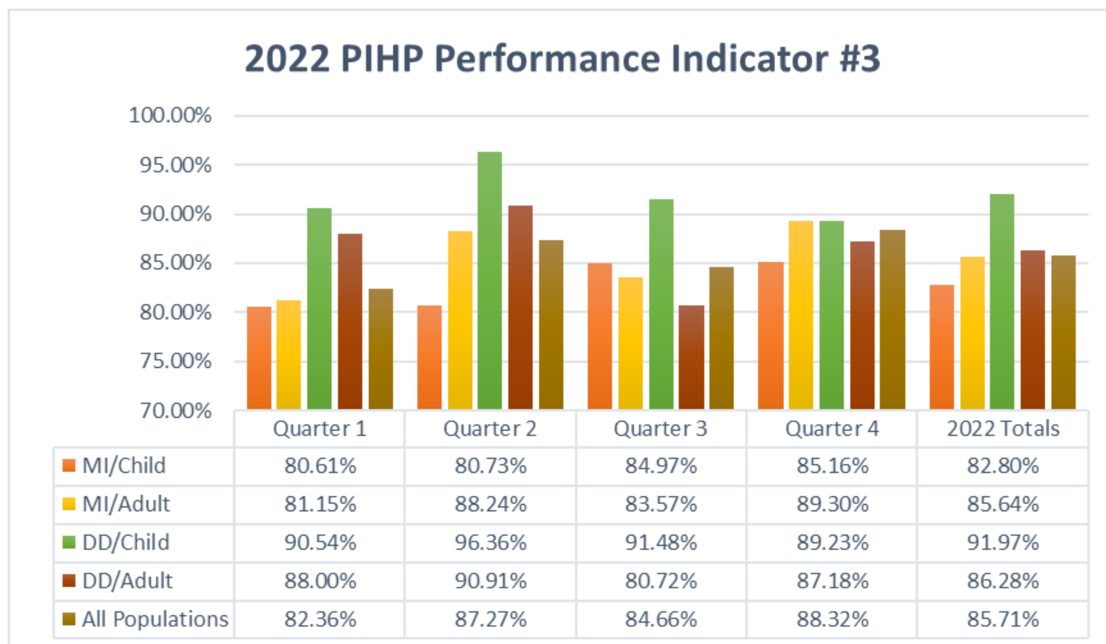
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2022 Totals
Child	97.78%	98.14%	98.91%	98.80%	98.35%
Adult	97.14%	98.81%	97.83%	97.69%	97.86%
All Populations	97.29%	98.65%	98.06%	97.89%	97.97%
Standard	95.00%	95.00%	95.00%	95.00%	95.00%

The percentage of persons during FY 2022 receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service. This measure allows for no exceptions. MDHHS has not established a minimum threshold for this measure. **Results**: Q1(52.85%), Q2 (59.23%), Q3 (37.84%) and Q4 (44.26%). Total population rate (48.30%).



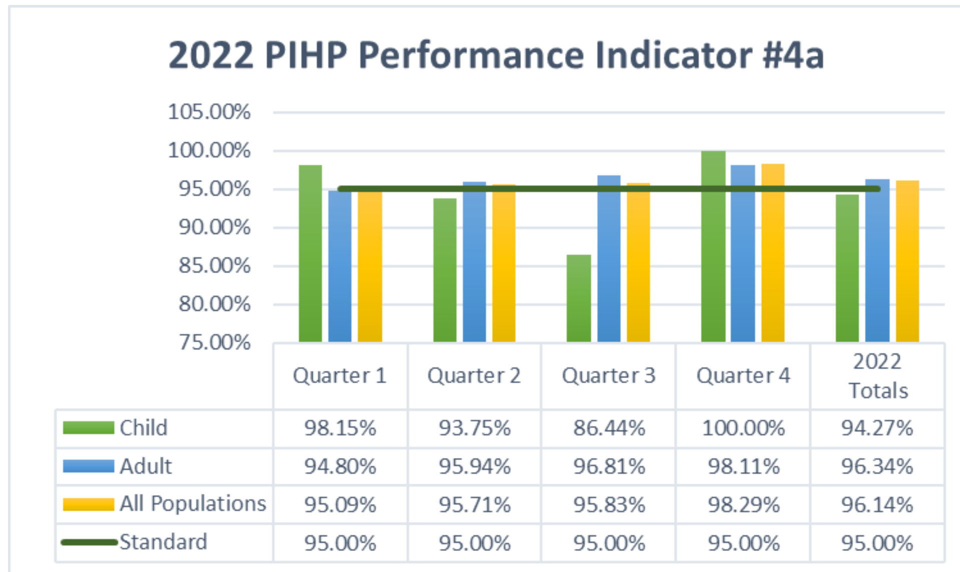
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2022 Totals
MI/Child	44.40%	45.65%	19.18%	27.71%	34.70%
MI/Adult	57.14%	62.94%	48.33%	51.87%	54.81%
DD/Child	47.90%	71.78%	21.06%	29.21%	41.42%
DD/Adult	53.45%	69.23%	48.89%	46.67%	54.11%
All Populations	52.85%	59.23%	37.84%	44.26%	48.30%

The percentage of persons during FY 2022 needed on-going service within 14 days of a completed non-emergent biopsychosocial assessment. This measure allows for no exceptions. MDHHS has not established a minimum threshold for this measure. **Results:** Q1(82.36%), Q2 (87.27%), Q3 (84.66%) and Q4 (88.32%). Total population rate (85.71%).



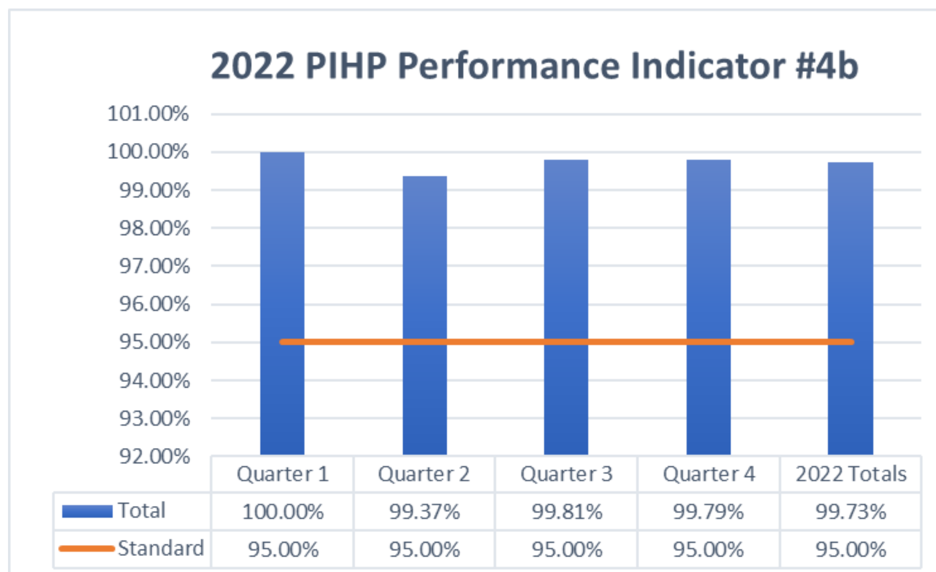
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2022 Totals
MI/Child	80.61%	80.73%	84.97%	85.16%	82.80%
MI/Adult	81.15%	88.24%	83.57%	89.30%	85.64%
DD/Child	90.54%	96.36%	91.48%	89.23%	91.97%
DD/Adult	88.00%	90.91%	80.72%	87.18%	86.28%
All Populations	82.36%	87.27%	84.66%	88.32%	85.71%

The percentage of discharges from a psychiatric inpatient unit during FY2022 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**: FY22 standard was not met for the following quarters/populations Q2 Child (93.75%), Q3 Child (86.44%) and Total Child (94.27%) and Q1 Adult (94.80%). Total population rate (96.14%).



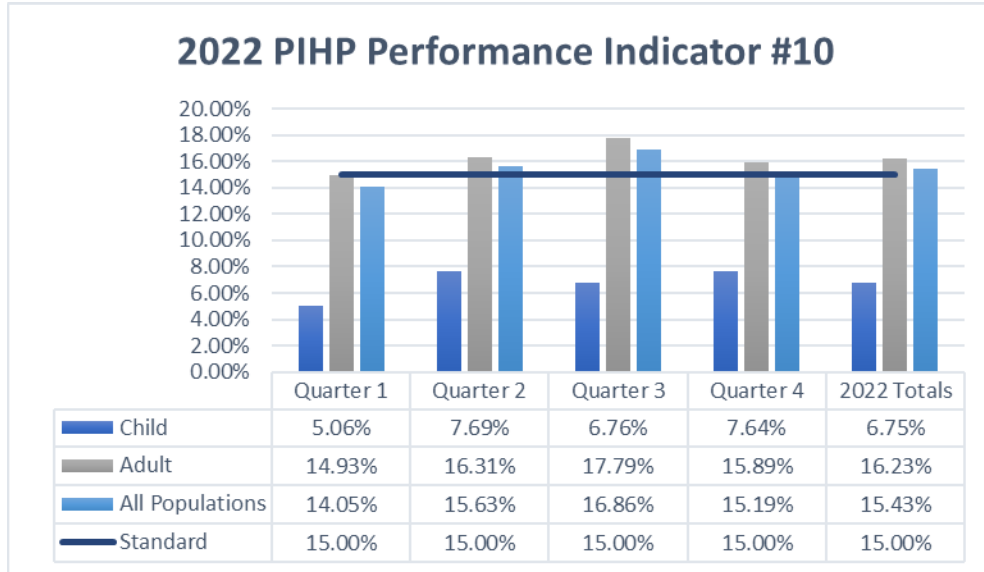
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2022 Totals
Child	98.15%	93.75%	86.44%	100.00%	94.27%
Adult	94.80%	95.94%	96.81%	98.11%	96.34%
All Populations	95.09%	95.71%	95.83%	98.29%	96.14%
Standard	95.00%	95.00%	95.00%	95.00%	95.00%

The percentage of discharges 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 four quarters during FY2022. Standard95%orabove.**Results**: FY2022 standard met for all 4 quarters. Total rate (99.73%).



	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2022 Totals
Total	100.00%	99.37%	99.81%	99.79%	99.73%
Standard	95.00%	95.00%	95.00%	95.00%	95.00%

The percentage of readmissions of children and adults during FY 2022 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 15% or below. **Results:** FY2022 standard met for the children population. Standard not met for the adult population for three out of four quarters Q2 (16.31%), Q3 (17.79%), Q4 (15.89%). Total population rate (15.43%).



Evaluation of Effectiveness

The results below show that the initiatives and interventions that were implemented in FY2021 were generally effective in reducing recidivism rates. In FY2022, the total number of Crisis Alerts received for the year was 269. The diversion rate for these alerts received was 55%, which positively impacted the recidivism rate. Also, as displayed in the table below, DWIHN's Recidivism Workgroups, led by DWIHN Crisis/Access team and includes our Clinically Responsible Service Providers (CRSP), have led to a decrease with the adult recidivism rate from 17.94% during Quarter 1 in FY2021 to 15.89% for Quarter 4 for FY2022, with a total population rate of 15.19%. The threshold for PI# 10 is 15% or less.

Indicator 10: Percentage who had a Re-Admission to Psychiatric Unit within 30 Days	Population	2021				2022			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Children	8.94%	12.03%	6.76%	8.22%	5.06%	7.69%	6.76%	7.64%
	Adults	17.94%	17.34%	17.03%	15.01%	14.93%	16.31%	17.79%	15.89%
	Total	17.12%	16.97%	16.23%	14.51%	14.05%	15.63%	16.86%	15.19%

DWIHN met the standards for PI#1 (Children & Adults), PI#4a (Adult), 4b (SUD) and PI#10 (Children) during FY22. 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. DWIHN demonstrated an 6.75% 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 PI#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 during Quarter 2 (93.75%) and Quarter 3 (86.44%). Root Cause Analysis (RCA) were requested from four CRSPs during these two quarters where the 95% MDHHS standard was not met. One CRSP reported lack of documentation to determine the outcome of the appointments. They reported that they would be increasing their monitoring efforts and implement a tool to track the data. The second CRSP reported DWIHN's Call Center incorrectly placed the members in the wrong appointment slots and members had to be reassigned. This was discussed with the Call Center and rectified. The third CRSP trained its administration on its scheduling process and restructured staff alignment to improve its reporting. The last CRSP also slightly restructured its processes and made one clinician primarily responsible for the hospital discharge appointments. An additional intervention during FY2022 was individual 30-45 Day meetings with all DWIHN's CRSPs. During each of these meetings, each providers PI#4a data was shared and discussed.

PI#4a for adults did not meet the 95% standard during Q1 of 2022 (94.80%). RCAs were requested from three CRSPs. The majority of the out of compliance events were assigned to two of the CRSPs. One CRSP was in the middle of a merger with another large CRSP and there were challenges with the integration of the two electronic systems. The second CRSP reported staff were rescheduling members outside of the timeframe and completed re-training of staff on this standard. Following Q1, the adult population for PI#4a met the standard for Q2, Q3 and Q4.

Data Analysis

- PI#1 - The adult rate was 97.69% for Q4 (95% standard), an increase of 0.55 percentage points from Q1 (97.14%).
- PI#1's - All populations rate for Q4 was 97.89% (95% standard), an increase 0.60 percentage points from Q1 (97.29%).
- PI#10 - The adult rate was 15.89% for Q4 (15% standard), an increase of 0.96 percentage point from Q1 (14.93%).
- PI#10's - All populations rate for Q4 was 15.19% (15% standard), an increase of 1.14 percentage points from Q1(14.05%).

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. MDHHS has not established a standard for these indicators. The indicators are for persons with mental illness, developmental disabilities, and substance use disorder. During FY2022, the total compliance rates ranged from 37.84% - 59.23% for #2a and 82.36% - 88.32% for #3.

Identified Barriers

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). PI#2a continues to demonstrate low scores. Providers are reporting a staffing shortage of intake workers as well as ongoing staff for members. Appointment meetings with DWIHN's clinical team, the Access Center, Quality, and providers' executive leadership have been occurring during all FY2022. These meetings discuss each CRSPs' data. Individual barriers and challenges are discussed with each provider during these meetings.

Other interventions included DWIHN distributing a transportation payment in March 2022 to its CRSP network to assist with member transportation and a financial incentive for high performing CRSPs for PI#2a, PI#3, PI#4a and PI#10. DWIHN's SED and AMI populations were eligible for this financial incentive. For the IDD population, there was a financial incentive created for PI#2a.

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 and ongoing staff. 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. 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. The 2022 overall rate of 48.30% did show a little improvement from the 44.95% rate in 2021.

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. The 15.43% rate for 2022 showed continued progress from the 16.20% from 2021.

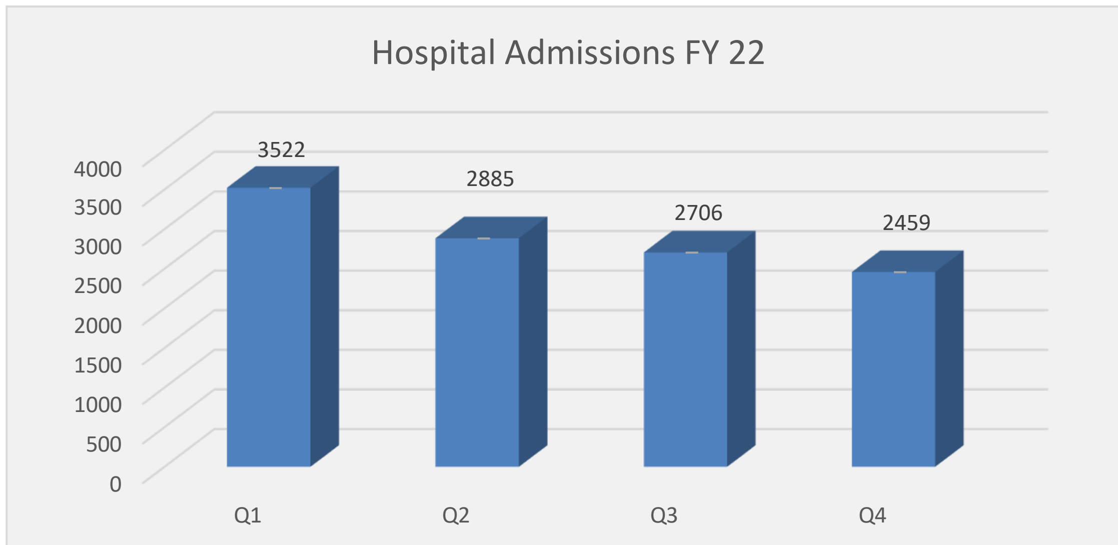
Opportunities for Improvement

DWIHN will continue to focus on utilizing a system for formal tracking 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.

Timeliness of Utilization Management

The role of the Utilization Management (UM) Department is to manage and monitor the utilization of services by members of the Detroit Wayne Integrated Health Network (DWIHN). The department reviews service requests for medical necessity, ensuring appropriateness for an identified level of care. The areas of work include the review of Outpatient Authorization Requests, Acute Inpatient Psychiatric Hospitalization, Partial Hospitalization, Crisis Residential Services, Substance Use Disorder Services, Autism Services, HSW (Habilitation Support Waiver), COFR (County of Financial Responsibility), and General Fund authorization requests.



Quantitative Analysis and Trending of Measures

The chart above indicates the trend of unique members served for each quarter during FY2022. There was a slight increase in the number of unique individuals served in each quarter. To decrease the average length of stay and hospital admissions, the UM department conducts biweekly case conferences with DWIHN's physician consultant to review inpatient admissions with lengths of stay equal to or beyond 14 days, promote treatment in the least restrictive environment and interdepartmental collaboration with Crisis Services, Residential, Quality, and Integrated Care. UM, leadership has also implemented weekly meetings with the staff that manages Stonecrest. This provider typically admits members who require longer admissions due to their severe presentation and higher acuity. Additional supervision is being provided to support staff and ensure members are receiving care that meets their needs and when clinically appropriate, step back into the community with services and support to continue their recovery.

There were 1,799 authorizations manually approved by the UM department. This number is reflective of non-SUD, non-ASD, nonurgent pre-service authorizations. Of these 1,799 authorizations, 1,522 (or 85%) were approved within 14 days of request; 244 (or 13.9%) were approved within 21 days of request; 33 (or 1.8%) were approved within 28 days; and none were approved beyond 28 days.

Alternative Levels of Care

Continued service provision during the COVID-19 pandemic has resulted in decreased unit capacity, units dedicated to individuals who test positive for COVID, and staff testing to ensure the health and safety of the consumers. The Crisis Residential Units provide a short-term alternative to inpatient psychiatric services for individuals experiencing an acute psychiatric crisis. Services are designed for a subset of individuals who meet psychiatric inpatient admission criteria or are at risk of admission, but who can be appropriately served in settings less intensive than a hospital. This level of care has continued to be an integral part of our treatment and service provision to our members.

Partial Hospital is a cost-effective diversion and alternative to inpatient hospitalization, as clinically appropriate. It offers a structured treatment setting, inclusive of individual and group therapy, psychoeducation, skill-building practice, and periodic evaluations but allows for the individual to return home.

Identified Barriers

The noted barriers include Improving hospital collaboration that will ensure positive rapport building and collaborative working relationships with inpatient psychiatric hospital and improving the Discharge Planning process with Crisis Services and Access Teams to ensure appropriate and supportive discharge plans for members, as well as to assist with reducing recidivism and over-utilization of higher levels of care.

Opportunities for Improvement

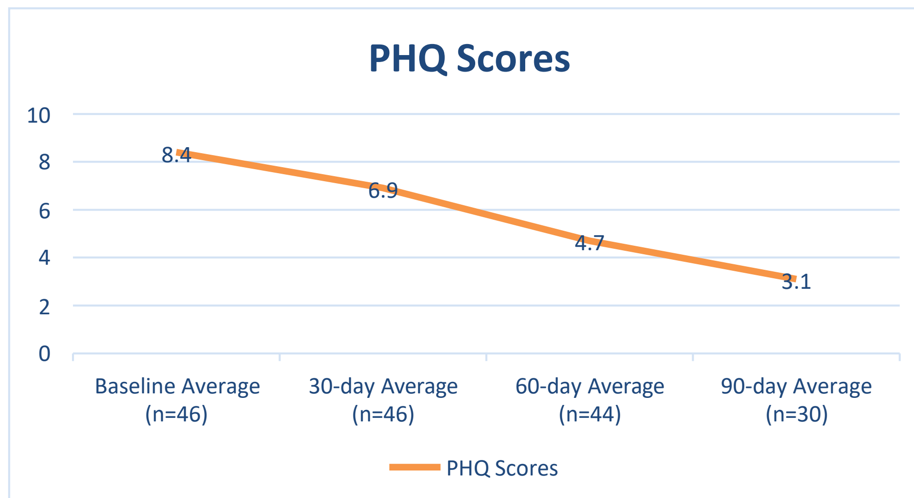
- Implementation of ongoing Authorization, Code, and Modifier training for Provider Network
- Expansion of Electronic Review Process to Crisis Residential and Partial Hospital providers
- Continued implementation of updates to current processes and procedures that reflect 42 CFR requirements including oral notification of members, use of extension letters for decision timeframes, updated language in Adverse/Adequate Benefit Determinations, ongoing staff training to support departmental changes.
- Continued cross-training of Clinical Specialists
- Development and Implementation of a Hospital UM Provider Meeting that will convene regularly to ensure positive rapport building and collaborative working relationships with inpatient psychiatric hospital UM Teams.
- Development and Implementation of a collaborative Discharge Planning process with Crisis Services and Access Teams to ensure appropriate and supportive discharge plans for members, as well as to assist with reducing recidivism and over-utilization of higher levels of care.

Complex Case Management (CCM)

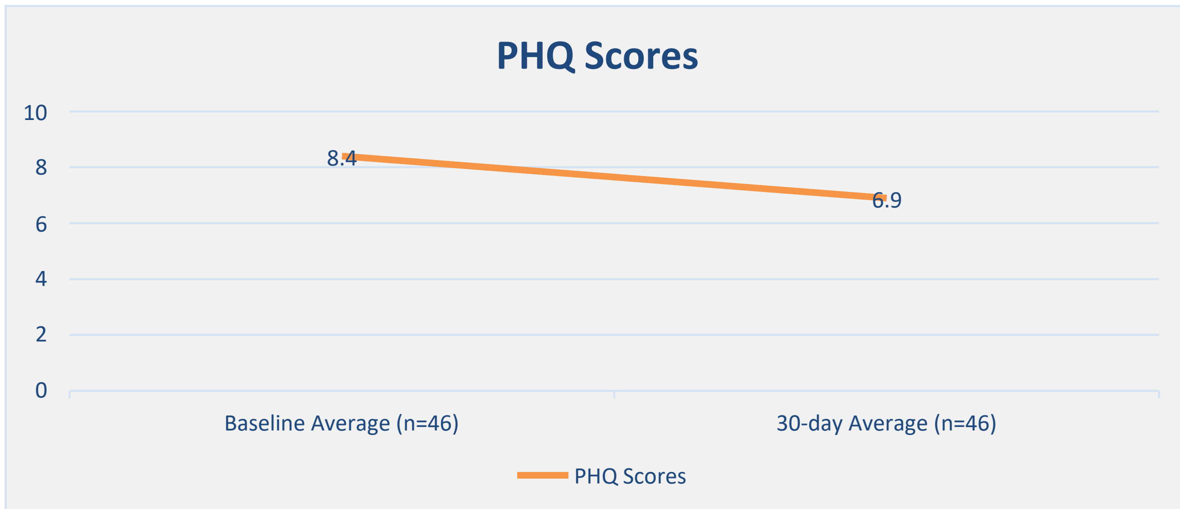
DWIHN utilizes various tools to measure effectiveness of the CCM program and ensure that outcomes are being improved for members served. DWIHN utilizes the evidenced-based assessment tools PHQ-9, PHQ- A, and WHO-DAS. These tools are embedded in the assessment that is completed upon the start of CCM services and every 30 days thereafter that the member is receiving CCM services. DWIHN also analyzes members utilization of Emergency Department and Hospital Admission data prior to and after starting CCM services, as well as utilization of out-patient services after starting CCM services. DWIHN also offers a Satisfaction Survey to all members upon closure of CCM services.

Qualitative Analysis and Trending of Measures

In FY2022, 74 members were enrolled in CCM services. 66 members were enrolled in CCM for at least 60 days and 65 members were enrolled in CCM for at least 90 days during FY2022. During FY2022, 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. PHQ scores were evaluated for members at closure who were open for at least 90 days in the CCM Program during FY2022. Members PHQ baseline scores ranged from 0 to 18, with an average score of 8.4. Members participating in Complex Case Management services demonstrated overall improvement in their PHQ scores, and the improvement increased the longer that the members participated in CCM services. As illustrated in the chart below, the average PHQ scores improved 18% from baseline at 30 days, 31% at 60 days and 34% at 90 days of receiving CCM services.



The averages of members' initial PHQ scores were also evaluated with their 30-day PHQ scores to see if there were any improvements within the first 30 days of starting CCM Services. 46 out of 60 members were included in this measure for the PHQ scores. 9 members were excluded due to not being open for 90 days and 19 members were excluded due to cases being active at and after the end of FY2022 (after 9/30/2022). The average decreased from baseline to 30 days, showing an improvement in PHQ scores within the first 30 days of starting CCM Services.



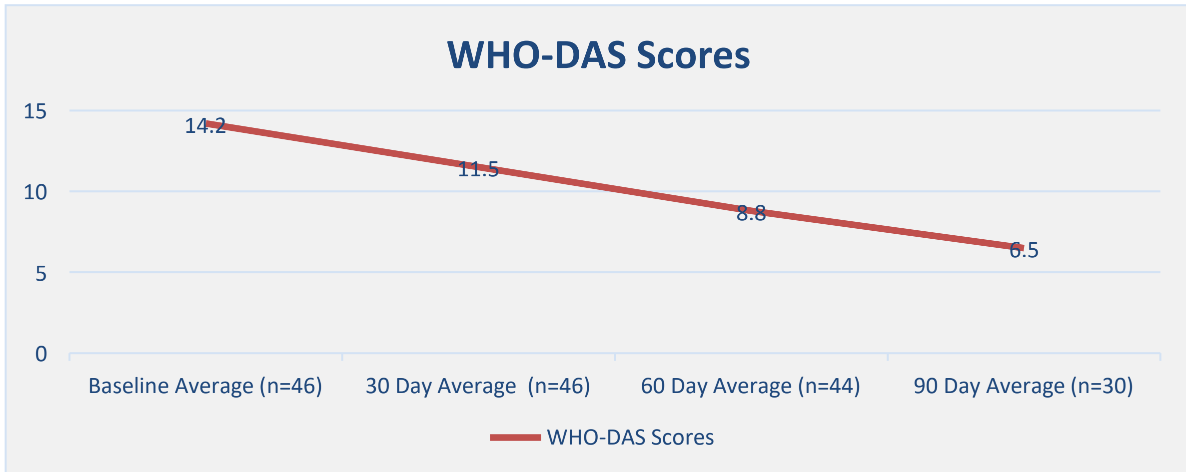
Causal Analysis

Although we met and exceeded our goal of an overall 10% improvement in PHQ scores, we will continue to monitor this measure in 2023 to assess if the improvement has been consistent over a sufficient time to either significantly increase the goal or retire this goal. Overall members who stayed in CCM even for just 30 days saw a significant improvement in their scores. There was a 44% improvement in 90-day PHQ scores from FY2022 in comparison to 90-day PHQ scores in FY2021. We are evaluating interventions that can continue to help us achieve our goal. Out of 46 members, four members did not show an improvement and had an increase in PHQ scores from baseline to the time that CCM services were ended. Two of the three members had continued high hospital admission utilization rates. One of the three members had the barrier of elopement and was difficult to reach while participating in CCM services. One-member scores remained the same and showed no change. The interventions that we believe helped us to meet and exceed our goal were connecting members to behavioral health providers, assisting with appointment scheduling, and assisting with arranging transportation as needed. To continue to promote an improvement in PHQ scores, CCM will review, and update Crisis Plans with members and existing care team after hospitalization and will also encourage a connection with Members and Peer Support Specialists as an added support in 2023.

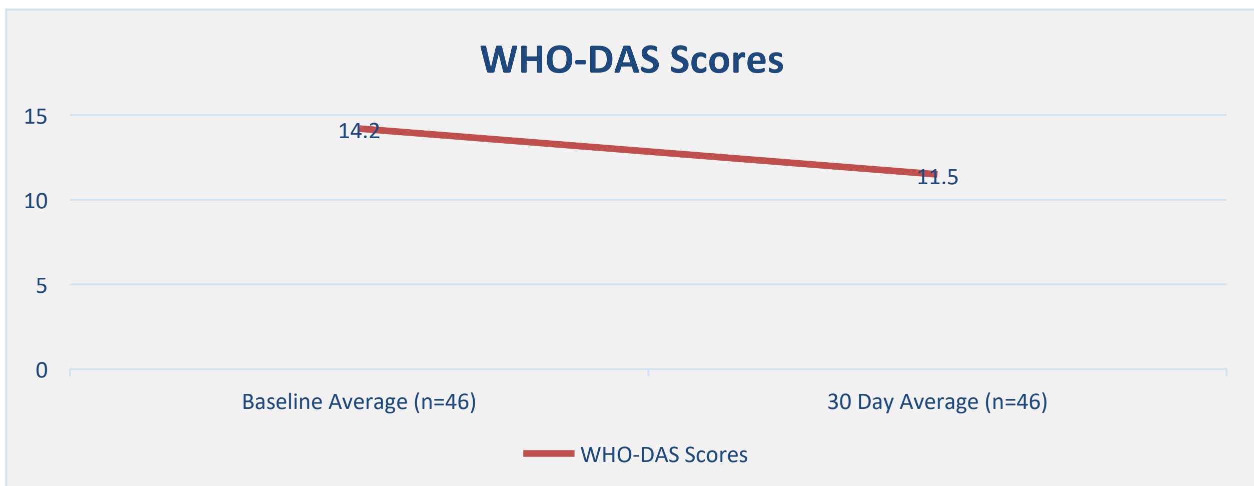
WHO DAS Scores

During Fiscal Year 2022, information was gathered to assess member quality of life using the World Health Organization's Disability Assessment Schedule (WHO-DAS). The WHO-DAS assessment is embedded in the CCM assessment and is 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 WHO-DAS, the greater the level of disability. The WHO-DAS assesses six domains: cognition, mobility, self-care, getting along with others, life activities and participation. Practitioners must be trained to administer this assessment. A decrease in WHO-DAS score indicates an improvement in level of disability. WHO-DAS 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. WHO-DAS scores were evaluated at closure for members who were open for at least 90 days in the CCM Program.

Members WHO-DAS baseline scores ranged from 8 to 41, with an average score of 14.2. Members participating in Complex Case Management services demonstrated overall improvement in their WHO-DAS scores, and the improvement increased the longer that the members participated in CCM services. Average WHO-DAS scores showed improvement from baseline to 30 days of receiving CCM services. As illustrated in the chart below, the average WHO-DAS scores improved 19% from baseline at 30 days, 23% at 60 days and 26% at 90 days of participating in CCM services.



The chart below presents 46 out of 60 members who were included in the denominator for the baseline WHO-DAS scores. 9 members were not included in the denominator due to the case not being opened for 90 days. 19-member cases were active at and after the end of FY2022 (after 9/30/2022). 45/46 members (97%) met the goal of having a 10% improvement in WHO-DAS scores from the start of CCM services to the closure of CCM services. The averages of members' initial WHO-DAS scores were also evaluated with their 30-day WHO-DAS scores to see if there were an improvement within the first 30 days of starting CCM Services. 46 out of 60 members were included in the denominator for WHO-DAS scores 9 members were not included in the denominator due to the case not being opened for 90 days. 19-member cases were active at and after the end of FY2022 (after 9/30/2022). The average decreased from baseline to 30 days, showing an improvement in WHO-DAS scores within the first 30 days of starting CCM Services.

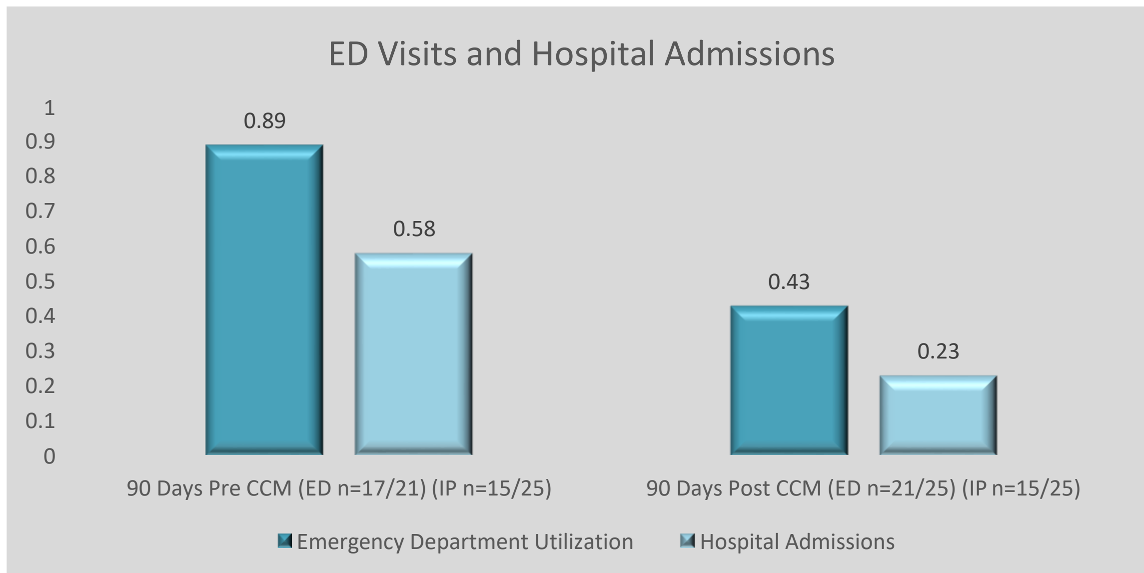


Causal Analysis

Although we met and exceeded our goal of an overall 10% improvement in WHO-DAS scores, we will continue to monitor this measure in FY2023 to see if the improvements are consistent over a long period of time and whether goal will be increased, changed or this goal retired. We are seeing a correlation between the time in CCM and a decrease in WHO-DAS score and that members had to be in CCM at least 60 days to achieve our current goal. We are evaluating interventions that could help us to continue to achieve our goal in 2023. There was a 34% improvement in 90-day WHO-DAS scores from FY2022 in comparison to 90-day WHO-DAS scores in FY2021. Out of 46 members, 45 members showed an improvement in WHO-DAS scores from baseline to the time that CCM services were ended. One-member scores remained the same and showed no change. Interventions that helped in reaching our goal were assisting members with obtaining services in their home and community as needed and encouraging participation in activities outside of the home. To promote an improvement in member WHO-DAS scores, CCM will continue to discuss added supports in the home with members. If a member shows a consistent increase in WHO-DAS scores, CCM will assess and assist members with becoming established with added home supports such as Physical Therapy, CLS Services, Occupational Therapy, and Adaptive Aids (Durable Medical Equipment). CCM will also assist with transitioning members to higher levels of care if need is identified.

Emergency Department Utilization and Hospital Admissions

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 at closure in FY 2022. Members participating in CCM services showed an average 50% reduction in Emergency Department utilization and average 60% reduction in Hospital Admissions from 90 days prior to 90 days after starting CCM services. Members had an average of 0.89 Emergency Department visits and .58 Hospital admissions during the 90 days prior to receiving CCM services and had an average of .43 Emergency Department visits and 0.23 Hospital admissions during the 90 days after starting CCM services.



Out of 74 active cases, 19 members were not included in the denominator due to their CCM cases still being active and closing after October 2022 at the time of the review. 7 members were not included in the denominator due to their CCM cases not having been open for 60 days at the time of the review. 27 members were not included in the denominator due to not having any Emergency Department visits within 90 days prior to or 90 days after starting CCM services. 17/21 (80%) of members met the goal of experiencing a 10% decrease in the number of Emergency Department visits from 90 days prior to 90 days after starting CCM services. 2 members showed no changes in ED visits and 2 members showed an increase in ED visits.

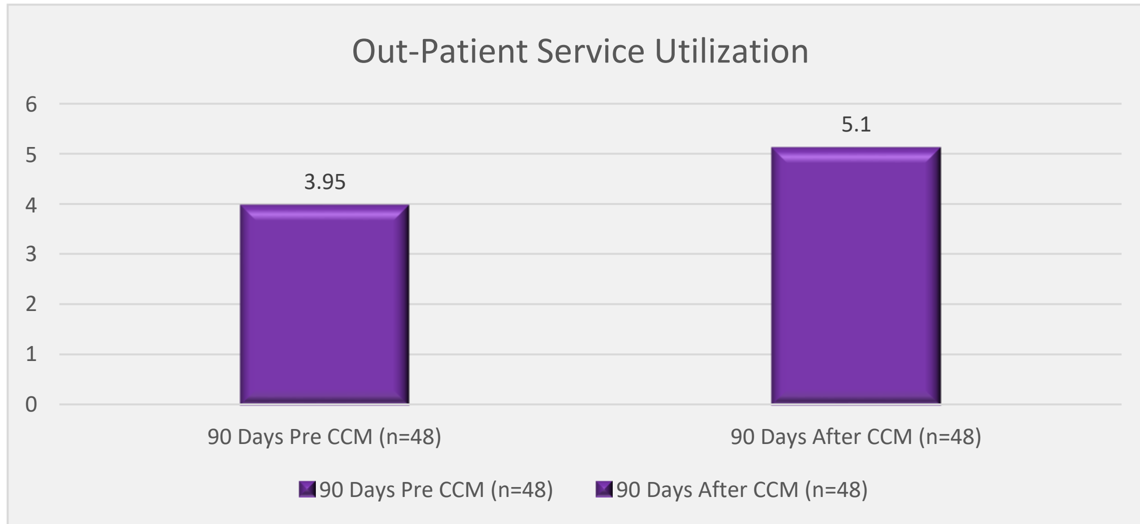
Out of 74 active cases, 19 members were not included in the denominator due to their CCM cases still being active and closing after October 2022 at the time of the review. 25 members were included in the denominator for inpatient hospitalizations. 7 members were not included in the denominator due to their CCM cases not having been open for 60 days at the time of the review. 23 members were not included in the denominator due to not having inpatient hospitalizations within 90 days prior to or 90 days after starting CCM services. 15/25 (60%) of members met the goal of experiencing at least a 10% decrease in inpatient hospitalizations from 90 days prior to 90 days after starting CCM services.

Causal Analysis

Although there was a slight increase in Emergency Department Utilization, we experienced a decrease in Hospital Admissions during FY22. We will continue to monitor these measures in 2023 to see if we see improvements in these measures. 2 members out of 21 experienced an increase in Emergency Department visits within 90 days prior to or 90 days after starting CCM services. 2 members experienced no change in Emergency Department visits from 90 days prior to receiving CCM services to 90 days after starting CCM services. 5 members out of 25 experienced an increase in Hospital Admissions from 90 days prior to receiving CCM services to 90 days after starting CCM services. 5 members experienced no change in Hospital Admissions visits from 90 days prior to receiving CCM services to 90 days after starting CCM services. We are evaluating interventions that could help us improve and achieve our goal. Interventions that we have employed are connecting members with behavioral health providers, assisting with appointment scheduling, and transition of care calls for members discharged from an inpatient admission. In order to promote a continued reduction of emergency room and inpatient admissions for members, CCM will review, and update Crisis Plans with members and existing care team after hospitalization. CCM will continue to work with members to ensure member is receiving the appropriate community supports, and connect if higher levels of care are needed (ex ACT Programs, Home Health Care, or other Care Management). CCM will provide member, member's staff and/or family member with numbers to mobile crisis service units/crisis intervention services and provide education on how MCU's can provide support and possible deflection.

Utilization of Out-patient Services

DWIHN analyzed members claims data for out-patient behavioral health service utilization 90 days prior to participating in CCM services and 90 days after starting CCM services for members who were enrolled in CCM for at least 60 days or more at closure. The average number of out-patient behavioral health services during the 90 days prior to CCM services was 3.95 and the average number of out-patient behavioral health services after starting CCM services was 5.1, which amounts to a 29% increase in out-patient services utilization in the 90 days post CCM closure.



DWIHN also measured the number of members who attended two out-patient behavioral health services within 60 days of starting CCM services who were in CCM for at least 60 days and closed by October 2022. Out of 48 members that were available to participate in 2 out-patient services after starting CCM services and were in CCM for at least 60 days, 36 members (75%) attended two or more out-patient behavioral health services within 60 days of starting CCM services. Seven members were not included in this measure due to not being enrolled in CCM services for 60 days at the time of the report. 19 members were not included in the denominator due to their CCM cases still being active and closing after October 2022 at the time of the review.

In addition, DWIHN measured the number of members who attended two out-patient behavioral health services within 60 days of the closure CCM services. Out of 48 members that were available to participate in 2 out-patient services after CCM case closure, 36 members (75%) attended two or more out-patient behavioral health services within 60 days of CCM case closure. Seven members were not included in this measure due to not being enrolled in CCM services for 60 days at the time of the report. 19 members were not included in the denominator due to their CCM cases still being active and closing after October 2022 at the time of the review.

Causal Analysis

For FY22, we did not meet the goal of an overall 10% improvement in Outpatient Behavioral Health Visit attendance, we will continue to monitor this measure in 2023. Comparing FY 2021 data with FY 2022 data there was an 18% decrease in this measure. We are evaluating additional interventions that could help us achieve our goal. 14 out of 45 members experienced a decrease in Outpatient visits within 90 days prior to or 90 days after starting CCM services. 7 members experienced no change in in Outpatient visits from 90 days prior to receiving CCM services to 90 days after starting CCM services.

DWIHN did not exceeded our goal of 10% increase in participation of two or more behavioral health services with 60-days of starting CCM services. As this is a new measure that was created in FY2021, we will continue to monitor this measure in FY 2023. 12 out of 48 members did not make the goal of attending two or more Outpatient visits within the first 60 days after starting CCM services. Some interventions that were to be utilized in FY 2022 and will continue to be utilized in FY2023 is to continue to address barriers to attendance but to do this at each discussion with member and to ensure that the provider is meeting the needs of the member and is a good match for the member and that it is emphasized with member how important attending Outpatient Appointments are in overall care. We will also continue connecting with Behavioral Health Service Providers, providing reminders to member and assistance with arranging transportation when needed.

Opportunities for Improvement

DWIHN will utilize some of the following interventions to reduce Emergency Department Utilization/Inpatient Admits and increase Outpatient Appointment Attendance:

- Increase communication with Hospital Liaisons to bridge the gap between Hospital Social Workers and ensure adequate discharge planning for members.
- Continue to coordinate with member Case Manager/Supports Coordinator for appointment reminders and address member barriers.
- Complex Case Managers will work with members to schedule follow up with Primary Care Physicians to manage any comorbidities as well as Behavioral Health Providers after every inpatient admit.
- Complex Case Managers will continue to send out the importance of attending Outpatient visits literature after closure and contact the member and CRSP 30 days after case closes to assist with any barriers to attending treatment.
- Before CCM closure and up to 2 months after closure date, Complex Case Managers will work with CRSP staff members to schedule out members appointments (Psychiatrist, Therapist, Nurse Practitioner, Case Manager) to increase Outpatient participation.
- Complex Case Managers will keep some members open 30 days after closure for Care Coordination to increase Outpatient utilization and decrease Inpatient utilization. Members will be reassessed after 30 days, and Care Coordination may be extended another 30 days up to 60 days after CCM closure date.
- Complex Case Managers will present any members that has high recidivism rates and low Outpatient attendance to the Outcomes Improvement Meeting Committee. This Committee is composed of Clinicians and Doctors working in different specialties to provide consultation to support staff on member related barriers.

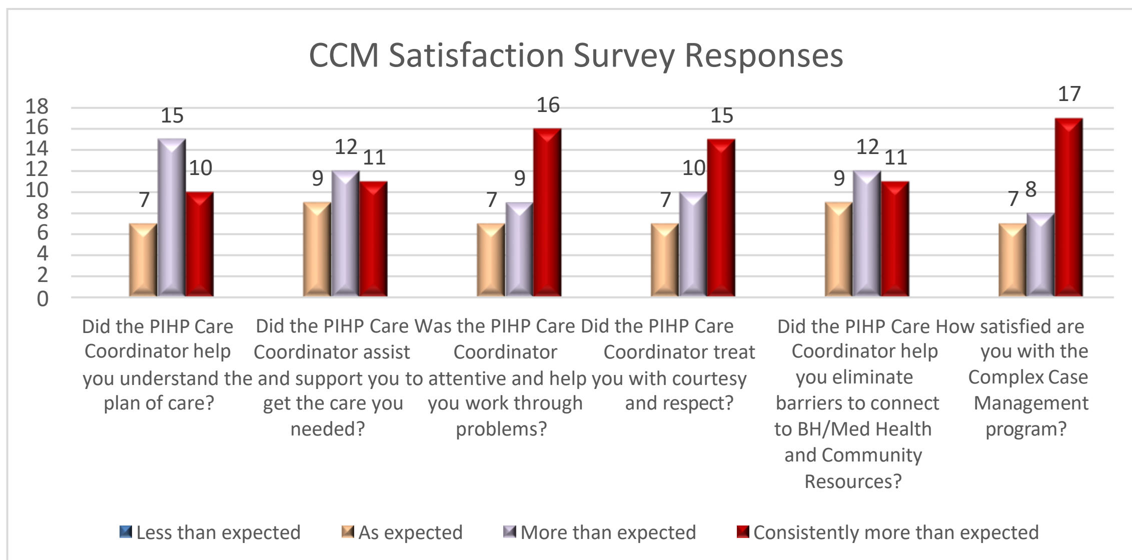
Evaluation of Effectiveness

DWIHN's Complex Case Management Program has been active and developing for the past six years, and for the past 3 years having consistent dedicated staff has assisted with growing the program and more consistency with application and training. With more focus on marketing, networking, and educating the Provider Network we have seen growth in member enrollment with each fiscal year. Additional efforts were focused on following up with members after they graduate/disenroll from Complex Case Management services. Complex Case Management utilizes various resources to proactively engage more members.

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 74 CCM cases opened during FY2022, 58 members had Complex Case Management services closed during FY2022. 32 (55%) Satisfaction Surveys were completed and returned. The goal was to have an 80% satisfaction rate.

No members reported responses of 'Less than expected' to the Survey questions. Six members provided a response of 'As expected' to all questions. All other members provided responses of 'More than expected' and 'Consistently more than expected'. With Less than expected being considered a negative response, the satisfaction rate for all questions were at 100%.

The first question had a 22% response of "As expected", a 47% response of "More than expected", and a 31% response of "Consistently more than expected". The second question had a 28% response of "As expected", a 38% response of "More than expected", and a 34% response of "Consistently more than expected". The third question had a 22% response of "As expected", a 28% response of "More than expected", and a 50% response of "Consistently more than expected". The fourth question had a 22% response of "As expected", a 31% response of "More than expected", and a 47% response of "Consistently more than expected". The fifth question had a 28% response of "As expected", a 38% response of "More than expected", and a 34% response of "Consistently more than expected". The sixth question had a 22% response of "As expected", a 25% response of "More than expected", and a 53% response of "Consistently more than expected".



Causal Analysis

Although we have consistently exceeded the 80% satisfaction goal for the last 4 years, we took a closer look at the response choices on the member satisfaction survey in 2022 and have made the decision to eliminate the more neutral response of as expected and will add another dissatisfaction answer of consistently less than expected to force either a positive or negative response by not offering a neutral response that we have considered to be a positive response this year and in the past. We continue to face challenges with reaching our members due to changed/disconnected phone numbers. Our members contact information may have also changed due to residential moves, homelessness, or higher levels of care which also adds a barrier in successfully contacting members. The rates of return have drastically increased in FY2022 compared to the previous program years. The electronic form of the CCM Satisfaction Survey is launched and being used for FY2023. In addition, DWIHN believes that with more monitoring and outreach to our members we will have more returns to evaluate for FY2023.

The results of the FY2022 analysis of CCM services can be compared to the results of analysis completed for FY2021 and FY2020. Comparisons can be made in the areas of PHQ scores, WHO-DAS scores, hospital admissions, behavioral health engagement, and Satisfaction Survey results. The 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 FY2022 compared to the previous fiscal years. PHQ and WHO-DAS score averages consistently declined the longer members participated in CCM services for all three fiscal years.

Another identified area of improvement identified for FY2021 was the completion of Satisfaction Surveys. While responses to the CCM Satisfaction Surveys that were returned were positive, the return rate increased in FY2022 (55%) from 48% in FY2021 and FY2020. Although we did not make the 60% return rate in 2022, we did have a significant increase in returns compared to the previous fiscal years. DWIHN still would like to increase the return rate to 60% in FY2023.

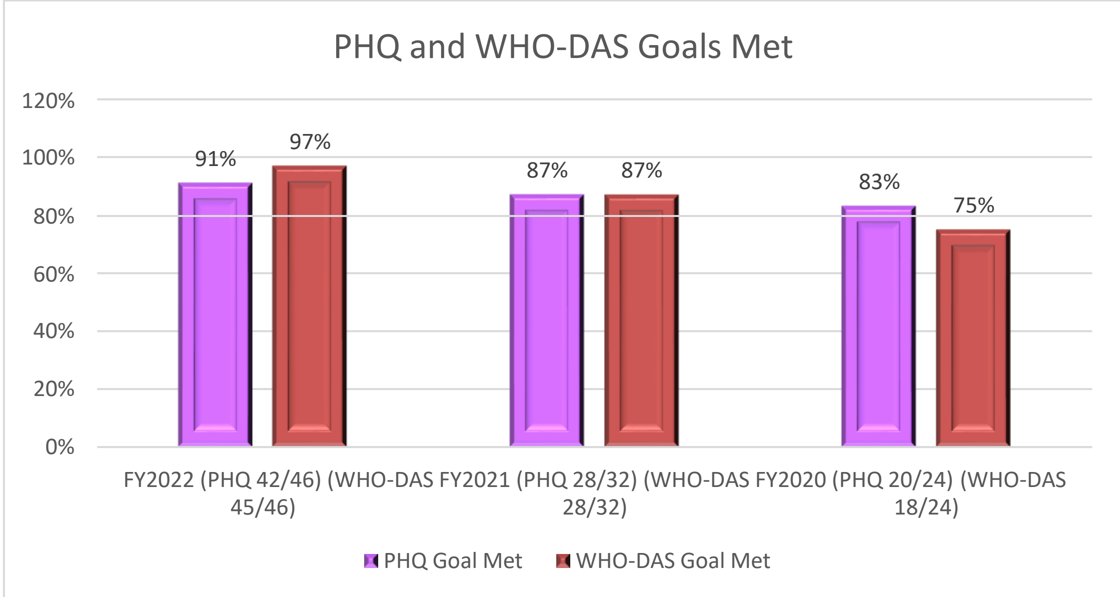
In effort to increase member sustainability and engagement in out-patient behavioral health services after they are no longer receiving CCM services, the percentage of members who engage in at least two out-patient behavioral health services within 60 days of closure of CCM services will continue to be measured. During FY22, Care Coordinators mailed out educational material to members about the benefits of attending Behavioral Health Outpatient appointments within 2-3 weeks after case closure. Care Coordinators also contacted members around 30 days post case closure for follow up to encourage outpatient appointment attendance. 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.

Qualitative Analysis and Trending of Measures

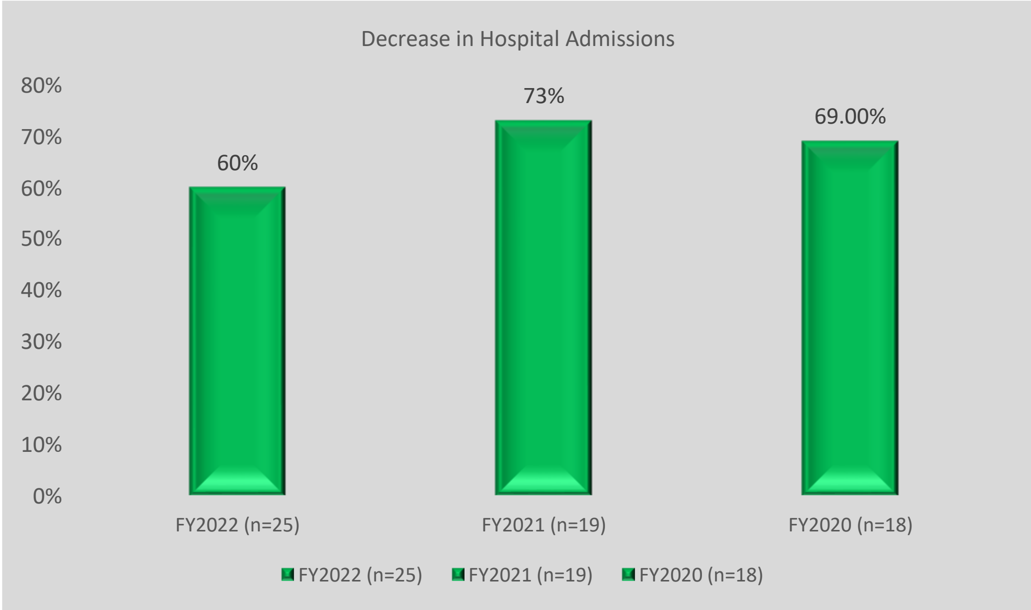
Overall, the percentage of members who met improvement PHQ scores goals were highest in FY2022 at 91%. The percentage decreased in FY2021 with 87% of members who met improvement and decreased in FY2020 with 83% of members meeting improvement. The percentage of members who met improvement WHO-DAS scores goals has gradually increased each fiscal year for the last 3 years. The percentage in FY2020 was 75%, 87% in FY2021, and 97% in FY2022. Majority of CCM members showed improvement in both PHQ and WHO-DAS scores. The scores for both assessments continued to improve for majority of CCM members the longer the duration of program participation. To continue to limit inconsistencies in any assessment data, the Team lead for Complex Case Management will continue to review a sample of assessments completed.
Members showed overall improvement in the areas analyzed to measure effectiveness of, and satisfaction with, the Complex Case Management program during FY2022.

DWIHN strives to continuously improve upon services and the Complex Case Management program is no exception to these efforts. Three areas that DWIHN will focus on improving during FY2023 are in the areas of reduction in Emergency Department utilization, increase in outpatient visits (at 60 days of CCM enrollment, 90 days of CCM enrollment and 60 days post case closure) and reduction of inpatient admissions. Complex Case Management consistently works to make great connections with DWIHN's Clinically Responsible Service Providers (CRSP) as a best practice to provide coordination of care for our members and ensure needs are met. These connections are also vital for fostering program enrollment rates. For FY2023, DWIHN would like to increase Complex Case Management Program enrollment by 20%.

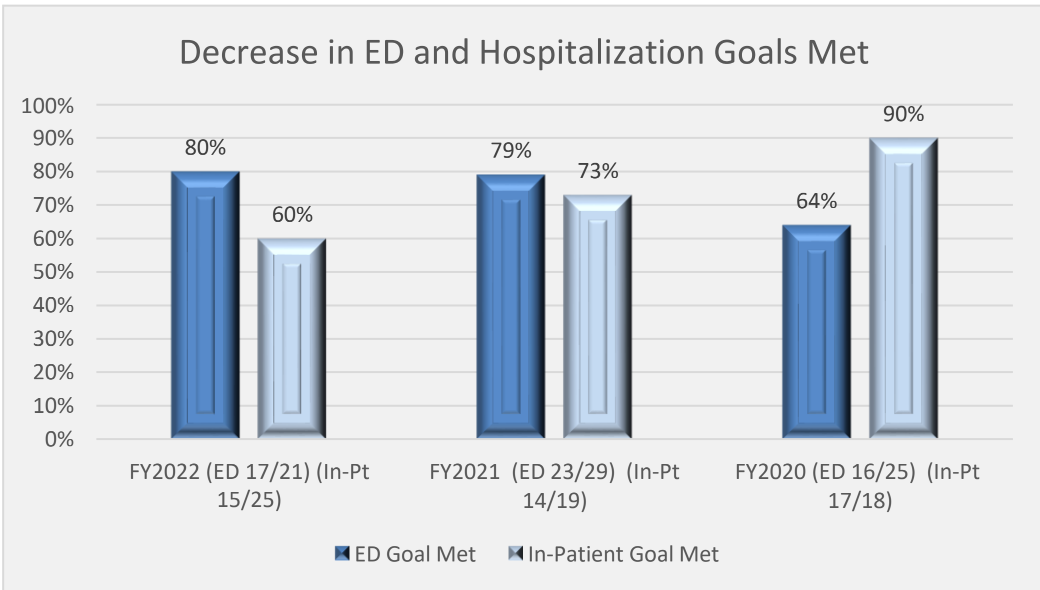
The number of members who met the goal of a 10% reduction in their PHQ and WHO-DAS scores at time of closure from CCM services increased in FY2022 compared to the previous fiscal years.



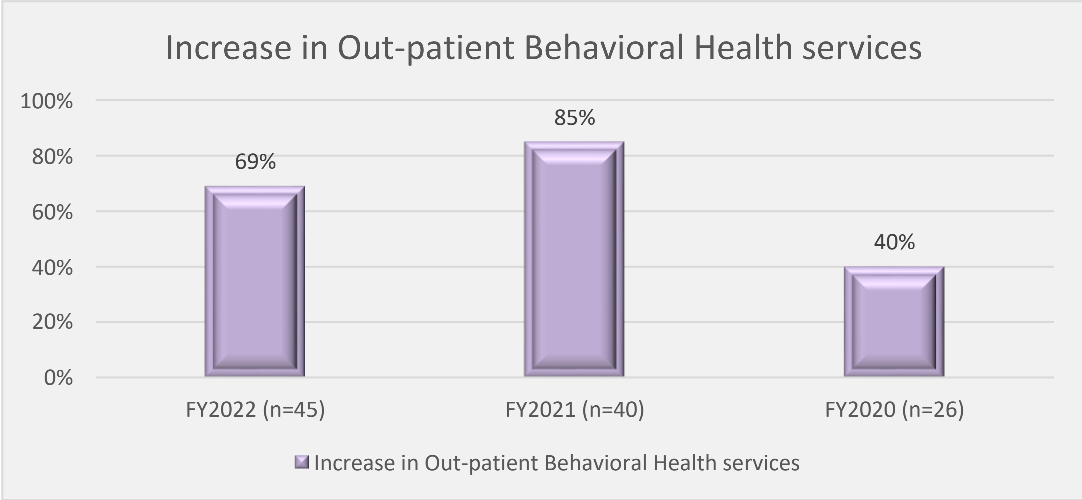
The average percentage of decreased hospital admissions from 90 days prior to starting CCM services to 90 days after starting CCM services decreased from FY2022 to the previous fiscal years, however, the percentage of decrease in hospital admissions was highest in FY2021.



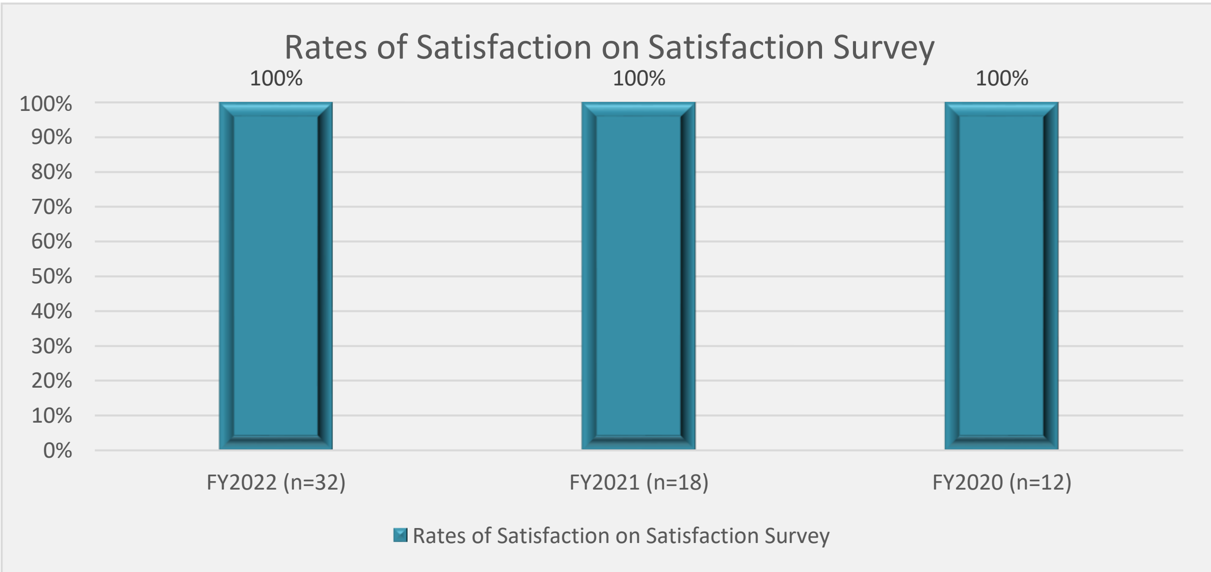
The percentage of members who met the goal of experiencing a 10% decrease in Emergency Department utilization was highest in FY2022. The goal of Emergency Department utilization increased with the passing of each fiscal year. The percentage of members who met the goal of experiencing a 10% decrease in Hospital Admissions was highest in FY2020 compared to previous years. The percentage in FY2022 has decreased from FY2021.



The percentage of members who experienced an increase in out-patient services from 90 days prior to starting CCM services to 90 after starting CCM services decreased from FY2022 to FY2021 but has increased from FY2020.



Members have consistently reported high levels of satisfaction with the CCM program. The rates of return of completed Satisfaction Survey decreased from FY2020 (48%) to FY2021 (38%) but significantly increased in FY2022 (55%) as noted in the charts.



Identified Barriers

The noted barriers across the Provider Network have been less availability of appointments for members due to staffing shortages. There has also been an increase in caseloads for the Care Teams to manage which also causes a decrease in availability for visits. The following interventions has been launched by DWIHN to maintain and increase services for our members:

- Provider incentives were offered across the Network to help with staffing.
- Increased Provider Reimbursement for services
- Added stability payments to Providers.
- The Director of Integrated Care meets with Providers across the network to review Hospital Readmits, FUH 30, and Michigan Based Performance Indicators 7- & 14-day appointment measures
- The Team Wellness Pilot Program has been launched with Team Wellness. It is aimed at reducing Emergency Department Visits, this program is led by The Director of Crisis Services.
- DWIHN Social Worker works with the Detroit Police Department to provide Crisis education to staff and handle non-violent crisis calls.
- DWIHN is opening a new Crisis Center towards the end of 2023 to provide crisis intervention to members and reduce Emergency Department Utilization and Inpatient admits.

Opportunities for Improvement

DWIHN will continue to focus on the following interventions and improvement efforts:

- Improve medical and/or behavioral health concerns and increase overall functional status as well as improve overall quality of life as evidenced by an overall 10% improvement in PHQ scores and an overall 10% improvement in WHO-DAS scores at CCM closure for members enrolled for at least 90 days.
- Provide early intervention for members appropriate for Complex Case Management to prevent recurrent crisis or unnecessary hospitalizations as evidenced by an overall 10% reduction in Emergency Department (ED) utilization and an overall 10% reduction in hospital admissions from 90 days prior to receiving CCM services to 90 days after receiving CCM services for members at closure who were enrolled for at least 60 days.
- Increase participation in attending out-patient appointments as evidenced by an overall 10% increase in out-patient behavioral health services from 90 days prior to receiving CCM services to 90 days after receiving CCM services for members at closure who were enrolled for at least 60 days.
- Improve participation in the number of members who attended two out-patient behavioral health services within 60 days of starting CCM services who were open for at least 60 days and closed as of October 2022 as evidenced by an overall 10% increase in participation.
- Improve 80% or greater member satisfaction scores for members at closure who have received CCM services.
- Continue to place greater emphasis on developing, reviewing, and updating crisis plans with members to reduce utilization of Emergency Department services.
- Continue working with current care team to increase members participation in Follow up after Hospitalization appointments as well as attendance for regular outpatient appointments.
- Continue to offer a $10 Walmart Gift Card to all members who complete and return a CCM Satisfaction Survey.
- 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.
- Continue to emphasize the importance of familiarization with crisis plans and becoming more knowledgeable of managing conditions. Care Coordinators will also emphasize the importance of member attendance and participation at outpatient behavioral health appointments.
- Continue to work 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.
- Continue to contact members assigned Clinically Responsible Service Provider (CRSP) for increased coordination to improve member attendance for aftercare appointments.

Access Call Center

In February 2021, DWIHN brought the Access Call Center in-house to streamline the process of how Community Mental Health services are initially accessed in Wayne County. For almost two years, the DWIHN Access Call Center continues with its goal of providing the community with prompt, efficient services while treating individuals with dignity and respect. The Access Call Center staff has been trained to use “First Call Resolution” as a sensitive approach to identify and accommodate the needs of callers (members and non-members) so that appropriate services or referrals are provided upon the first request. This principle allows staff to manage calls with efficiency and care. The Call Center continues to focus on: Establishing specific performance metrics, implementing quality standards, and leveraging technology to enhance operational processes.

Qualitative Analysis and Trending of Measures

For FY2021-2022, Performance of the DWIHN Access Call Center in relationship to National Standards for Access Call Centers is as follows:

- Call Center overall Average Abandonment Rate= 3.5%- Standard Met
- Call Center overall Average Speed to Answer (ASA) = 22 seconds- Standard Met
- Call Center overall Average Percent of Calls Answered = 95.6% - Standard Met
- Call Center overall Average Service Level Percent: 84.9% - below standard by less than 0.1 %.

Opportunities for Improvement

To improve the services level, over the next 3 -6 months DWIHN will:

- continue to hire additional staff and adjust schedules to accommodate high call volume periods.
- Hired additional staff in the SUD and clinical units to better address high call volumes Staff completed trainings for Implicit Bias, Corporate Compliance, CAFAS and LOCUS.
- Implemented regular overviews and training sessions to educate staff on functions of other DWIHN departments and the providers.

Crisis Services

The Crisis Services Department works to ensure access to care for members via DWIHN’s full array of services within the Crisis Continuum Service System. Data shows an increase in requests for children and a decrease for adults compared to last fiscal year. Diversion rates increased for both adults and children. This has been a direct result from the Crisis Services Department increasing communication between the provider network, DWIHN Liaisons, and the Clinically Responsible Service Providers (CRSP) to place members in the least restrictive environment.

Mobile outreach efforts continue with newly formed relationships with Wayne Metropolitan Community Action Agency and Black Family Development, Inc. to outreach to those in need in the communities in which they reside. The Community Law Enforcement Liaison has solidified processes related to the newly formed Behavioral Health Unit (BHU) with Probate Court for education and collaboration on Assisted Outpatient Treatment Orders (AOT), transport orders, and communication with the court. Crisis Services created a Hospital Discharge Liaison to work specifically with complex discharges in order to promote community stabilization after an inpatient hospitalization.

Crisis Data

Children's Crisis Providers: The Children's Center (TCC), The Guidance Center (TGC) and New Oakland (NO). Services continue to be telephonic with the exception of TCC.

FY	RFS	Unique consum er	Inpatient admits	% Admitted	# Diverted	% Diverted	Crisis Stab
FY 20/21	2,770	2395	712	26%	2007	72%	1,334
FY 21/22	3,111	2,803	729	23%	2,301	74%	1,594

The RFS total is 12% higher than FY 20/21. Diversion rates increased by 12% as compared to last year. Intensive Crisis Stabilization Services (ICSS) has seen an upward trend from the previous years.

Community Outreach for Psychiatric Emergencies (COPE): Hegira with Neighborhood Services Organization as a contracted provider.

FY	RFS	Unique consumer	Inpatient admits	% Admitted	# Diverted	% Diverted	# Inpt due to no CRU
FY 20/21	12,423	11,182	8,379	67%	3,688	30%	42
FY 21/22	11,316	10,344	7,463	66%	3,553	31%	78

The overall number of RFS decreased in FY 21/22 by 8%, and the admission/diversion rates have remained similar over the course of the last 3 years. Members going inpatient due to no Crisis Residential Unit (CRU) beds available have increased by 85% from FY 20/21 after having decreased by 68% between FY 19/20 and FY 20/21, the increase is related to the closing of the Boulevard Crisis Residential program this year. Additionally, there was a 21% decrease in CRU admissions in comparison to FY 20/21. CRU capacity decreased from 16 to 9 beds with the closing of Boulevard Crisis Residential program.

Crisis Residential Services (CRU)

There was a 21% decrease in CRU admissions in comparison to FY 20/21. CRU capacity decreased from 16 to 9 beds with the closing of Boulevard Crisis Residential program. COPE Crisis Stabilization Units (CSU) services increased by 5% as compared to FY2020/2121 and Team Wellness CSU members served increased by 49% from last year.

Causal Analysis

Recidivism to inpatient hospitalization remains as an opportunity for improvement. In FY2021/2022, crisis services liaisons saw 79 members that were recidivistic on the 23-hour report, and diverted 57% of those members to the least restrictive environment. The total number of Crisis Alerts received for the year is 269 and the diversion rate for the alerts received was 55% which positively impacted recidivism. DWIHN continues to work toward solidifying another crisis residential site to promote stabilization in the community.

DWIHN is in the process of building a Crisis Care Center in the heart of Detroit. This care center will be utilized to evaluate and determined medical necessity for crisis-level service for adults and children. DWIHN will also open a regional integrated behavioral healthcare campus in Detroit in 2024, providing physical and behavioral healthcare to the surrounding communities and counties. There are also plans to open a third crisis center in the downriver area.

Wewill continue placing special emphasis on children, as we look to thefuture on how tobetter serve children and families through innovation, technology, and community engagement. Our community partnerships with the city of Detroit and the Detroit Police Department continue as we train more law enforcement on Crisis Intervention Training and improve ways to help those with serious mental illness.

Opportunities for Improvement

- Develop mobile outreach clinician area to include mobile crisis stabilization.
- Develop additional methods to reduce member recidivism.
- Coordinate with DWIHN Utilization Management Department and CRSP providers to streamline processes to improve engagement, planning, and treatment for members being discharged from inpatient settings.
- Incorporate 988 into the crisis continuum.

Quality Pillar

Provider Network

On an annual basis the performance monitoring staff conduct provider reviews to ensure the safety and wellness of all persons served. Quality Improvement (QI) staff monitor compliance with federal and state regulations including MI Health Link demonstration project, through a process that may include a combination of desk and/or on-site reviews, verification activities and claims verification. When necessary other oversight and compliance enforcement strategies are enacted to improve quality outcomes and minimize risk. CMHSP organizations and SUD Providers that are unable to demonstrate acceptable performance may be subject to additional oversight and intervention.

Quantitative Analysis and Trending of Measures

During FY2022, a total of 82 network providers were reviewed by the Quality Department. These reviews consisted of administrative, case records, and comprehensive staff reviews. The completed reviews were inclusive of the Clinically Responsible Service Providers (CRSP), and Substance Abuse Disorder (SUD) treatment and prevention providers. Additional reviews occurred with 17 Autism providers, 59 B3 providers, and 8 inpatient hospital settings. Plans of correction were required for providers with review scores less than 95%. Follow-up validation reviews were completed on those providers to ensure the implementation of the plan. Monitoring of trends and practices to improve quality outcomes was also exhibited through CRSP Self-monitoring Audits. Data from these provider self-reviews were analyzed on a quarterly basis by performance monitoring staff and consultation was provided as needed.

CRSP Providers were found to have good, thorough assessments and implementation of the person-centered planning process, including when changes or amendments were needed to the plan, were evident. Progress notes were detailed and provided a snapshot of the person being served. Reviewers found; however, that members' Individual Plans of Service did not include "SMART" goals, or goals in the members' own words, and/or had a lack of specific amount, scope, frequency, & duration of support and services. There was also a lack of evidence that members received a copy of their IPOS within 15 business days and a lack of periodic reviews. Another area for improvement includes the need for DWIHN to edit the DWIHN IPOS Review form to include a section for documenting member/legal representative's satisfaction with goal progress and supports and services (we received citations from MDHHS for this information missing in the reviews). Reviewers also found that documentation frequently lacked evidence of members' signatures or a witness for verbal consent. Coordination of care was also noted as a challenge this fiscal year as many providers lacked evidence of this occurring. There were also some discrepancies in agency policies reflecting the most updated DWIHN policies.

CRSP Self-monitoring Audits

Monitoring of trends and practices to improve quality outcomes was also exhibited through CRSP Self-monitoring audits. Data from these provider self-reviews were analyzed on a quarterly basis by performance monitoring staff and consultation was provided as needed. Results from the provider self-reviews are as follows:

- FY22 Quarter 1 the average combined score for 22 CRSP providers reviewing a total of 35 case records each, revealed a 93% compliant rate.
- FY22 Quarter 2 the average combined score for 25 CRSP providers reviewing a total of 35 case records each, revealed a 92% compliant rate.
- FY22 Quarter 3 the average combined score for 24 CRSP providers reviewing a total of 35 case records each, revealed a 90% compliant rate.
- FY22 Quarter 4 the average combined score for 14 CRSP providers reviewing a total of 35 case records each, revealed a 92% compliant rate. (During this quarter providers demonstrated a poor response rate due to having to complete Medicaid claims verifications.)

1915(c) Waiver Reviews

In FY2022, DWIHN received a 1915(c) Waiver review conducted by MDHHS. This review included a review of the Children's Waiver Program (CWP), Habilitation Supports Waiver (HSW), and Waiver for Children with Serious Emotional Disturbance (SEDW) case files, staff qualifications, and administrative process related to health and welfare. The QI department collaborated with 31 network providers to facilitate the review of 46 case records and 230 staff files. Findings from the review resulted in plans of correction. Technical assistance, training, and monitoring activities were provided to the provider network by QI staff resulting in the successful completion of the plans of correction.

Monitoring of B3 Service Providers

Monitoring of providers of B3 services occurs through the Medicaid claims audit process. This occurs twice a year and is a collaboration with the billing provider. It involves a detailed look at the documentation of the service claimed, as well as staff's eligibility to provide the service. During FY 2022 there were 59 providers of B3 services consulted and 1492 Medicaid claims audited which averaged 91%.

Evaluation of Effectiveness

During reviewing documentation of services, feedback and education are provided, as applicable. These consultative discussions focus on the importance of staff being trained on the Individual Plans of Service, delivering services as outlined in the IPOS, as well as the importance of writing detailed notes to adequately support the Medicaid Claims. If there is no documentation to support the claim, or the documentation is insufficient, the recoupment process is initiated.

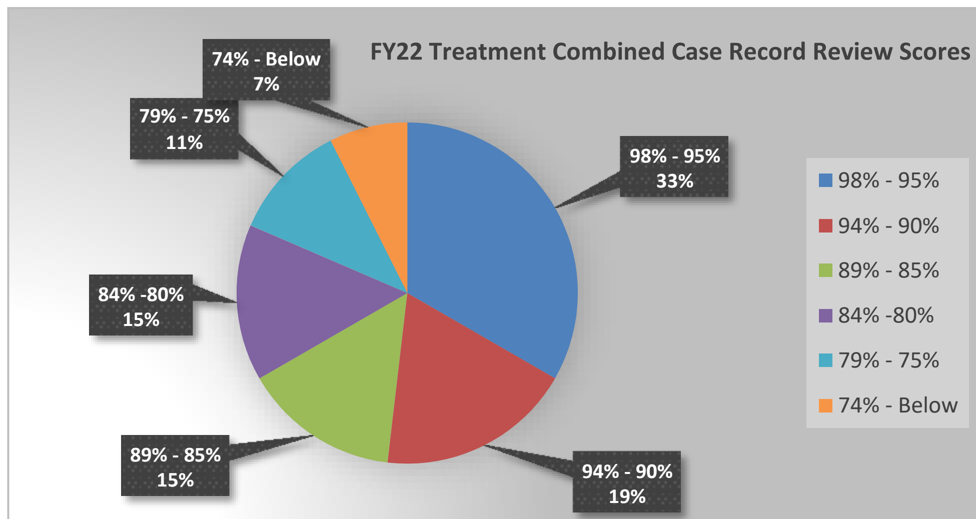
Quality improvement staff determined the eligibility of at least 1492 direct care staff that worked with the member during the time of the claims being audited, based on Medicaid's Provider Qualifications requirements. This is accomplished by verifying that the individual is at least 18 years of age; able to prevent the transmission of communicable disease; able to communicate expressively to follow individual plan requirements and beneficiary-specific emergency procedures and to report on activities performed; able to perform basic first aid procedures, is trained in the member's plan of service; and is in good standing with the law. If staff are found to have been ineligible to deliver the service, the recoupment process is initiated.

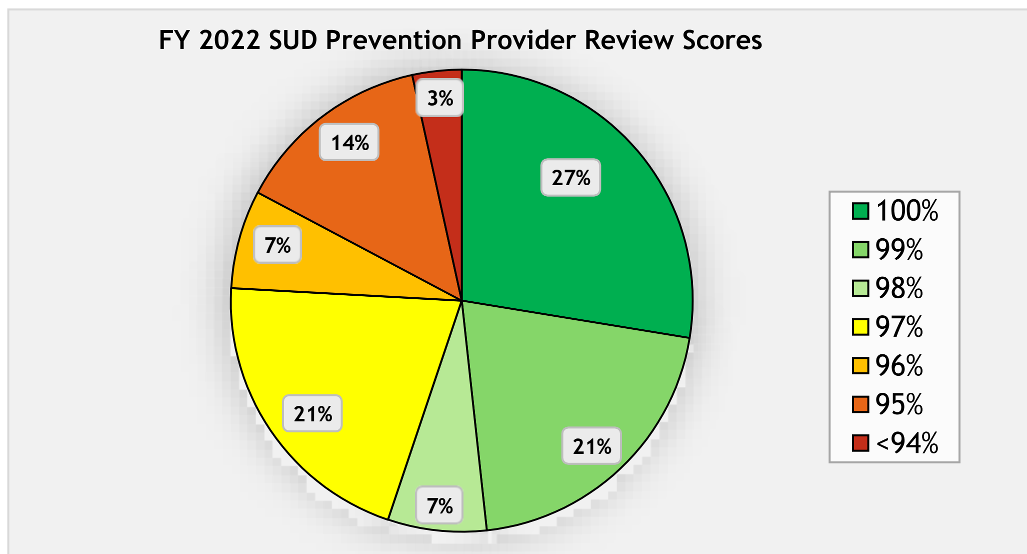
During FY 2021-20222, the DWIHN Quality Team and other units provided six system-wide trainings on Home Community Based Services (HCBS), the Habilitation Supports Waiver (HSW), Children's Waiver Program (CWP) and the Waiver for Children with Serious Emotional Disturbance (SEDW), and Individual Plan of Service (IPOS) on the MDHHS requirements for the programs as part of the person-centered process. There was approximately 800+ throughout the provider network that participated in those training. All training was conducted via the Zoom platform.

Substance Abuse Disorder (SUD) Results

During FY2022, there were 3,001 members treated for outpatient treatment services, 895 new admits for opioid Treatment Program services, 4,812 residential services, 3,537 for withdrawal management services, and 753 treated for recovery support services.

The noted charts below are a visual display of cumulative data from the average combined Case Record Review from the Treatment provider network, with an average score of 88%, 15 out of the 23 treatment providers required plans of correction in FY2022. The Prevention providers scored 95% or above with an average score of 98%. 3 out of the 29 prevention providers required plans of correction, due to programming requirements and staff non-compliance.





Naloxone Initiative

Each year thousands of individuals die from opioid overdoses, with oxycodone, morphine, and fentanyl accounting for a significant number of deaths in Detroit, Wayne County. To support the Governor's initiative to respond to the increase in opioid overdose-related deaths, DWIHN began providing free Naloxone (Narcan) training and kits in 2016 to all Wayne County residents.

DWIHN's Narcan Initiative program has saved 886 lives since its inception. The life-saving drug reverses an opioid overdose. DWIHN partnered with Wayne State University (WSU) in purchasing the vending machines which are located at two provider organizations: Quality Behavioral Health and Abundant Recovery Services. The vending machines dispense free Narcan kits.

In addition, DWIHN offers free life-saving training to local small businesses including barbershops, beauty salons and night clubs throughout Wayne County. A Narcan kit contains gloves, a CPR mask, and 2 nasal sprays. Anyone can get Narcan, including family members, friends, and caregivers of at-risk individuals.

Opportunities for Improvement

- Continue to monitor the network to determine if additional contracts need to be executed to provide more access to services.
- 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.
- 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.

Autism Results

DWIHN continues to increase its capacity with the number of Autism providers by adding three separate Diagnostic Evaluation providers through a Request for Proposal (RFP) to improve the timelines standards and reduce conflict of interest and potential bias of treatment providers providing initial diagnoses of autism. In FY2022, DWIHN QI staff conducted on-site and remote reviews of case records to ensure full compliance with the autism spectrum disorder (ASD) regulatory requirements. The results from the reviews demonstrated that the average clinical score for the Autism provider has increased when compared to last fiscal year from (76%) to (83%) in FY2022. The average staff review score has also increased from (91%) in FY2021 to (95%) during FY2022. DWIHN has also implemented provider quarterly self-reviews that have contributed to improved performance outcomes. This process has allowed plan engagement and case monitoring to ensure each case is moving through the benefit in a streamlined process.

Evaluation of Effectiveness

To meet the member needs, DWIHN focuses on increasing communication and coordination in the network about recruiting appropriate professionals and timely initiation of treatment. DWIHN aimed to remove barriers to service access by streamlining processes and educating the network and community on the ABA Benefit. DWIHN improved the feedback look and workflow through restructuring contracts and service flow, establishing workflow and instructional guide, maintaining on-going monthly ABA System of Care Meetings, establishing on-going comprehensive training and engagement plan. DWIHN also implemented ongoing case monitoring system and notices to ensure each case is moving through the benefit in a streamlined process. The eligibility population increased from 18 months through 5 years of age to birth through 20 years of age on January 1, 2016. This increase significantly increases the eligible population and increased capacity needs therefore impacting performance areas.

Identified Barriers

Providers continued to experience many barriers related to staffing shortage, adjusting to tele-health. services, and engaging members in person. Another reported barrier involved an analysis of the potential. Variables impacting eligible individuals accessing ABA services in a timely manner was compiled and feedback from the provider network indicated a lack of staffing to implement the direct intervention.

Opportunities for Improvement

Improved access point for referral process

- Established an Autism Benefit group email for all inquiries from the community.
- Createda direct link between the Autism Benefit and the Access Call Center to improve timeliness ofreferral process.
- Education & Training provided to physician offices, Head Start, and other community professionals Established a direct point of access to ABA providers intake calendar through the Access Call Center DWIHN increased the Service Utilization Guidelines (SUG) for CPT code 97155 (ABA Adaptive Behavior
- Treatment with Protocol Modification, Administered by Physician or Other Qualified Health Professional) from 10% of 97153 to 20% of 97153. By increasing direct supervision of Behavior Technicians, providers report an improvement in staff retention and quality of service delivery.
- DWIHN hosted job fairs for ABA providers to hire Behavior Technicians and provided support, literature, and trainings related to staff retention.
- Improved communication between CRSP and ABA
- Providers Education & Training provided by both.
- ABA and CRSP outlooks Improved reporting integrity on service utilization.

Verification of Services

Additional monitoring of network providers also included verification activities and Medicaid Claims Verification reviews, this process involved 222 providers, 3,598 individual claims randomly selected, and 3,598 of staff delivering the service associated with the claim. Plans of correction were requested for all providers scoring less than 95% compliance.

Quantitative Analysis and Trending of Measures

In FY2022, a total of 3,598 claims were randomly selected for verification. Of those claims, 3,524 were reviewed and validated for 98.03%, which is a 35.75% increase from the previous fiscal year 2021 (1260). 3,210 of the claims reviewed were compliant, having received scores of at least 95%, and 215 of the claims reviewed had scores ≤ 95%, of which 124 required a Plan of Correction.

Identified Barriers

The noted barriers are due to the CRSP not ensuring service providers have access to a signed copy of the Individual Plan of Service (IPOS) and incomplete claims or clinical documentation appearing inappropriate for the service provided. Actions were taken to improve the process. DWIHN has implemented a process to assist providers with obtaining the signed IPOS from the CRSP provider.

Opportunities for 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 Corporate Compliance and Finance to ensure that all quality-of-care concerns identified and forwarded to Quality for investigation

Critical/Sentinel, Unexpected Deaths, and Risk Reporting

The following data represents fiscal years 2018 through 2022 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 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 thatoccur at residential treatment provider settings.

Quantitative Analysis and Trending of Measures

In FY2022, the Quality Performance Improvement Team processed 1,915 Critical/Sentinel Events, which is a decrease of (39.3%) from FY2021. This decrease is attributed ongoing training with the Provider Network on correct and accurate reporting. 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 FY2022, the highest category being reported is Deaths (492); Serious Challenging Behavior (437); the next top category is Physical Illness Requiring Hospitalization (239); and the lowest number of critical incidents is Medication Error (14).

The Sentinel Event Committee/Peer Review Committee (SEC/PRC) was expanded to include other DWIHN department representation. Committee focusing on issues impacting a particular department are now able to be addressed during the review thus allowing for more expedient resolutions to the individual event and any systemic problem.

5-YEAR AGGREGATE DATA

CATEGORY	FY 2021/2022	FY 2020/2021	FY 2019/2020	FY 2018/2019	FY 2017/2018
ARREST	64	72	83	161	153
BEHAVIOR TREATMENT (New 2020/2021)	88	61	0	0	0
DEATHS	492	551	731	480	444
ENVIRONMENTAL EMERGENCIES	57	79	38	65	205
Injuries Requiring ER	177	227	259	498	673
Injuries Requiring Hospitalization	35	47	203	88	83
Medication Errors	14	16	27	123	172
Physical Illness Requiring ER	216	975	634	1039	2188
Physical Illness Requiring Hospitalization	239	445	400	763	1107
Serious Challenging Behavior	437	609	815	1322	2199
OTHER/ADMINISTRATIVE	96	77	166	409	361
TOTAL	1915	3159	3356	4948	7585

Evaluation of Effectiveness

In FY 2021/2022 the Quality Performance Improvement Team (QPIT) identified and presented a myriad of Trends/Patterns throughout DWIHN's system that resulted in heightened scrutiny for some providers, implementation of changes throughout the entire network, and improvements in the MHWIN reporting document. QPIT instituted weekly root cause analysis meetings providing technical assistance to providers based on actual case reviews and problem identification. The qualitative review process included notification to the clinically responsible service provider (CRSP) at the time of the review of the incident and requesting a root cause analysis (RCA) for all sentinel events which had to include the CRSP's plan of action to eliminate or remediate the identified problems. Technical assistance meetings were instituted to discuss those cases and problems along with requirements for remedial actions to be implemented within 30-day time frames. Monitoring and follow-up was provided by QPIT. The Quality Monitoring team was provided the remedial actions requirements which they monitored during their site review visits. QPIT presented all RCA results to the Sentinel Event Committee/Peer Review Committee (SEC/PRC) for discussion and input for closure of all Sentinel Event cases. This process was utilized for the entire DWIHN network (Behavioral and SUD providers).

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 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?
- 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.?

<u>Common Issue #3— Physical Illness</u>: 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?
- 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 must 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.

Identified Barriers

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- 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?

Another major barrier is the underreporting of CRSP providers. DWIHN is discussing, reviewing, and training the provider network on underreporting.

Opportunities for Improvement

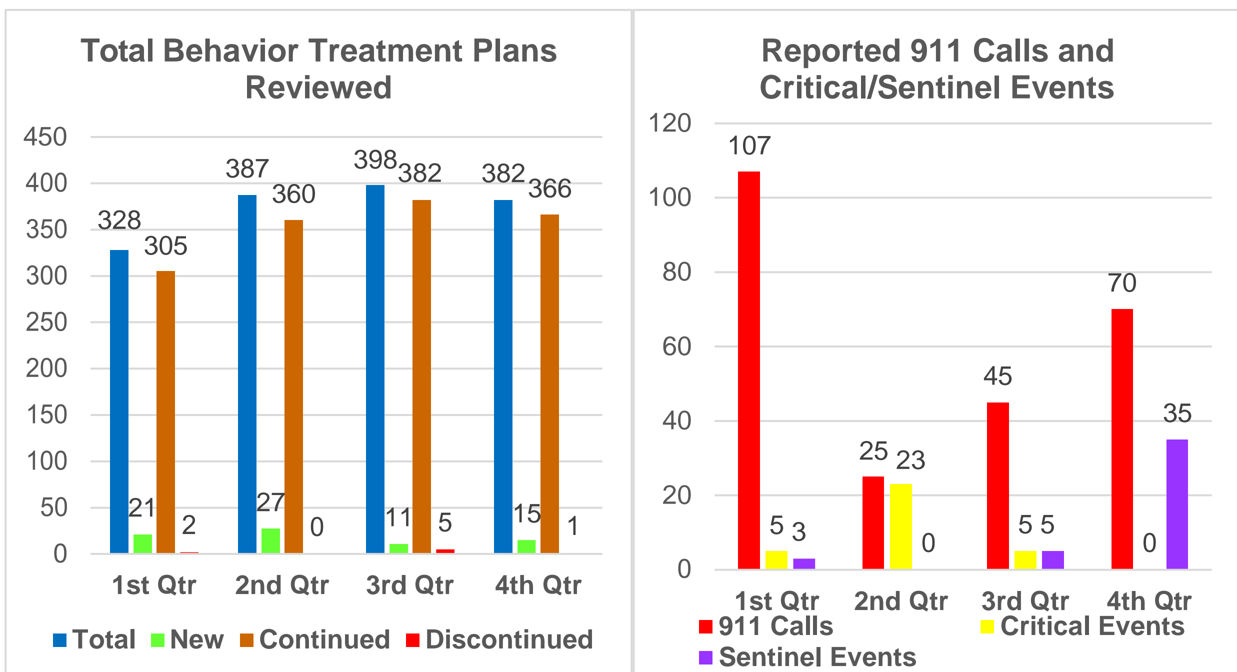
- Development of training modules for the entire network and members on "Choking Hazards" to include instructions on the Heimlich Maneuver.
- Standards and instructional manual on "Eating Guidelines" for members with plans that require guidance and support in eating meals.
- Positioning the committee responsibilities to meet all contractual and policy requirements and updated Case Review Agenda Grid.

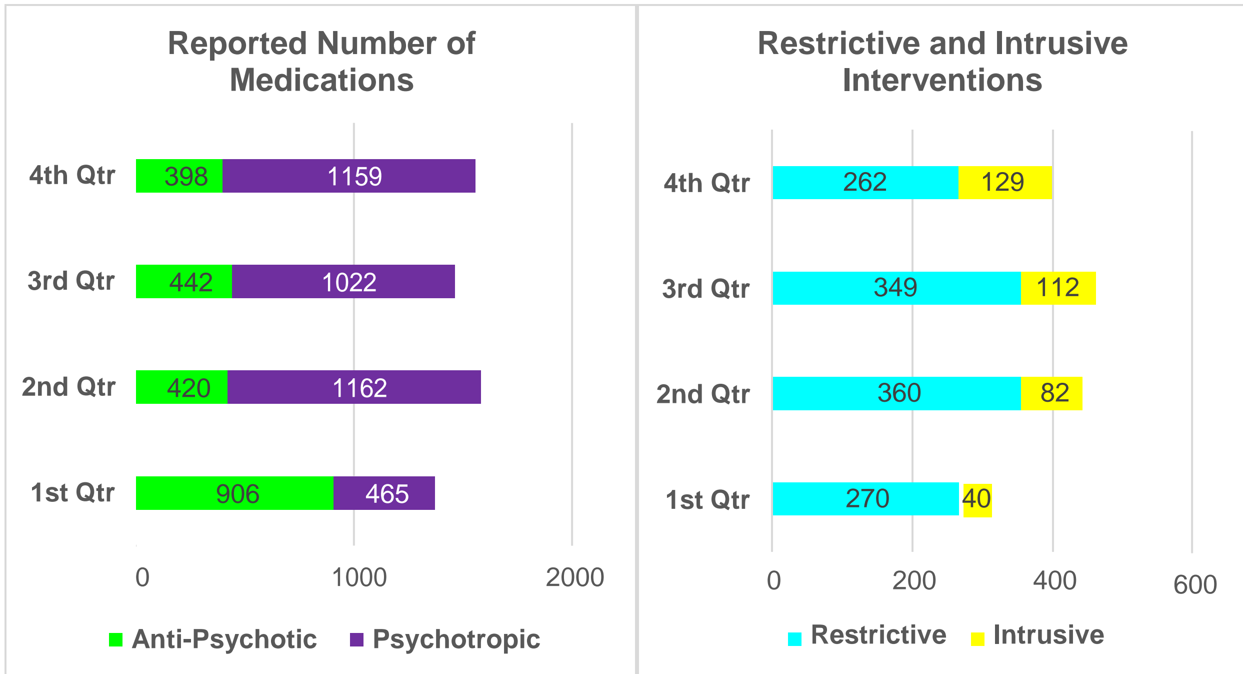
Behavioral Treatment Review

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 FY22, DWIHN BTPRC reviewed 1,495 members on Behavior Treatment Plans which is an increase of 334 (28.76%) 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 FY22.





Evaluation of Effectiveness

During FY 2021-2022, DWIHN BTAC staff provided three system-wide trainings on Technical Requirements of Behavior Treatment Plan Review Committee (BTPRC) Processes. A total of 1215 staff throughout the provider network participated in these trainings. All trainings were conducted via the Zoom platform. The first training was focused solely on MDHHS requirements for Behavior Treatment whereas the second and the third training focused on the Behavior Treatment requirements as part of IPOS writing. DWIHN is in full compliance with PIHP Administrative Review Procedures of Behavior Treatment (B.1) for the fourth consecutive year based on the findings of MDHHS Habilitative Supports Waiver 1915(c) Review.

DWIHN BTAC staff has been appointed to serve on MDHHS Behavior Treatment Advisory Group. Effective October 1, 2020, DWIHN has delegated all contracted Mental Health (MH) Clinically Responsible Service Providers (CRSP) to have the Behavior Treatment review process in place. The BTPRC requirements are included in the CRSP written contract for FY 2021-2022. During FY2022, the network providers presented fourteen (14) complex cases to the Behavior Treatment Advisory Committee (BTAC). DWIHN continues to submit quarterly data analysis reports on system-wide trends of BTPRC to MDHHS. The BTAC staff works with SEC/PRC team, and MH CRSPs on the Root Cause Analysis involving Behavior Treatment and also provides systemwide consultation to the twenty BTPRC providers, Performance Monitoring unit, and DWIHN departments (Utilization Management, Office of Recipient Rights, Residential, Children's Initiatives) on clinical matters related to Behavior Treatment services.

Identified Barriers

The required data of Behavior Treatment beneficiaries which includes 911 Calls, Deaths, Emergency Treatment, and Use of Physical Management is still being under-reported.

Opportunities for Improvement

DWIHN has identified the following interventions and improvement efforts:

- Develop a mechanism to track instances where physical management or 911 calls to law enforcement have been used in an emergency behavioral crisis and ensure the length of time the emergency intervention was used per individual is included.
- Behavior Treatment Category is live in MH-WIN Critical and Sentinel Reporting Module to improve the systemic under-reporting of the four reportable categories for the members on BTP, however the required data of Behavior Treatment beneficiaries which includes 911 Calls, Deaths, Emergency Treatment, and Use of Physical Management is still being under-reported.
- CRSP and BTPRCs must work in collaboration to ensure that IPOS and Behavior Treatment Plans are specific, measurable, and are revised per the policy/procedural guidelines.
- Crisis Prevention Intervention (CPI) training is recommended to be included in the Detroit-Wayne Connect required list of trainings for network providers staff to help reduce recidivism and emergency hospitalizations.
- Each CRSP ensures the Supports Coordinator or Case Manager provide the Individual's IPOS and ancillary plans before delivery of service at the service site.

Children's Initiatives

DWIHN provides a comprehensive and integrated array of services/supports which inspires hope and promotes recovery/self-determination for children and teens ages 0 to 21 with Severe Emotional Disturbances (SED) and/or Intellectual Developmental Disabilities (I/DD). Children, youth, and families with co-occurring mental health, substance use, and physical health conditions receive services within a System of Care that is:

Pillar 1 Clinical Services & Consultation	**Pillar 2** Stability & Sustainability	**Pillar 3** Outreach & Engagement	**Pillar 4** Collaboration & Partnership

Values	Goals
Community Based Family Centered Youth Guided Culturally and Linguistically Responsive Trauma Informed	1. Increase Access to Services 2. Improve Quality of Services 3. Increase Youth and Parent Voice 4. Improve Quality of Workforce

Mental Health Care: Putting Children First Initiative

Access	Prevention	Crisis Intervention	Treatment

These initiatives include:

- Increased accessing community mental health presentations within the community.
- Began a pilot with DHHS North Central Office to receive trauma screenings for youth ages 0 to 6 and have community mental health screenings completed with DWIHN Access Department
- Partnered with Wayne RESA to develop a return to school letter and safety plan for when students see a mental health professional prior to returning to school.
- Workforce Development hosted School Violence Trainings
- 11 Children's Providers participated in the SED Value Based Incentive to receive additional funding for meeting MDHHS Performance Indicators and HB service hours.
- Children's Initiative assisted with facilitating Career Fairs with various universities to assist with recruitment efforts for clinical staff.
- Sexual Orientation Gender Identity Expression (SOGIE) languages was incorporated into the Integrated Biopsychosocial Assessment electronic health record. Also hosted SOGIE trainings throughout the network and staff.
- Participated in panel discussions for Wayne County Community College students and high school students involved in the Biomedical Career Advancement Program (BCAP).
- Reduced administrative burden for Children Providers by streamlining CAFAS / PECFAS reporting.
- Updated children's services policy to extend services up to age 20 per MDHHS guidance.

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

Goal: Improving the Attendance at Follow up Appointments with a Mental Health Professional after Hospitalization for Mental Illness

NCQA's HEDIS assesses the percentage of inpatient discharges for a diagnosis of mental illness or intentional self-harm among patients aged 6 years and older that resulted in follow-up care with a mental health provider, (Adult Core Set, appendix C), within 7 and 30 days**.** 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
The State of Michigan specifications for this measure for 30 day is 70% for children 6-17 and 58% for adults 18-64. DWIHN has chosen to use the State of Michigan measures as a comparison goal. DWIHN 2020 rate for 30 days for ages 6-17 is 62.96%. DWIHN 2021 rate for 30 days for ages 6-17 is 66.32%. This is a 3.36 percentage point increase. DWIHN 2020 rate for 30 days for ages 18-64 is 48.74%. DWIHN 2021 rate for 30 days for ages 18-64 is 46.67%. This is a 2.07 percentage point decrease. DWIHN will continue to compare its goal to the State of Michigan goal. The State of Michigan specifications for measure for 7 days is 45% for 6 years and older. DWIHN has chosen to use the State of Michigan measures as a comparison goal. DWIHN 2020 rate for 7 days for ages 18-older is 29.14%. DWIHN 2021 rate for 7 days for ages 18- older is 28.33%. This is a 0.81 percentage point increase. DWIHN will continue to compare its goal to the State of Michigan goal of 45%. DWIHN is in the process of purchasing Quality Compass to run customer reports that will report HEDIS percentile to determine where we fall, 25th, 50th, 75th or 95th percentile.

FUH 30 Day

Time period	Measurement	Numerator	Denominator	Rate	Goal	Comparison to Goal State of Michigan
1/1/2020- 12/31/2020	6-17 years 18-64 years	323 1803	513 3699	62.96 48.74		70% 58%
1/1/2021- 12/31/2021	6-17years 18-64 years	317 2606	478 5584	66.32 46.67	70% 58%	70% 58%

FUH 7 Day

Time period	Measurement	Numerator	Denominator	Rate	Goal	Comparison to Goal State of Michigan
1/1/2020-12/31/2020	6-17 years 18-64 years	212 1078	513 3699	41.33 29.14	45%	45%
1/1/2021-12/31/2021	6-17years 18-64 years	211 1582	478 5584	44.14 28.33	45%	

This measure was also presented to the Improving Practice Leadership Team (IPLT) committee for additional insight in 2020, 2021 and 2022 to discuss opportunity for improvement, barriers, and potential interventions to meet the state performance measures for follow-up after hospitalization and readmission within thirty days. The IPLT membership consists of the Director of Children's Initiatives, Director of Integrated Care, Chief Medical Officer, Director, Director of Clinical Practice Improvement, Director of Quality Improvement, Provider Network Clinical Officer, Director of Utilization Management and Director of Substance Use Disorders Initiatives and community-based providers.

Barriers identified by IPLT

- 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 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)
- 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 lack of understanding 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)

Barriers Identified by Contracted Providers

- When facility called for seven-day follow-up appointment for member often there is no appointment available within the timeframe at member's preferred provider site. (Referral access)
- Develop written educational material for members regarding importance of follow-up appointments, providing oral and written information.
- 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 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.

Causal Analysis

Annually starting in 2021, the analysis of the re-measurement data was presented to the Quality Improvement Steering Committee (QISC) and the following recommendations were made, to continue to review and monitor QIP and implement interventions. The QISC membership consists of the Director of Children's Initiatives, Director of Integrated Care, Chief Medical Officer , Director of Clinical Practice Improvement, Director of Quality Improvement, Provider Network Clinical Officer, Director of Utilization Management and Director of Substance Use Disorders Initiatives.

Key Interventions

The interventions that have had the most impact on improving this measure by:

- Enrollee/members have a 7- and 30-day follow-up visit scheduled before being discharged with a mental health practitioner.
- Process developed to have hospital contact Access Center to schedule an appointment. Access will now have 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.
- 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.
- Telephone calls made to clients as a reminder of upcoming appointment. Providers are expected to make 3 calls to the client to assess barriers to client's care.
- Face to face visit to the client by care coordinators at the treating facility to assess client's barriers to follow up care (ex. transportation). Educational material given to client while hospitalized that address, transportation, importance of medication compliance, follow up after hospitalization and importance of primary care physician visits.
- DWIHN will continue to mail letter from our Chief Medical Officer, stating the importance of follow up care along with the educational material that states the same.
- Text messaging as a reminder will continue for those clients that give permission to have the information texted to their phone.

- Education for providers and clients regarding the importance of follow up after hospitalization. Interventions will continue to include providing educational material that address FUH, medication compliance, and provider tools.
- Posting of educational material on DWIHN website and updated as needed.
- Publish educational articles in client's newsletter Patient Point of View

Identified Barriers

Barriers to care have been identified. Covid continues to be a barrier. The State of Michigan did not allow in person face to face visits with our population until July 2021. Some remote workers did not have equipment to work from home at the onset of Covid.

Telehealth continues to be a preferred form of contact. Not all clients are computer literate or have the equipment needed to perform the service. Some clients that have government issued phones are preferring to use their phone minutes for emergencies. Transportation continues to be a barrier for those that chose to attend their appointments face to face. The state continues to work on this issue.

Post Covid there is a shortage of mental health staff. The Covid vaccine is a requirement to work at some provider sites with few exceptions. Social workers are needed at many of the provider agencies. Providers are struggling with a large client population with very little staff to take on the numbers causing a gap in care for DWIHN client population. Post Covid, agencies are trying to reorganize.

Opportunities to Improvement

To improve clients understanding of the importance of medication adherence, DWIHN's will implement the following:

- Registered nurse will call clients that are identified as non-adherent to care.
- The nurse will educate the client regarding the importance of adherence.
- The nurse will help clients identify barriers to care and provide resources that will help the client achieve their medical goal.
- DWIHN's registered nurse will serve as mentor to several nursing students. This internship will address the shortage of nurses in the mental health field. The nurse interns will assist in educating the clients on the importance to medication adherence and follow up care. Nurse interns will conduct integrated health education classes that address chronic conditions such as, diabetes, heart failure, hypertension, and asthma.
- DWIHN's registered nurse will schedule Lunch and Learns quarterly with providers to address HEDIS measure goals and barriers to care. Laboratory blood draw reminders automatically built into providers system.

Goal: Improving Adherence to Antipsychotic Medications for Individuals with Schizophrenia

HEDIS Measurement-Adherence to antipsychotic medications for individuals with schizophrenia: percentage of members 18 and older 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
Michigan HSAG 2021, reports the adherence to antipsychotic medication average health plan result for 2020 was 68.17%, putting them in the 75th percentile for this measure. DWIHN result for 2020 was 79.34% which is above the 75th percentile. DWIHN's goal is to be in the 95th percentile. In 2021 DWIHN results have trended down to 46.92%. This is a 32.42 percentage point decrease.

Time Period	Measurement	Numerator	Denominator	Rate	Goal	Comparison to goal
1/1/2020-12/31/2020		4163	5247	79.34%		68.17% 2020 HEDIS Aggregate Report for Michigan Medicaid
1/1/2021-12/31/2021		2462	5304	46.92%	68.17%	68.17% 2020 HEDIS Aggregate Report for Michigan Medicaid

Results of data for adherence to antipsychotic medication was presented to IPLT Committee initially to discuss opportunity for improvement and need for improvement due to MDHHS expectations and improving medication adherence as well as improving the state performance measure on readmissions and benefits for member to prevent readmissions. The IPLT membership consists of the Director of Children's Initiatives, Director of Integrated Care, Chief Medical Officer, Director of Clinical Practice Improvement, Director of Quality Improvement, Provider Network Clinical Officer, Director of Utilization Management, Director of Substance Use Disorders Initiatives, and quality directors from provider organizations.

Barriers identified by IPLT

- 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 regarding presence of illness or need to take medication. (Member knowledge)
- Lack of family and social support (Member knowledge)
- Medication side effects and/or lack of treatment benefits (Member knowledge)
- Patient forgets to take medications (Member knowledge)
- Patient forgets to re-fill 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 physicians by memo's sent to physicians quarterly regarding review of member's medication.
- Improve patient compliance with medication adherence by educating client of the importance.
- Improve patient adherence to medication refill by educating client of the importance.
- Improve patient follow up by telephone calls, text and mailed letters to clients addressing the importance of follow up care. Case managers are also instructed to provide a follow up appointment for the client.

Committee Participation

Quarterly analysis of the re-measurement data is presented to the Quality Improvement Steering Committee (QISC) and the following recommendations were made, moving forward. The focus will be to continue to educate members and providers on the importance of medication adherence by continuing to evaluate interventions that have the greatest impact.

Identified Barriers

Covid continues to be a barrier. The State of Michigan did not allow in person face to face visits with our population until July 2021. Some remote workers did not have equipment to work from home at the onset of Covid. Telehealth continues to be a preferred form of contact. Not all clients are computer literate or have the equipment needed to perform the service. Some clients that have government issued phones are preferring to use their phone minutes for emergencies. Transportation continues to be a barrier for those that chose to attend their appointments face to face. The state continues to work on this issue.

Post Covid there is a shortage of mental health staff. The Covid vaccine is a requirement at some of DWIHN provider site with few exceptions. Social workers are needed at many of the provider agencies. Providers are struggling with a large client population with very little staff to take on the numbers causing a gap in care for DWIHN client population. Post Covid, agencies are trying to reorganize.

DWIHN was invited to over 100 community engagement events this past year which included presentations to community groups, outreach events for children, and recovery and prevention programs. Another major focus was youth mental health as billboards and messaging were created to reflect how families and children are struggling during this pandemic. DWIHN also launched Mind wise, a free, anonymous mental health assessment tool located on the homepage of the dwihn.org website this past year.

DWIHN launched its partnership with Wayne Health and Ford Motor Company utilizing mobile health clinics that offer physical and mental health resources in communities.

The Communications team also produced a video promoting the mobile units which is posted on social media and the website. DWIHN also worked with Walgreens, the city of Detroit and Wayne Health to offer vaccinations to people we serve, group homes, direct care workers and staff. DWIHN also expanded its partnership with the Detroit Police Department and added more Crisis Intervention Teams (CIT) who help officers identify people that they encounter who may be in a mental health crisis. During 2021, the Access Center transitioned into DWIHN as the department oriented all new Access Center staff on standards. Customer Service continued to adjust in staffing and procedures to ensure standards remained in compliance.

Performance Monitoring

The Quality and Performance Monitoring Team conducted 39 CRSP provider site reviews to ensure compliance standards were addressed and maintained. Plans of correction were addressed with network providers. The division monitored and tallied monthly provider network reports and Quarterly Customer Service Provider meetings were held to ensure providers were advised of updates. In addition, the Member Engagement division continued to find new ways to connect with members. Staff continued outreach efforts using its Quarterly member meetings (EVOLVE), the Persons Point of View newsletter, educational materials, and the What's Coming Up video updates as a means of communicating with members. The divisions' initiative of promoting virtual platforms and distributing computers and training to residential facilities and clubhouses proved to be beneficial in keeping members engaged. In collaboration with the Constituent's Voice Advisory group, the division organized members, peers, and ambassadors to participate in the "Walk a Mile in My Shoes" rally and organized the annual Reaching for the Stars award ceremony. The DWIHN Ambassador program participated in more than 170 outreach events, activities, and trainings. Also, the Quality Improvement department audits compliance with the Diabetes Screening clinical guidelines for Schizophrenic and/or bipolar disorder enrollee/members.

Integrated Health Care (IHC) staff performed monthly Care Coordination Data Sharing meetings with each of the 8 Medicaid Health Plans (MHP). Joint Care Plans between DWIHN and the Medicaid Health Plans were developed, and outreach completed to members and providers to address gaps in care, for almost 200 members. IHC staff participated in integration pilot projects with two MHPs: Blue Cross Complete of Michigan (BCC) and Total Health Care/Priority Health Care (THC). DWIHN and THC began sharing electronic data to assist in risk stratification, develop shared care plans, and document care coordination activities. DWIHN and BCC staff held meetings to review a sample of shared members who experience a psychiatric admission within the past month. In September, DWIHN and Vital Data Technologies completed a demonstration of the shared platform with BCC who is interested in collaborating to further the care coordination and risk stratification of shared members.

Identified Barriers

The State of Michigan changed the taxonomy code causing discrepancy in data. DWIHN is educating vital data regarding State changes asking that data be run again when discrepancies are found. DWIHN partnered with Vital Data in January 2020 after it was determined their current data vendor was not NCQA accredited. DWIHN meets with Vital Data monthly. DWIHN believes the interventions are strong. Care Space in Vital Data allows CRSP to pull their member data and see specific clients that are not meeting HEDIS measure. CRSP can now see medical data of any doctor that has treated the member.

- Initial discussion with IPLT focused on ways to improve adherence. Quarterly the analysis of the re-measurement data is presented to the Quality Improvement Steering Committee (QISC) and the following recommendations were made, moving forward the focus will be to continue to educate members and providers on the importance of medication adherence by continuing to evaluate interventions that have the greatest impact.
- Covid continues to be a barrier. The State of Michigan did not allow in person face to face visits with our population until July 2021. Some remote workers did not have equipment to work from home at the onset of Covid.
- Telehealth continues to be a preferred form of contact. Not all clients are computer literate or have the equipment needed to perform the service. Some clients that have government issued phones are preferring to use their phone minutes for emergencies. Transportation continues to be a barrier for those that chose to attend their appointments face to face. The state continues to work on this issue.
- Telehealth has caused non-adherence to medication refill possibly due to clients not having a prescription in hand. Post Covid there is a shortage of mental health staff. Caseloads continue to be over 100 for case managers which causes difficulty in assisting member with care. Social workers are needed at many of the provider agencies. Providers are struggling with a large client population with very little staff to take on the numbers causing a gap in care for DWIHN client population.
- Staffs fears of exposure to COVID.
- Private companies are paying higher salaries causing a shortage within our agency. Educational requirement has changed from a BA to BSW for case manager positions which lowered our pool for staffing.
- Shortage of nursing staff to give injections.
- Insurance covering new antipsychotic medications.
- Post Covid, agencies are trying to reorganize.
- MDHHS service back log.
- Restructuring of DWIHN Access Center caused a lag in timely access to care.
- The Covid vaccine is a requirement at some of DWIHN provider site with few exceptions.

Opportunities for Improvement

To improve the client's understanding of the importance of medication adherence, DWIHNs will implement the following:

- The registered nurse will call members identified in complex case managers that are identified as non-adherent to care.
- Educate the client regarding the importance of adherence and assist the client to identify barriers to care and provide resources that will help the client achieve their medical goal.
- The registered nurse will serve as mentor to several nursing students. This internship will address the shortage of nurses in the mental health field. The nurse interns will assist in educating the clients on the importance of medication adherence and follow-up care.
- Conduct integrated health education classes that address chronic conditions such as diabetes, heart failure, hypertension, and asthma.
- Laboratory blood draws reminders are automatically built into the provider's system.
- Developing a HEDIS tool kit on our website.
- HEDIS scorecard data review is presented to providers every 45 days.
- We continue to hire more staff to access the center and updated the infrastructure.

Goal: Improving Diabetes Monitoring for People with Schizophrenia and Bipolar Disorder

Diabetes Screening for People with Schizophrenia or bipolar disorder who are using antipsychotic medications: Assesses adults 18-64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

Quantitative Analysis and Trending of Measures

Time period	Measurement	Numerator	Denominator	Rate	Goal	Comparison to Goal
1/1/2020-12/31/2020		4891	7597	64.38		78.01% 2020 HEDIS Aggregate Report for Michigan Medicaid
1/1/2021-12/31/2021		5228	8061	64.86	78.01%	

MDHHS contracts with Health Services Advisory Group, (HSAG) to analyze Michigan Medicaid health plan HEDIS results objectively and evaluate each health plan's performance relative to national Medicaid percentiles. The Michigan Medicaid HEDIS Results Statewide Aggregate for 2021 reports the diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications, average health plan results as 78.01% which is above the 75th percentile. DWIHN results for 2020 diabetic screening was 64.38%. DWIHN results for 2021 was 64.86%. This is a 0.48 percentage point increase. DWIHN has chosen to compare its rate results with the HSAQ Medicaid weighted average (MWA) of 10 health plans that provide managed care services to Michigan Medicaid Members.

DWIHN's Improvement Practice Leadership Team (IPLT) reviewed data findings and the recommended improvement project and suggested possible in-home lab draws for diabetes screening. The IPLT membership consists of the Director of Children's Initiatives, Director of Integrated Care, Chief Medical Officer, Director of Clinical Practice Improvement, Director of Quality Improvement, Provider Network Clinical Officer, Director of Utilization Management and Director of Substance Use Disorders Initiatives and community-based providers.

Evaluation of Effectiveness

There is an opportunity for improvement. Detroit Wayne Integrated Health Network 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.

Clinical literature search was initially used to identify barriers in January 2021 to identify interventions to address any opportunities to improve the measure, NCQA: https://www.ncqa.org/hedis/measures/diabetes-and-cardiovascular-disease-screening-and-monitoring-for-peoplewith-schizophrenia-or-bipolar-disorder.

To determine the root cause for DWIHN's current performance, the following barriers have been identified:

- Lack of knowledge/consistent practice among 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 providers of recommendations for screening for diabetes in members with schizophrenia and bipolar disorder.
- Lack of knowledge among providers of HEDIS measure or DWIHN's HEDIS measure results.
- 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.
- Enrollee/Members may not be linked to a primary care physician or not consistent in follow up.

Identified Barriers

- Covid continues to be a barrier. The State of Michigan did not allow in person face to face visits with our population until July 2021. Some remote workers did not have equipment to work from home at the onset of Covid.
- Telehealth continues to be a preferred form of contact. Not all clients are computer literate or have the equipment needed to perform the service. Some clients that have government issued phones are preferring to use their phone minutes for emergencies.
- Transportation continues to be a barrier for those that chose to attend their appointments face to face. The state continues to work on transportation issues.
- Telehealth takes away the client's ability to have a prescription in hand which aids as a reminder.
- Post Covid there is a shortage of mental health staff. Social workers are needed at many of the provider agencies. Providers are struggling with a large client population with very little staff to take on the numbers causing a gap in care for DWIHN client population.
- Post Covid, agencies are trying to reorganize.

Opportunities for Improvement

There has been a strong initiative to encourage providers to integrate MyStrength use as a complement to treatment resulting in an 11.3% month over month growth, (DWIHN MyStrength Scorecard). DWIHN offers the My Strength app free of charge. This app allows you to access videos and great information about self-care, depression, anxiety and much more. There are almost 5,000 subscribers which are mostly female ages 35-64. Most people access the app daily with depression and anxiety being the top two most searched topics.

Goal: Increasing Compliance with Antidepressant Medication adults 18 years and older with a diagnosis of major depression who were newly treated with antidepressant medication and remained on their antidepressant medications.

AMM Data Results/HEDIS 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).
Acute Phase Treatment

Time Period	Measurement	Numerator*	Denominator*	Rate	Goal	Comparison to goal
1/1/2020-12/31/2020		826	3066	26.94%	59.28%	59.28% 2020 HEDIS Aggregate Report for Michigan Medicaid
1/1/2021-12/31/2021		989	2396	41.28%	59.28%	

AMM Data Results/HEDIS Measurement-Medication Compliance for Members 18 years or Older with a diagnosis of Major Depression on Antidepressant Medication for at least 180 Days (6 months)
Effective Continuation Phase Treatment

Time Period	Measurement	Numerator*	Denominator*	Rate	Goal	Comparison to goal
1/1/2020-12/31/2020		664	3066	21.66	42.98%	42.98 2020 HEDIS Aggregate Report for Michigan Medicaid
1/1/2021-12/31/2021		320	2396	13.36	42.98%	Waiting for 2021 HEDIS Aggregate report

Quantitative Analysis and Trending of Measures
Detroit Wayne Integrated Network implemented guidelines that instruct providers on the importance of educating members of the importance of medication adherence. DWIHN assessed the top reasons for poor antidepressant adherence, medication side effects, substance abuse, patient insight into illness, attitude towards mediation and lack of efficacy. DWIHN has developed a self-management tool policy that describes the standards for self-management, give direction to the network and to encourage the use of self-management tools. DWIHN offers self-management tools, derived from available evidence, that provide members/staff with information on wellness and health promotion.

Michigan HSAG 2021 reports the antidepressant medication management average health plan results for 2020 for effective acute phase treatment rate as 59.28% which is above the 75th percentile. The 2020 effective continuation phase treatment rate as 42.98%, putting them in the greater than 50th percentile. DWIHN results for 2020 effective acute phase treatment rate, using vital data, was 26.94%. DWIHN results for 2021 effective acute phase treatment rate, using vital data was 41.28%. This is a 14.37 percentage point increase. DWIHN results for 2020 effective continuation phase, using vital data, was 21.66%. DWIHN results for 2021 effective continuation phase, using vital data, was 13.36%. This is an 8.3 percentage point decrease.

Identified Barriers
Covid continues to be a barrier. The State of Michigan did not allow in person face to face visits with our population until July 2021. Some remote workers did not have equipment to work from home at the onset of Covid. Telehealth continues to be a preferred form of contact. Not all clients are computer literate or have the equipment needed to perform the service. Some clients that have government issued phones are preferring to use their phone minutes for emergencies. Transportation continues to be a barrier for those that chose to attend their appointments face to face. The state continues to work on transportation issues.

Post Covid there is a shortage of mental health staff. The Covid vaccine is a requirement to work at provider sites with few exceptions. Social workers are needed at many of the provider agencies. Providers are struggling with a large client population with very little staff to take on the numbers, causing a gap in care for DWIHN client population. Post Covid, agencies are trying to reorganize.

This measure was also presented to the Improving Practice Leadership Team (IPLT) committee for additional insight and to discuss opportunity for improvement. The IPLT membership consists of the Director of Children’s Initiatives, Director of Integrated Care, Chief Medical Officer, Director of Clinical Practice Improvement, Director of Quality Improvement, Provider Network Clinical Officer, Director of Utilization Management and Director of Substance Use Disorders Initiatives and community-based providers.

- Poor instruction by the clinician regarding antidepressant medication including side effects, how to take, purpose of medication.
- Medication related side effects.
- Enrollee/members forgetting to take their medication.
- Emotional concerns of enrollee/members such as fears that antidepressant medications will alter their personality.
- Lack of follow-up care
- Lack of knowledge by the enrollee/member of the importance of medication compliance
- Clients were also found to have difficulty getting to their appointments to obtain medication. Causing a delay with medication fills.
- Feedback was also elicited from contracted facilities in January 2021 and these barriers were identified: clients miss appointments, shortage of staff causing increased caseloads.
- DWIHN has a high transient population causing missed follow up appointments.
- Poor instruction by the clinician regarding antidepressant medication including side effects, how to take, purpose of medication.
- Improve members knowledge regarding importance of taking medication as prescribed.
- Identification of ways that member can be reminded of medication.
- Providing information to members both verbally and written using simple language that is focused and using teach back method.
- 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 ability for member to get appointments at a convenient time and date.
- Identify a process that address members financial status to determine client's qualifications for assistance with medication payments.

Opportunities for Improvement

DWIHN is exploring the idea of having lunch and learns to educate providers on the importance of educating members on the importance of medication adherence.

Acting as a learning institution for Nursing Students in need of a psychiatric clinical experience.

Goal: Increasing the Screening of Members at Risk for Opioid Abuse Through Outreach by Peer Recovery Coaches

This measure proposes to utilize case findings as an intervention in the organization's approach to the Opioid epidemic in Wayne County. This measure will be used to identify at-risk individuals with opioid misuse or addition.

Quantitative Analysis and Trending of Measures

Comparing the FY2020 baseline data for Case Finding for Opiate Treatment for the re-measurement 3 period of FY2021, showed an increase in this measure. FY20 rate (49%) compared to FY2021 (68%). The comparison goal was (79%). During FY2019 DWIHN exceeded its goal for the percentage of persons referred to Peer Recovery Coach to an SBIRT/SUD Screening by Mobile Units, FQHC, Urgent Care, and Primary Care. The goal was 34% or 10% over the Baseline Measurement. The actual measurement was 72%. The goal was not met for both FY2020 and FY2021.

Time Period	Measurement	Numerator	Denominator	Rate	Goal	Statistical Test and Significance
10/1/2018 – 9/30/2019	Remeasurement 1	1690	2353	72%	34%	Met
10/1/2019-9/30/2020	Remeasurement 2	2028	4141	49%	79%	Not Met
10/1/2021-9/30/2022	Remeasurement 3	2896	4263	68%	79%	Not Met

Evaluation of Effectiveness

To improve their skills and image as professionals in substance use treatment, the Peer Recovery Coaches had been trained to screening members found through case finding through SBIRT methods. There was a total of 28 Peer Recovery Coaches who received Motivational Interviewing trainings in the SUD Treatment Provider Network. DWIHN reviewed and monitored these 28 Peer Recovery Coaches and according to the results from the review, their motivational interviewing skills levels were in the low range. DWIHN will continue to provide Motivational Interviewing training and prove technical assistance to their Providers.

DWIHN SUD staff meet with Henry Ford Hospitals (Detroit and Wyandotte) and Garden City Hospitals about having peer recovery coaches in their Emergency Rooms providing SBIRT services. Henry Ford did not place our Peer Recovery Coaches in their Emergency Rooms but accepted placement in their Communicable Disease Unit. On the other hand, Garden City Hospitals and Ascension St. John Hospital allowed our Peer Recovery Coaches in their Emergency Rooms. SUD providers continue to engage in conversations with various hospital staff to discuss the importance of Peer Recovery Coach model and to address the opioid epidemic.

In FY2019 the Peer Recovery Model was active in four hospital settings. Given the resistance other health care setting were sought out. The SBIRT screenings are increasing as the Peer Recovery Coaches in various health care settings (FQHCs, Urgent Care, PCs) are increasing. Various health care setting is beginning to recognize that this Peer Recovery Coach program keeps the individual/members engaged in the primary care needs well meeting their substance use disorder needs. Wayne County Healthy Communities, Western Wayne Family Health Centers, Detroit Community Health Connection, and Central City Integrated Health entered the program. Also, this is no cost to the health care settings since DWIHN funds this service. Progress in the reduction of stigmas was made when DWIHN established relationships with two Office Based Opioid Treatment (OBOTs) and implemented Peer Recovery Coaches working specific days and times in these PCs settings.

The mobile units were a success from the beginning once they began operation in the latter part of this FY18. These units traveled to less desirable areas in Wayne County where those vulnerable to opioid addiction were known to hang out. The mobile units have established dates and times to be at specific locations such as police stations, Church parking lots, and homeless shelters. The mobile units brought services to a population that had no knowledge of or desire to participate in substance use disorder services. The mobile units with embedded Peer Recovery Coaches continue to be successful in increasing their SBIRT screenings.

The Peer Recovery Coaches in conjunction with SBIRT/SUD screening resulted in 1690 screening from mobile unit and health care settings. Of these, 643 individuals were referred to SUD treatment (which was a reduction from Baseline: 89% to 38%). Providers noted that some persons screened were either not in need of SUD treatment or in a pre-contemplative stage and not ready to engage in treatment at this time. Motivational Interviewing skills trainings were conducted to work with those in a pre-contemplative stage.
Other stigma reducing activities in the community were implemented. DWIHN established and disseminated miniature and roadside billboards about how to access prevention, treatment, and recovery services. Twenty (20) large roadside billboards were in high traffic areas throughout Wayne County in 43 cities promoting DWIHN access number, increasing awareness and educating the community on DWIHN SUD services. DWIHN has distributed over 500 miniature billboards to be placed in doctors' offices, FQHCs, in schools and providers sites. DWIHN's intention was to provide additional community education, outreach, and marketing with the use of billboards that will advertise access to SUD services.

These billboards have increased referrals to treatment, heighted relationships with other stake holders, increased access to services, reduced stigma, and increased awareness. The roadside billboards are making a huge impact on referrals to treatment services. Opioid Town Hall meetings and events were held to increase community acceptance of recovery options for opioid addiction:

- 5-11-18 Heroin and Opioid Summit, Livonia (478 attendees)
- 7-15-18 Women and Girls Opioid Conference Detroit (218 attendees)
- 7-21-18 Families Against Narcotics (FAN) Town Hall Meeting (200 attendees)
- 11-17-18 Drug Court Holiday Relapse Prevention Program at the Port Authority (135 attendees)

Another stigma reduction activity was the Hope Not Handcuffs/FAN Program where Peer Recovery Coaches or "angels" to be in law enforcement agencies. The Hope Not Handcuffs/FAN Project is not in all law enforcement agencies in Wayne County but only those in Out-Wayne excluding the City of Detroit. These individuals are not screened by FAN but are referred to be screened from DWIHNs access center for treatment. These individuals are not arrested when at these locations, even if they have warrants for their arrest (these are usually related to drug seeking behavior). If they have assault or murder chargers, then they may be arrested and seek service in our jail or prison programs. There were 267 referrals to treatment from this source.

Identified Barriers

The noted barriers include:

- Some health care settings limit Peer Recovery Coaches in their Emergency Rooms (ER), Federally Qualified Health Centers (FQHCs), Urgent Care and Primary Care (PC) setting which limits the ability of the Peer Recovery Coach to engage persons diagnosed with a substance use disorder with an emphasis on Opioid Use Disorder (OUD)
- Area hospitals do not see the benefit of the Peer Recovery Coach concept. Hospitals limited access to them as they did not identify Peer Recovery Coach's as professional staff.
- Stigma surrounding addition is barrier.

Opportunities for Improvement

DWIHN will continue roadside billboards with messages about how to access prevention, treatment, and recovery services. Twenty (20) large roadside billboards were in high traffic areas throughout Wayne County in 43 cities promoting DWIHN access number, increasing awareness and educating the community on DWIHN SUD services. These billboards have increased referrals to treatment, heighted relationships with other stake holders, increased access to services, reduced stigma, and increased awareness. Funding was reduced; only billboards continue as an intervention in public awareness. The roadside billboards are making a huge impact on referrals to treatment services. They are a low impact intervention as they do not directly impact the Peer Recovery Coach Program, rather the anti-stigma campaigns appear to impact acceptance of recovery options.

Goal: Improving Access to Applied Behavior Analysis (ABA) for Individuals with Autism Spectrum Disorders (ASD) ages 0-20 years of age covered by Medicaid in Wayne County

Quantitative Analysis and Trending of Measures

The goal of reducing the days from the date of approval for ABA services to the appointment with ABA staff was not met. There was improvement (65 % of members received the appointment within 90 days in Q1 2019 to 98% in Q4). The barriers continue to be the difficulty recruiting and retaining ABA staff. MDHHS has a goal for 2018 to focus on the training and recruitment of ABA staff which will help DWIHN. DWIHN continues to work with providers on these issues. The number of providers has increased to twelve, but staff move from provider. The baseline was identified as a measure of timely initiation of ABA service. Currently the number of days from the MDHHS Approval to the date of the initiation of the ABA Direct Service is an average of 90 days to identify those approved for the ASD benefit and date of service initiation.

Increase the number of eligible individuals who are receiving ABA services from an ABA Behavior Technician within 90 days of MDHHS approval

Time period	Measurement	Numerator	Denominator	Rate	Goal	Benchmark
FY22 1st Quarter	Baseline	91	174	52%	100%	
FY22 2nd Quarter	Re-measurement 1	115	186	62%	100%	**Under Goal**
FY22 3rd Quarter	Re-measurement 2	42	69	61%	100%	**Under Goal**
FY22 4th Quarter	Re-measurement 3	20	21	95%	100%	**Under Goal**
FY23 1st Quarter	Re-measurement 4	1	1	100%	100%	

Increase the number of Registered Behavior Technicians and Behavior Technicians working in the DWIHN network to ensure at least 1 RBT or BT for every eligible individual seeking ABA services

Time period	Measurement	Numerator	Denominator	Rate	Goal	Benchmark
FY22 1st Quarter	Baseline	1290	2112	0.61 to 1	1:1	
FY22 2nd Quarter	Re-measurement 1	1287	1724	0.74 to 1	1:1	**Under Goal**
FY22 3rd Quarter	Re-measurement 2	1369	1784	0.77 to 1	1:1	**Under Goal**
FY22 4th Quarter	Re-measurement 3	1370	1804	0.76 to 1	1:1	**Under Goal**
FY23 1st Quarter	Re-measurement 4	1435	1805	0.80 to 1	1:1	**Under Goal**

Evaluation of Effectiveness
The goals remained the same for all measures throughout the project. Tracking of staff begin in October 2014 with the direct contract restructuring. The eligibility population increased from 18 months through 5 years of age to birth through 20 years of age on January 1, 2016. This increase significantly increases the eligible population and increased capacity needs therefore impacting performance areas.

Identified Barriers
Providers continued to experience barriers related to staff shortages and timely access to ABA continues to be an issue. The staff needed to provide direct intervention of ABA therapy must be trained with specific Practice Standards per the BACB®. Using these Practice Standards, the BCBA® created a third level of certification which is called the Registered Behavior Technician (RBT®). An RBT® is defined as a paraprofessional who provides direct implementation of behavioral procedures for skill acquisition and aberrant behavior reduction developed by a supervisor, and receives weekly supervision by a BCBA®, BCaBA®, or individuals working toward certification. The State of Michigan requires these individuals to receive RBT® specialized training prior to furnishing services but are not required to register with the BACB® upon completion.

Opportunities for Improvement
To meet the member needs:

- Increase communication and coordination in the network about recruiting appropriate professionals and timely initiation of treatment.
- Remove barriers to service access by streamlining processes and educating the network and community on the ABA Benefit.
- Improve the feedback look and workflow through restructuring contracts and service flow, establishing workflow and instructional guide, maintaining on-going monthly ABA System of Care Meetings, establishing on-going comprehensive training and engagement plan.
- Implement ongoing case monitoring system and notices to ensure each case is moving through the benefit in a streamlined process.

Goal: *Increase the Percentage of Youth Members Who Received the PHQ-A Screening at Initial Intake*

The Patient Health Questionnaire-A (PHQ-A) is the nine-item depression scale of the patient health questionnaire. It is one the most validated tools in mental health and can be a powerful tool to assist clinicians in diagnosing depression and monitoring treatment response. The nine items of the PHQ-A are based directly on the nine diagnostic criteria for major depressive disorder in the DSM-IV. The PHQ-A is unique in that it functions as a screening tool to aid in diagnosis and as a symptom tracking tool that can help track a youth's overall depression severity as well as track the improvement of specific symptoms in response to treatment, whether psychotherapy, psychopharmaceutical or both. While assessment for major depression must be completed and documented, the PHQ-A does not substitute for a clinical assessment. Formal assessment of suicide risk is required of clinicians and must be documented in the medical record.

Clinicians are expected to assess for comorbid conditions that may impact treatment recommendations and utilize the PHQ-A scores as well as assessment findings to identify target symptoms for treatment and monitoring. It is recommended that the PHQ-A should be administered 16 weeks after intake visit, if the youth has a score of 10 or higher on the initial screening, and clinicians should document changes to target symptoms. A lack of significant response to treatment should result in an adjustment to the treatment regime as well e.g., frequency, adherence, diagnosis, psychosocial stressors, and other causes for exacerbation of symptoms. Clinicians will treat to remission (PHQ-A less than 10) and continue to treat for at least 9-12 months from the initiation of the treatment. The PHQ-A will continue to be used to monitor for any exacerbation/recurrence of symptoms at least annually.

Quantitative Analysis and Trending of Measures

As illustrated in the charts below, the baseline measurement was obtained by finding the percentage of youth who received the PHQ-A screening at the initial intake between October 1, 2019 and September 30, 2020. The baseline goal was set as 100% compliance for all youth ages 11-17 and designated as SED and/or SUD. Within Fiscal Year 2020 (baseline measurement), 4,452 intakes for youth with an SED/SUD designation were completed and 4,170 PHQ-A screenings were completed upon intake. The baseline rate equaled 93%._The first remeasurement covered Fiscal Year 2021 (October 1, 2020-September 30, 2021), during which 4,218 intakes were completed and 4,061 received the PHQ-A screening. The rate then increased to 96% completed intakes with a PHQ-A screening. The second remeasurement covered Fiscal Year 2022 (October 1, 2021- September 30, 2022) during which 3,291 intakes were completed and 3,267 received the PHQ- A screening. The rate increased to 99.2% completed intakes with a PHQ-A screening.

Quantifiable Measure Percentage of Youth Members Who Received the PHQ-A Screening at Initial Intake

Measurement Period	Measurement	Numerator	Denominator	Rate	Comparison Goal
10/1/2019 -9/30/20 (FY2020)	Baseline	4170	4452	93%	N/A
10/1/2020- 9/30/2021 (FY2021)	Remeasurement 1	4061	4218	96%	95%
10/1/2021- 9/30/2022 (FY2022)	Remeasurement 2	3267	3291	99.2%	100%

The quantifiable measure in chart 2 was created based on the expectation that, with the addition of behavioral health treatment services through a DWIHN provider, there will be a decrease in PHQ-A scores for youth who screen positive for depression at intake when compared to the subsequent screenings every 16 weeks for the year. This measure should solely capture those who received a score of 10 or higher on the initial screening and received a follow-up screening within 16 weeks of their initial PHQ-A until the score drops below a 10. The baseline measurement reflects the number of youths designated as SED/SUD who received the PHQ-A upon intake who then had a follow-up PHQ-A screening at 16 weeks thereafter until the score dropped below a 10, between October 1, 2019, and September 30, 2020. There were 1,693 with a PHQ-A greater than 10 and 654 of those youth had compliant follow-up. Based on these numbers, the baseline rate was 38.6%.

During the rating period of October 1, 2020, and September 30, 2021, 1,639 youth had a PHQ-A greater than 10 upon intake and, of those youth, 763 received a follow up PHQ-A within 16 weeks until their score dropped below a 10. The rate increased to 46.5% and the rate of compliant follow up compared to the previous rating period increased by 7.9%. During the rating period of October 1, 2021, and September 30, 2022, 1,370 youth had a PHQ-A greater than 10 upon intake and, of those youth, 594 received a follow up PHQ-A consistently every 16 weeks until their score dropped below a 10. The rate decreased from 46.5% in Fiscal Year 2021, dropping to 43.4% compliance (a decrease of 3.1%).

Quantifiable Measure Percentage of youth members ages 11-17 with an SED/SUD disability designation that had a PHQ-A score equal to or greater than 10 upon Intake who received PHQ-A screening every 16 weeks thereafter until the resolution of depressive symptoms (PHQ-A score <10)

Measurement Period	Measurement	Numerator	Denominator	Rate	Comparison Goal
10/1/2019 -9/30/20 (FY2020)	Baseline	654	1693	38.6	N/A
10/1/2020-9/30/2021 (FY2021)	Remeasurement 1	763	1693	46.5%	95%
10/1/2021-9/30/2022 (FY2022)	Remeasurement 2	594	1370	43.4%	95%

Evaluation of Effectiveness

DWIHN has made considerable progress with the initiative to have practitioners consistently complete a PHQ-A with youth ages 11-17 upon initial intake, with the rate of completion rising from 93% (baseline), to 96% during the first remeasurement (October 1, 2020-September 30, 2021), to 99.2% at the end of the second remeasurement (October 1, 2021-September 30, 2022). Meaningful progress was also made in the timely completion of follow-up PHQ-A screenings if the youth scored 10 or higher on the screening. The requirement is, as mentioned above, that a screening should occur every 16 weeks from the initial score of a 10 on the PHQ-A until the score drops below a 10. The rate of timely follow-up rose from 38.6% compliance at baseline to 46.5% at the first remeasurement (October 1, 2020-September 30, 2021) but then dropped from 46.5% to 43.4% at the second remeasurement.

Identified Barriers

A review of the baseline data from Fiscal Year 2020 showed that while progress was being made in the completion of PHQ-A screenings at intake, barriers to achieving objectives:

- Lack of consistent completion of follow-up PHQ-A screening done by providers
- Lack of knowledge among providers of the importance of measuring response to treatment using an objective measure (PHQ-A tool) versus clinical observation.
- Lack of knowledge of the PHQ-A and use of the PHQ-A across the provider network, specific to working with children and youth.
- High rates of turnover and inability to fill vacant positions has reportedly become a barrier to clinical staff consistently completing PHQ-A screenings.
- Cases closed in the provider Electronic Medical Record do not close in MH-WIN for 90 days resulting in inaccurate data (i.e., cases showing that they did not have a follow-up screening in a timely manner however they were closed, and MH-WIN was not updated).

Opportunities for Improvement

- Create uniformity in EMR systems by potentially having all the agencies within the provider network move to a PCE system or work with IT department to link their Electronic Medical Record to MH-WIN, allowing an easier exchange of data and record with the MH-WIN system monitored by DWIHN.
- Address lack of knowledge of the importance of completing the PHQ-A both initially and in follow-up by providing additional education on the importance of use and technical support to those agencies who are struggling with compliance.
- Work with PCE systems and DWIHN to create a “hard stop” within the Integrated Biopsychosocial which would disallow the signing of the document (completion) until the PHQ-A is reviewed and scored, if applicable to the person being screened.
- Work with PCE systems and DWIHN to recommend and enforce that all agencies with a PCE system are creating a reminder within their system to prompt when the subsequent PHQ-A is due, based on the member’s previous score.
- Reports to be created for practitioners listing members who have not had an initial PHQ-A and/or a follow-up PHQ-A to monitor response to treatment with expectation set that these will be completed.

Goal: *Increase the Percentage of Adults Who Scored 10 Or Greater on the PHQ-9 Screening at Intake Who Had a Follow-up PHQ-9 Screening*

DWIHN has an organizational goal to reduce the suicide rate for enrolled members. It is estimated 90% of those who died by suicide have had a mental health concern. 60% of those had a mood disorder (e.g., major depression, bipolar depression, persistent depressive disorder - dysthymia). Even among those treated for depression, the rate of death by suicide can be 4% to 7% higher than other mental health concerns. In the DWIHN system, 15% of adults with a disability designation of serious mental illness (SMI) and/or substance use disorder (SUD) are diagnosed with Major Depression or Bipolar Depressive Disorder.

Data Results/ Measurement – Percentage of Adults Who Scored 10 or Greater on the PHQ-9 Screening at the Initial Intake that had a Second PHQ-9 Screening within 16 Weeks

Quantitative Analysis and Trending of Measures

The baseline goal was set at 75% compliance for all adults seeking SMI and/or SUD services. Within the first two quarter for FY2019 (FY 2019 Q1 and Q2) 1842 adult completed intakes for SMI and SUD during the first and second quarter. Of that number, 257 scored 10 or greater, and placed them in the category for 90-day rescreening. The data indicated only 44 reassessments were conducted. Comparing the FY2021 baseline data, showed the first two quarter for FY 2021 (FY 2021 Q1 and Q2) 9,433 adults completed intakes for SMI and SUD during the first and second quarter. Of that number, 4,412 scored 10 or greater, and placed them in the category for 90-day rescreening. The data indicated only 5,021 reassessments were conducted.

Percentage of Adults Who Scored 10 Or Greater on the PHQ-9 Screening at Intake Who Had a Follow-up PHQ-9 Screening

Time period	Measurement	Numerator	Denominator	Rate	Goal	Difference
FY 2021 Q1	First Quarterly Data Query	3802	2285	60.1%	95%	**-34.9%**
FY 2021 Q2	Second Quarterly Data Query	4079	2651	65%	95%	**-30%**
FY 2021 Q3	Third Quarterly Data Query	4341	2757	63.5%	95%	**-31.5%**
FY 2021 Q4	Fourth Quarterly Data Query	4328	2617	60.5%	95%	**-34.5%**
FY 2021	3rd Full Year Remeasurement	10252	3817	37.2%	95%	**-57.8%**

The baseline goal was set at 95% compliance for all adults seeking SMI and/or SUD services. Within the first two quarter for FY2022 (FY2021 Q1 and Q2) 9,433 adults completed intakes for SMI and SUD during the first and second quarter. Of that number, 4,412 scored 10 or greater, and placed them in the category for 90-day rescreening. The data indicated only 5,021 reassessments were conducted. The results are displayed in the tables below.

Percentage of Adults Who Scored 10 Or Greater on the PHQ-9 Screening at the Initial Intake

Time period	Measurement	Numerator	Denominator	Rate	Goal	Difference
FY 2022	First Quarterly Data Query	3803	3755	98.7%	95%	**3.7%**
FY 2022	Second Quarterly Data Query	6214	6152	99.2%	95%	**4.2%**
FY 2022	Third Quarterly Data Query	5648	5606	98.9%	95%	**3.9%**
FY 2022	Fourth Quarterly Data Query	6090	6043	99.4%	95%	**+4.4%**
FY 2022	4th Full Year Remeasurement	21755	21556	99.1%	95%	**4.1%**

Percentage of Adults Who Scored 10 Or Greater on the PHQ-9 Screening at Intake Who Had a Follow-up PHQ-9 Screening

Time period	Measurement	Numerator	Denominator	Rate	Goal	Difference
FY 2022 Q1	First Quarterly Data Query	3767	2089	57.2%	95%	**-37.8%**
FY 2022 Q2	Second Quarterly Data Query	4239	2912	65.6%	95%	**-29.4%**
FY 2022 Q3	Third Quarterly Data Query	4776	2887	60.6%	95%	**-34.4%**
FY 2022 Q4	Fourth Quarterly Data Query	4842	3079	62.6%	95%	**-32.4%**
FY 2022	4th Full Year Remeasurement	11184	4302	38.5%	95%	**-53.5%**

Evaluation of Effectiveness

DWIHN utilizes the PHQ-9 to monitor members' depressive symptoms. Using the SMART goal setting method, (specific, measurable, attainable, realistic, timely), DWIHN has set a goal of implementation of the initial PHQ-9 screening for all intakes by 75 % between October 1, 2020 – December 31, 2021, and 95% in the period between January 1, 2022 – December 31, 2022.There are two measures of compliance to the clinical guidelines for managing adults with major depression: The percentage adult members age 18 and older with a screening PHQ-9 at intake of all intakes after September 27, 2019, and the percentage of adult members age 18 and older with a diagnosis of Major Depression (PHQ-9 score greater than or equal 10) who received the second screening with a PHQ-9 within a three-month measurement period. There is one outcome measure: The percentage of adult members aged 18 and older that obtained a PHQ9 screening at intake and scored 10 or higher, who had a subsequent PHQ9 done, and whether this score was higher, lower or equivalent to the initial score. The baseline measurement for the 'Results of Adults, who received the PHQ-9 Screening at the initial intake'. The baseline goal was set at 75% compliance for all adults seeking SMI and/or SUD services.

Identified Barriers

- Historically providers have not been as methodical in utilizing standard tools for screening, and for monitoring the outcomes of treatment. Opportunity: Improve compliance of providers and practitioners in utilizing standardized tools to monitor treatment outcomes.
- Lack of knowledge among providers of the importance of measuring outcomes using an objective measure (PHQ-9 tool) versus clinical observation.
- Lack of knowledge/consistent practice among providers of the clinical guidelines for managing adults with major depression.
- Disconnection of electronic data systems. Providers were not able to upload PHQ-9 data to MHWIN. It is difficult to determine to what degree provider data was not able to be loaded to MHWIN due to the lack of having a functional Health Information Exchange (HIE) system in place, or to the lack of consistently administration of the screening measure. There is an opportunity to address both items.

Goal: *Improve care coordination and communication across the behavioral health network*

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 for Members getting the care or services they need and 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. During Fiscal Year 2021, Detroit Wayne Integrated Health Network (DWIHN) issued a Provider Network Satisfaction Survey to 529 provider organizations. DWIHN received responses from 140 provider organizations (26.5% response rate). The total number of actual respondents for was 280 out of 1243 individual practitioners (22.5% response rate). The Survey included several questions regarding provider satisfaction with coordination and communication across the behavioral health network such as "How satisfied are you with the information you receive on the course of treatment between the Psychiatrist and SUD Providers on an ongoing basis (at least once a month)?", "How satisfied are you with the information you receive on the course of treatment between the Support Coordinator and Direct Care workers on an ongoing basis (at least once a month)?", and "In your specific role, how satisfied are you with the communication related to treatment, services, and supports among all Healthcare Practitioners, Psychiatrist, and Support Personnel within your system?".

76.4 % reported satisfaction with the information received on the course of treatment between Psychiatry and SUD Providers on an ongoing basis. This was a 1.4 percentage point increase over the previous fiscal year (75%). 80.1% reported satisfaction with the information received on the course of treatment between Supports Coordinator and Direct Care Workers on an ongoing basis. This was a 6.9 percentage point increase over the previous fiscal year (73.2%). 72.5% reported satisfaction with the communications related to treatment, services, and supports among all Health Care Practitioners, Psychiatrists, and Support Personnel within the system. This was a 0.9 percentage point decrease from the previous fiscal year (73.4%)

DWIHN set a goal of 80% or greater for all the questions on the practitioner satisfaction survey and for questions scoring under this goal an action plan is required. Although DWIHN saw improvements in the satisfaction of communication between psychiatry and SUD providers and Supports Coordinators and Direct Care Workers, the 80% goal set by DWIHN nor the State Performance Measure goal of 95% set by the state of Michigan for the PIHP's for Continuity and Coordination of Care was met. This may be attributed to a shutdown of face-to-face services mandated except for the most critical services, 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.
which is still considerably.

Evaluation of Effectiveness

DWIHN worked with the following health plans in FY2021: 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 FY2021, 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 FY2021. During FY2020, DWIHN managed 560 community hospital admissions of MI-Health Link members. 92 MHL members were readmitted in FY2020 and in FY2021, there were 58 members who were readmitted within 30 days of discharge. The number of readmissions decreased by (47%) in FY2021. Molina saw the highest number of admissions during FY2021 at 251, (40%) of the DWIHN MHL admissions for FY2020. AmeriHealth had the lowest number with 60 members admitted, followed by MI Complete, with 62 admissions.

Identified Barriers

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

DWIHN strives to provide continuous support to the community through educational outreach and engagement while placing an emphasis on recovery and supporting resilience. Workforce Development and Retention efforts continue to focus on maintaining and expanding a centralized training program for 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.

More than 60 mental health professionals engaged in interprofessional education to enhance competency in culturally responsive and trauma informed engagement, assessment, treatment planning, and intervention with individuals diagnosed with co-occurring disorders. Several dozen training sessions in areas identified as high need to improve engagement and collaboration with local stakeholders (law enforcement, employment providers, faith-based communities, etc.), strategies for working with youth that are at risk for community violence, and social determinants of health have been provided at no charge to providers within the network.

Quantitative Analysis and Trending of Measures

During the past fiscal year, the country has grappled with challenges of workforce retention which causes a burden on the ability to develop a workforce that is able to implement evidence-based and best practice methods. Prior to COVID19, behavioral health workforce systems had a significantly high turnover rate. In efforts to address historical and future workforce retention challenges, the department continued efforts 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 recognized the innovative university and community partnership model nationally and regionally. Recently, a publication that shares the outcomes of the training model has been accepted for publication.

Area on Health Education Centers (AHEC) is a national program committed to expanding of the healthcare workforce by offering creative, practical, and innovative health career curriculums for pre-college level students. AHEC provided additional inter-professional training to 19 trainees accepted as AHEC scholars..

DWIHN has active affiliation agreements with academic institutions at the undergraduate and graduate training level. Current trainees completing field practicums within the provider network represent Wayne State University, University of Michigan, Eastern Michigan University, Wayne County Community College, Madonna University, Central Michigan University, Simmons University, University of Phoenix, Michigan School of Psychology, and Michigan State University. Student learners are actively engaged in didactic and practical training that meets the State of Michigan health code requirements for community mental health providers. While providing the minimum required training for new practitioners, efforts for recruitment and retention included attending virtual job fairs and student organization career events at local institutions.

Provider trainings are available at Detroit Wayne Connect, a continuing education platform for stakeholders of the behavioral health workforce. We strive to provide a variety of live and online courses. Log on at dwctraining.com. SUD Trainings are also available on Improving MI Practices posted at www.dwihn.org.

Future Workforce Initiatives

DWIHN has partnered with WSU on a ‘pathway' to a professional program which is geared toward Recovery Support Specialists who are interested in furthering their career in behavioral health by way of continuing education, certifications, bachelor or Master level programs. As we lay out these 'stackable' credentials for peers – we are meeting to review participant interest and how we can include Peers on multiple projects collectively. DWIHN has also partnered with WSU to apply for the Gilbert Family Foundation for a program that would pay a stipend for social workers to intern in CMH specific settings. It would include up to 30 interns and would offer $5,000 per semester. To date, no decision has been made by the Foundation so we are still hopeful this funding will be awarded.

Credentialing and Re-Credentialing

DWIHN has established written policy and procedures, in accordance with MDHHS’s Credentialing and Re-Credentialing Processes, 42 CFR 422.204, and National Committee for Quality Assurance (NCQA) for ensuring appropriate credentialing and re-credentialing of the provider network. Whether directly implemented, delegated, or contracted, DWIHN ensures that credentialing activities occur upon employment/contract initiation, and minimally every two (2) years thereafter. DWIHN written policies and procedures also ensure that non-licensed providers of care or support are qualified to perform their jobs, in accordance with the Michigan PIHP/CMHSP Provider Qualifications per Medicaid Services & HCPCS/CPT Codes.

Quantitative Analysis and Trending of Measures

There are over 4,000 practitioners in the network and over 2,000 have been credentialed. CVO refers to the use of a Credentials Verification Organization to perform medical credentialing on behalf of a healthcare practice or organization. Our CVO Medversant verifies a provider's credentials by obtaining primary source verification of a practitioners or provider's qualifications on our behalf. In FY2021/2022, there were 1126 practitioners credentialed and 93 Behavioral Health and Substance Use Disorder providers credentialed, which is a 23% increase when compared to the last fiscal year (913). All files were clean, had appropriate checks done, and had no issues or concerns.

Evaluation of Effectiveness

DWIHN has oversight of the Credentialing Verification Organization to ensure that they comply with the contractual requirements. DWIHN meet weekly with the CVO. During each meeting an Action Item list is reviewed with goals to improve the primary source verification process. Each Action Item has a due date and the person responsible for achieving the goals. The individual might be a staff of the CVO or DWIHN. The items most of the time are systemic. There are instances where the items are specific to a provider or practitioner. This tool is utilized also to determine compliance with identified NCQA standards. The CVO also has a Call Center that practitioners and providers call to resolve credentialing issues and a report is submitted monthly.

In addition, the DWIHN Credentialing Committee has a process to provisionally credential organizations that are providing services that are needed urgently, providers that are given deemed status as a result of credentialing by another PIHP. The time period is 120 days from approval by the Credentialing Committee. The Credentialing staff will conduct the following reviews: determine that there are not any sanctions—Office of Inspector General, Systems for Award Management, Michigan Department of Health and Human Services, that the licenses and certifications are current, a site visit to determine that there are no environmental issues if it a residential facility does it comply with the Home and Community-Based Services standards, whether there are enough staff trained to provide the services. If all those elements are substantially met the provider will be given provisional approval at the next Credentialing Meeting. They will be scheduled for the next credentialing application training. The Credentialing Unit maintains a spreadsheet regarding provisional credentialing.

Workforce Shortages

There is currently a critical shortage of healthcare workers, particularly in behavioral health. The shortage is not just in our county or State but is Nationwide. Unfortunately, according to data, Michigan is in the top five states with a healthcare workforce shortage. Evidence and resources indicate that the shortage is attributed to several factors:

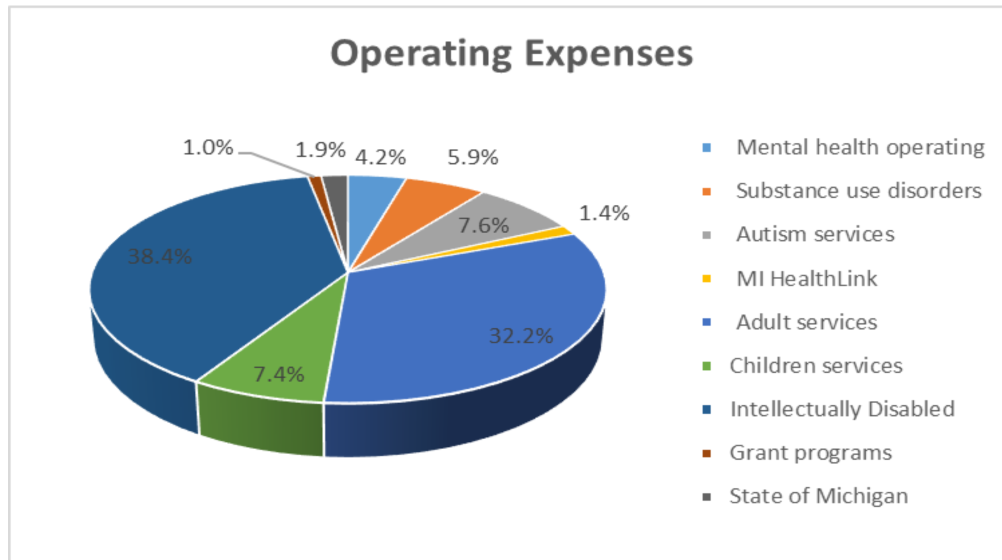
1. Covid-19 resulted in many staff resignations
    - ➢ More options to work from home
    - ➢ People changing career paths
2. Shortage of behavioral health workforce particularly: Master's Level Licensed Social Works, psychiatrists and Nurses.
    - ➢ Organizations are pulling from the same limited pool of professionals
3. Current staff are moving into private clinical practice as there is less paperwork and what is described as administrative burden.
4. Current shortage staff shortages have resulted in high caseloads and creates a vicious cycle.
5. Staff believe that they do not have training and resources that help them feel supported.
6. Increasing staff burnout due to all of the above.

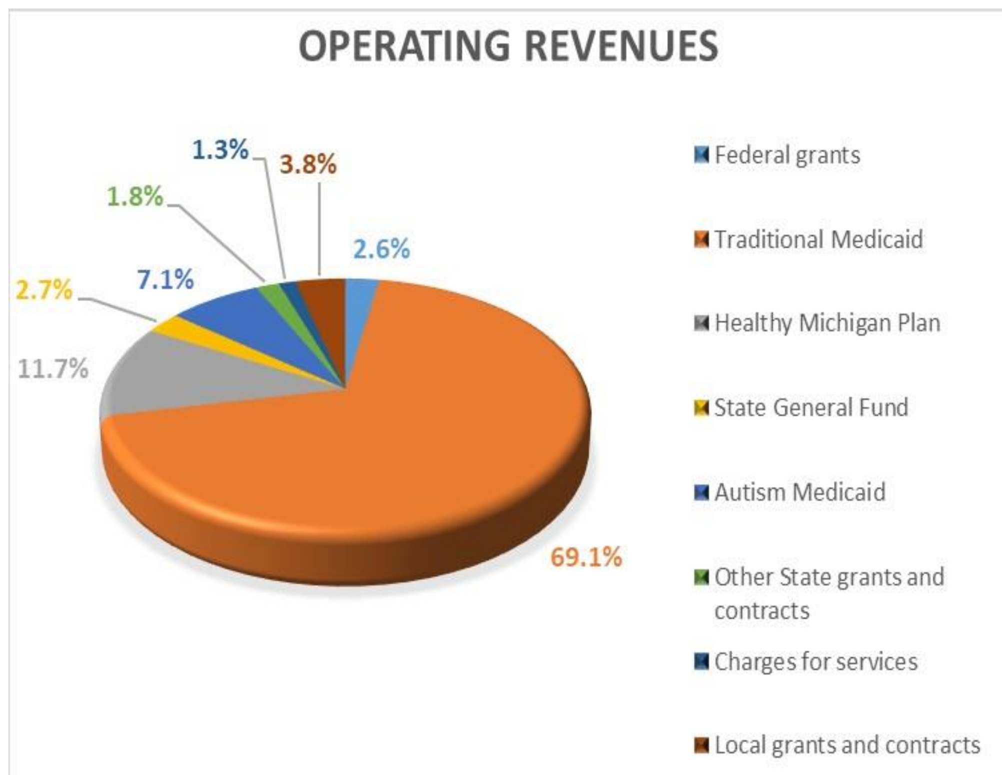
Opportunities for Improvement

- Established a modifier that allows clinicians with a bachelor degree with proper credentials the option of completing the readmission and annual IBPS. This supported the provider network by reducing the strain on Master level clinicians.
- Removed the pre-authorization requirement for Assessments and Treatment Plans which allows staff to provide those services without any potential pre-authorization barrier.
- Added additional Service Utilization Guidelines so frequently used, medically necessary services could be automatically approved in the system based on a member's level of care. υ
- Removed duplicative provider reporting in the Children's Initiative Department. υ
- Ongoing discussion with the providers in a workgroup to do a crosswalk that streamlines areas of assessed need from the IBPS to populate as goals that should be addressed in the IPOS (this is announced and will be in development)
- To help our providers and members, we have continued to support use of Telemedicine at this time, though we are waiting for finalized State guidelines that are moving towards use of audio-visual and not just audio
- Ensure that providers who are not accredited, that an on-site quality assessment or alternative quality assessment is conducted.
- Ensure that the recredentialing process occurred within the two-year time frame requirement.
- Ensure that providers are validated to be approved by an accredited body.

Finance Pillar

The charts below indicate funding sources utilized to pay for an individual's service in FY2021/2022. It combines general Medicaid, Healthy Michigan, Habilitation Waiver, and other waiver programs which are all Medicaid, accounting for (80.8%) 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 (6.9%); decreased from (2.1%) last fiscal year. General Fund is reflected at 2.7% (a changed from 3.3% in FY2021/2022) and MI Health Link is at 1.4% (no change from the previous last year). The funding source mix is very similar to last year. Further analysis is required to determine if funding source impacts overall utilization.





Advocacy Pillar

The goal is to monitor network implementation of the Home and Community Based Services (HCBS) transition to ensure quality of clinical care and service. The HCBS rule requires that providers make sure that individuals receiving services have the opportunity to make decisions about their lives, are supported in their desire to participate in the community, and have their rights respected. All transition planning will occur through the person-centered planning process and be consistent with all Medicaid requirements.

Home and Community Based Services (HCBS)

In FY2022, Performance Monitoring staff conducted provider site reviews to ensure HCBS compliance with standards were the supports and services individuals receive, give individuals the opportunity for independent decision-making, to fully participate in community life, and to make sure their rights are respected. The transition planning process have identified 54 members as being in setting as "non-compliant" and were placed on the "Heightened Scrutiny" List. These Members required Transition Planning by March 17, 2023. In FY2022, Performance Monitoring staff conducted fifty-two (52) residential treatment provider reviews and twenty-forty (24) HCBS validation reviews.

Evaluation of Effectiveness

The compliance with Home and Community Based Services (HCBS) Rules under Medicaid is ongoing. DWIHN has developed and prioritized an action plan to conduct monitoring reviews of our provider network to ensure full compliance with HCBS requirements. DWIHN remains steadfast in its commitment to continue to provide technical assistance to our members and stakeholders to identify implementation approaches that ensure the provision of Medicaid services in a manner consistent with the HCBS program requirements. The HCBS information can be accessed on DWIHN's website at dwihn.org under "For Providers" and "For Members

Identified Barriers

The noted barrier is that the HCBS implementation process must be completed no later than March 17, 2023. Without the adequate implementation of comprehensively overhaul individual care/service plans to include HCBS standards and quality monitoring for compliance to meet those standards, members could be subject to a reduction in services and lack of access to care. In addition, members will be at-risk for reduced federal funding for services and supports that do not meet the requirements of the HCBS Rule. HCBS services include community living supports (CLS), skill building and supported employment services.

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 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.
- Define person-centered planning requirements. This includes:
    - ✓ Plain language writing that is understandable by all parties, including the beneficiary.
    - ✓ Achievable, culturally sensitive goals that have meaning to the beneficiary.
    - ✓ Offering a choice of programs and demonstrating which programs and providers the beneficiary has chosen from available offerings.
    - ✓ Building in the philosophy of the dignity of risk with defined and agreed-upon measures to minimize risk to the beneficiary.
    - ✓ Using evidence-based, functional needs assessments to determine the clinically assessed need tied to the beneficiary's disability.

Community Outreach

The department attended over 100 community outreach and engagement events during FY2021-2022. DWIHN has developed a Community mobile application titled myDWIHN. The myDWIHN app allows you to find out information about mental health, substance use disorder, disability, and children's resources. It also allows you to find any one of our 400 service providers. The myDWIHN app is available to be downloaded by anyone.

Social Media

DWIHN's social media accounts are growing with an increase in impressions across all four channels. DWIHN utilizes Facebook, Instagram, Twitter, SnapChat Tik-Tok and You Tube to get its messaging across all platforms. It also streams educational messaging on Snap Chat, Spotify and Pandora.

Self-Management Performance Improvement

DWIHN also offers the My Strength app free of charge. This app allows you to access videos and great information about self-care, depression, anxiety, and much more. There are almost 5,000 subscribers which are mostly females ages 35-64. Most people access the app on a daily basis with depression and anxiety being the top two most searched topics.

Ask the Doc

DWIHN's Chief Medical Officer Dr. Shama Faheem continues to educate the public with her bimonthly newsletter containing information about mental health-related questions that are sent in by staff, stakeholders, and 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/.

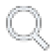
DWIHN Website

Members, Stakeholders and Providers can access DWIHN's website to view member handbooks, provider directory, access to services, reports, annual evaluation, policies, and procedures. For more information on the DWIHN website, please visit the link https://dwihn.org/.

The Persons Point of View newsletters continued to be published quarterly. In addition, monthly video announcements on trending topics were featured on YouTube, and reached 341 (86%) individuals.

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

Find a Provider



https://dwihn.org

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

Sharing 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 FY2019-2021
  - QAPIP Description Plan FY2021-2023
- QAPIP Annual Evaluation
  - QAPIP Annual Evaluation FY2017
  - QAPIP Annual Evaluation FY2018
  - QAPIP Annual Evaluation FY2019
  - QAPIP Annual Evaluation FY2020
  - QAPIP Annual Evaluation FY 2021
  - QAPIP Annual Evaluation FY 2022
- Home and Community Based Services (HCBS)
  - For HCBS Questions please E-Mail to Quality@dwihn.org and HCBSInfor.PIHP@dwihn.org.

DWIHN Accreditation

DWIHN has been accredited for three years through the National Committee for Quality Assurance (NCQA). In FY2021, 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.

Preformance Improvement Project (PIP)

During FY2022 validation, DWIHN initiated the PIP topic*: Reducing the Racial Disparity of African Americans Seen for Follow-Up Care Within 7-Days of Discharge from a Psychiatric Inpatient Unit*. 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 DWIHN identified through data analysis, a disparity between its Black or African American and White populations for the PIP topic. The goals are to increase the percentage of eligible Black or African-American members who receive a follow-up visit with a mental health practitioner within seven days of a hospital discharge for mental illness and eliminate the identified disparity without a decline in performance for the White population. The follow-up after inpatient discharge is important in the continuity of care between treatment settings and in ensuring that members receive care and services. Members receiving appropriate follow-up care with a mental health practitioner can reduce the risk of repeat hospitalization.

African American's make up the largest portion of our population served at 55%. In addition to supporting the initiative by the state to address issues of racial and ethnic disparities, DWIHN reports state performance measures to MDHHS in relation to 7 and 30-day follow-up after a behavioral health admission which has a goal of 95% set by the state and readmission rates whose goal set by the state is of 15% or less. DWIHN readmission rate in 2020 was 19.67% and in 2021 16.82%, the state performance measures are part of how DWIHN is evaluated by the state. Improving the follow-up after 7 days after an inpatient behavioral health admission in African Americans this will help to positively affect these state performance measures and our annual evaluation by the state.

Performance Indicator Results

Performance Indicator	Baseline (1/1/2021–12/31/2021)	Remeasurement 1 (1/1/2023–12/31/2023)	Remeasurement 2 (1/1/2024–12/31/2024)	Sustained Improvement
Follow-Up within 7 Days After Hospitalization for Mental Illness for the Black or African-American Population.	35.7%			
Follow-Up within 7 Days After Hospitalization for Mental Illness for the White Population.	40.2%			

Evaluation of Effectiveness

As illustrated above, DWIHN reported that 35.7 percent of Black or African-American members who were hospitalized for treatment of selected mental illness diagnoses had a follow-up visit with a mental health practitioner within seven days of discharge, and 40.2 percent of White members who were hospitalized for treatment of selected mental illness diagnoses had a follow-up visit with a mental health practitioner within seven days of discharge. The goals for the PIP are that there will no longer be a statistically significant rate difference between the two subgroups, and that the disparate subgroup (Black or African-American population) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (White population). The re-measurement 1 period will be calculated from January 1, 2023 – December 31, 2023.

Identified Barriers

No goal set at this point as awaiting baseline data to set the goal for 2022.

Opportunities for Improvement

- Improve the Crisis Providers and Outpatient providers communication and practices to ensure seamless transitions for members transferring levels of care.
- Increase resources and solutions to assist members to get to their appointments.
- Increase member awareness of the importance of follow-up appointments.
- Creation of educational materials, and advertising resources and increase communication with members.
- Encourage and educate healthcare providers to convey respect and compassion to members including acknowledging members' feelings and perspectives during appointments.
- Stigma among the African American population in relation to having mental health issues.
- Improve education and awareness about mental health and stigma through public education campaigns and community educational presentations.

Performance Measures Validation (PMV)

The purpose of performance measure validation is to assess the accuracy of performance indicators reported by PIHPs and to determine the extent to which performance indicators reported by the PIHPs follow state specifications and reporting requirements.

Quantitative Analysis and Trending of Measures

In FY22, 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), for the second consecutive year.

Evaluation of Effectiveness

DWIHN continues to meet all required reportable areas with the performance indicator data, confirming that DWIHN's systems and processes successfully captured critical data elements needed to calculate performance indicators in alignment with MDHHS' expectations and codebook.

Identified Barriers
No barriers Identified

Opportunities for Improvement

- 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.
- Ensure that subsequent re-evaluations of members do not affect the original PAR disposition date and time
- Access to provider notes on their attempts to reach members when they no show for intake appointments.

Compliance Review

This part of the review focuses on standards identified in 42 CFR §438 and applicable State contract requirements. FY2021 commenced a new 3-year review cycle. The compliance reviews consist of 13 program areas referred to as standards. HSAG conducted a review of the first six standards in Year One (FY 2021). The remaining seven standards w reviewed in Year Two of (FY 2022). In Year Three (FY 2023), a comprehensive review will be conducted on each element scored as Not Met during the FY 2021 and FY 2022 compliance reviews.

Quantitative Analysis and Trending of Measures

DWIHN achieved an overall compliance review score of 83 percent in FY2022 compared to 77 percent in FY2021. The areas with the greatest opportunity for improvement were related to Provider Selection, Grievance and Appeal Systems, Sub-contractual Relationships and Delegation, Practice Guidelines, Health Information Systems, and Quality Assessment and Performance Improvement Program, as these areas received performance scores below 90 percent as illustrated below.

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VII—Provider Selection	16	16	12	4	0	75%
Standard VIII—Confidentiality[1]	11	11	10	1	0	91%
Standard IX—Grievance and Appeal Systems	38	38	32	6	0	84%
Standard X—Sub-contractual Relationships and Delegation	5	5	4	1	0	80%
Standard XI—Practice Guidelines	7	7	6	1	0	86%
Standard XII—Health Information Systems	12	11	9	2	1	82%
Standard XIII—Quality Assessment and Performance Improvement Program	30	30	25	5	0	83%
Total	119	118	98	20	1	83%

Evaluation of Effectiveness

DWIHN scored a total compliance score of 83 percent during SFY2022 compliance monitoring review, as compared to 77 percent in SFY2021. DWIHN scored above (90%) indicating strong performance in the area Confidentiality. DWIHN scored (75) percent, (84) percent, (80) percent, (86) percent, (82) percent, and (83) percent respectively in Grievance and Appeal Systems, Sub-contractual Relationships and Delegation, Practice Guidelines, Health Information Systems, and Quality Assessment and Performance Improvement Program, indicating that additional focus is needed in these areas.

Identified Barriers

Plan and follow-through processes and tasks needed to fulfill the intent of the requirements and associated correction actions.

Opportunities for Improvement

- Review and prioritization of all findings so those processes at higher risk can be assessed and validated or remediated as early as possible.
- Guide development and implementation of an immediate action plan to reduce ongoing risks of findings, particularly to avoid any repeat findings.
- Identify methods and documents as needed to further prove success of implemented corrective actions.
- Increase key staff understanding and rationale behind processes and remediation steps including interdepartmental, small group learning sessions/discussions.
- Identify strongest possible documentation to provide to EQRO as validation that corrective actions were implemented and processes are in place ensure compliance.

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:

- Evaluate Utilization Management Program goals.
- Critically evaluate over and underutilization reporting
- Identify opportunities to improve the quality of Utilization Management processes.
- Manage the clinical review process and operational efficiency.
- Implementation of clinical protocols.

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
Chief Medical Officer	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	50%
Director of Managed Care Operations	Managed Care Operations	10%
Strategic Planning Manager	Compliance	5%
Information Technology	Information Technology	1%
Practitioner Participation	Provider Network	100%

Overall Effectiveness

An evaluation of DWIHN's QI Work Plan for FY2022 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 2022 QAPIP Evaluation and FY2022 Work Plan (Attachment A). The FY2022 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 HEDISmeasuresandenablesustopartnerwithHealthPlansto manage Behavioral and Physical Health services. As part of the 21st Century Cures Act, the Centers for Medicare & Medicaid Services (CMS) is requiring statesto 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 Chief Medical Officer chairs the QISC with the Quality Improvement Administrator. The Chief Medical Officer 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 Chief Medical Officer. The Chief Medical Officer 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 2023.

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 FY2023.

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 ensureprogram alignment withevidence-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 FY2023.

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 2023, DWIHN will continue to address identified opportunities for improvement to ensure optimal member experience.

2023 Work Plan Goals and Objectives

In FY 2023, 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 service, specialized residential provider 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. 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 FY 2022-2023

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, key strengths and opportunities for improvement guided DWIHN's overall quality-related efforts in FY2022.

QAPIP Work Plan

FY 2021 - 2022 (October 1, 2021 through September 30, 2022)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
Customer Pillar							
Goal I (Members Experience and Quality of Service)	Improve Members Experience with Services						

QAPIP Work Plan
FY 2021 - 2022 (October 1, 2021 through September 30, 2022)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
I.1	ECHO Annual Satisfaction Surveys (Adult and Children)	Director of Customer Service	The 2022 Echo Survey will be distributed to members/guardians/families by Q4 (July 1, 2022 - September 30,2022) of FY 2022. The results of surveys will be collated, reviewed, analyzed and reported by Q1 (October 1, 2022 - December 31, 2022) of January 2023.	The target goal is to increase each score response rates from the 2021 reports for both Adults and Children. **Adults:** Improve member access to behavioral health services for the 3 reporting measures scoring < 50% which include:1) Perceived Improvement 29%; 2)Getting Treatment Quickly 46% 3). Office Wait 44%. **Children:** **I**mprove member access to behavioral health services for the 2 reporting measures scoring < 50% which include: 1).	Previously identified issues are to increase outcomes for the 5 reporting areas scoring <50% during FY2021 for Adults and Children. This is a continuation goal from FY2022.	**Target goal not met.** Results of the ECHO® survey for (Adult and Children) is not available for FY2022. The preliminary ECHO® reports will be available in Q3 (April 1, 2023 - June 30, 2023) of FY 2023, with final reports available Q4 (July 1, 2023 - September 30, 2023) of FY 2023.The results will be shared with stakeholders and contract providers to promote use of findings to inform and improve service delivery. This will be a continuation goal for FY2023.	Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 3 of FY-2023.

QAPIP Work Plan

FY 2021 - 2022 (October 1, 2021 through September 30, 2022)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
I.2	National Core Indicator Survey (NCI) for Adults	Director of Customer Service	In FY 2023 Q3 (April 1, 2023 through June 30, 2023) results of the surveys will be collated, reviewed, analyzed and reported to the PIHPs by MDHHS. The survey is distributed to Adults with Intellectual Developmental Disabilities by MDHHS.	The target goal is to improve each score response rate to identify areas for system enhancement to improve areas of dissatisfaction, access to service and quality of care.	Previously identified issue. DWIHN does not control or participate in the completion of this report. MDHHS has declined request to provide data of the actual survey. This is a continuation goal from FY2022.	**Target goal not met.** DWIHN does not control or participate in the completion of the NCI for Adults survey report. DWIHN will identify individual terms of satisfaction on a research study of persons who receive I/DD Services and their involvement in the decision making process of their IPOS/ PCP. This will **not** be a continuation goal for FY2023.	Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 4 of FY-2023.

QAPIP Work Plan
FY 2021 - 2022 (October 1, 2021 through September 30, 2022)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
I.3	Provider and Practitioner Satisfaction Survey	Director of Strategic Operations; Director of Managed Care Operations	In FY 2022 Q4 (July 1, 2022 - September 30, 2022) results of the Provider Satisfaction surveys will be collated, reviewed, analyzed and reported in February of 2023. The 2022 Practitioner Satisfaction Survey will be distributed to providers by Q4 (July 1, 2022 - September 30, 2022) results of the survey will be collated, reviewed, analyzed and reported by Q1 (October 1, 2022 - December 31, 2022) of 2022.	The target goal is to increase the providers response rates from FY2021 by 50% or higher.	Previously identified issue. Provider Satisfaction survey response rate was 24% during FY2021.	**Target goal not met.** The response return rate from the Provider Satisfaction survey was 27%, a slight increase of 3% from the previous year 24%. 247 provider organizations participated in the survey. The Practitioner Satisfaction survey is scheduled for release during the month of January 2023. The final results for the Practitioner Satisfaction survey will be available in Q4 (July 1, 2023 - September 30, 2023)of 2023. This will be a continuation goal for FY2023.	Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 4 of FY-2023.

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
I.4	Grievance/Appeals	Director of Customer Service	FY 2021-2022 (October 1, 2021 through September 30, 2022) results will be collated, reviewed, analyzed and reported by Q2 (January 1, 2023 - March 31, 2023) of 2023.	The target goal is to improve outcomes by decreasing grievances and appeals reported in FY 2021 by no less than 5% in the top 4 areas: Delivery of Service, Interpersonal, Access to	Previously identified issue. There was high number of grievances filed in the area of Delivery of Service and Customer Service in FY2021. This is a continuation goal from FY2022.	**Target goal not met.** There was more grievances reported in FY22 compared to the last three years. This will be a continuation goal for FY2023.	Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.
I.5	Timeliness of Utilization Management Decisions	Director of Utilization Management	FY 2021-2022 (October 1, 2021 through September 30, 2022) Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to meet or exceed performance standards set by MDHHS/NCQA for timely UM decisions making, timeframes and notification. Threshold 90% .	No previously identified issues during FY2021.	**Target goal met at 95%.** This will be a continuation goal for FY2023**.**	Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.

QAPIP Work Plan

FY 2021 - 2022 (October 1, 2021 through September 30, 2022)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
I.6	Practice Guidelines	Chief Medical Officer	FY 2021-2022 (October 1, 2021 through September 30, 2022). Guidelines are reviewed and disseminated throughout the provider network no less than every two years.	The target goal is to ensure guidelines are reviewed at least every two years and shared with the provider network periodically through reports, clinical record reviews, and/or	Previously identified issues. Lack provider feedback and participation to review practice guidelines as required. This is a continuation goal from FY2022.	**Target goal partially met.** DWIHN failed to provide consultation with network providers as it relates to the adoption of Practice Guidelines. This will be a continuation goal for FY2023.	Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.

QAPIP Work Plan
FY 2021 - 2022 (October 1, 2021 through September 30, 2022)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
I.7	Cultural and Linguistic Needs	Director of Customer Service, Director of Managed Care Operations, Director of Quality Improvement, Deputy Chief Information Officer	FY 2021-2022 (October 1, 2021 through September 30, 2022). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to improve outcomes through cultural competency, language, and physical accessibility by identifying existing racial and ethnic disparities within our provider network for all populations.	Previously identified issues. In FY2021 member satisfaction survey revealed that 69% of adult members reported that their cultural needs were met, however 31% reported their cultural needs were not met.	**Target goal met**. DWIHN has hired a Diversity Equity and Inclusion (DEI) Administrator whose primary responsibility is to recognize, create and implement plans to promote diversity within DWIHN & promote and develop training programs to enhance Employee & Provider understanding of inclusion issues. In addition, DWIHN is seeking to expand its scope of activity beyond cultural competence with an added focus on actively seeking to address implicit bias and to reduce health disparities. This will be a continuation goal for FY2023.	Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.
Access Pillar							
Goal II (Quality of Service and Quality of Clinical Care)	**Improve members Access to Services, Quality of Clinical Care, and Health and**						

QAPIP Work Plan

FY 2021 - 2022 (October 1, 2021 through September 30, 2022)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
	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.	Director of Quality Improvement	FY 2021-2022 (October 1, 2021 through September 30, 2022). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to meet or exceed performance standard. Standard is 95% or above.	No previously identified issues during FY2021.	**Target goal met.** Results: FY2022 standard met for all 4 quarters. Total population rate (97.97%). This will be a continuation goal for FY2023.	Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.
II.2	Indicator 2(a) and 2(b) - Percentage of persons (Children and Adults) receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.	Director of Quality Improvement	FY 2021-2022 (October 1, 2021 through September 30, 2022). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to achieve comparable scores within the region to the state wide average. No standard/benchmark for performance indicator has been established by MDHHS. No exceptions allowed.	Previously identified issues. Targeted goal not met; scores was the lowest within the region during FY2021 for all population served. The statewide average during FY2021 (63%).	**Target goal met.** This measure allows for no exceptions. MDHHS has not established a minimum threshold for this measure. Results: Q1(52.85%), Q2 (59.23%), Q3 (37.84%) and Q4 (44.26%). Total population rate (48.30%). This will be a continuation goal for FY2023.	Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.

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FY 2021 - 2022 (October 1, 2021 through September 30, 2022)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
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.	Director of Quality Improvement	FY 2021-2022 (October 1, 2021 through September 30, 2022). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to achieve comparable scores within the region to the state wide average.	No previously identified issues during FY2021. No standard/benchmark for performance indicator has been established by MDHHS.	**Target goal met.** This measure allows for no exceptions. MDHHS has not established a minimum threshold for this measure. Results: Q1(82.36%), Q2 (87.27%), Q3 (84.66%) and Q4 (88.32%). Total population rate (85.71%). This will be a continuation goal for FY2023.	Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.
II.4	Indicator 4a(1) and 4a(2) - Percentage of discharges from a psychiatric inpatient unit (Children and Adults) who are seen for follow up care within 7 days.	Director of Quality Improvement	FY 2021-2022 (October 1, 2021 through September 30, 2022). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to meet or exceed performance standard. Standard is 95% or above.	No previously identified issues during FY2021.	**Target goal partially met.** Results: FY22 standard was not met for the following quarters/populations Q2 Child (93.75%), Q3 Child (86.44%) and Total Child (94.27%) and Q1 Adult (94.80%). Total population rate (96.14%). This will be a continuation goal for FY2023.	Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.

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QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
II.5	Indicator 4b - Percentage of discharges from a Substance Abuse Detox Unit who are seen for follow-up care within 7 days.	Director of Quality Improvement	FY 2021-2022 (October 1, 2021 through September 30, 2022). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to meet or exceed performance standard. Standard is 95% or above.	No previously identified issues during FY2021.	**Target goal met.** Results: FY2022 standard met for all 4 quarters. Total rate (99.73%). This will be a continuation goal for FY2023.	Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.
II.6	Indicator 10 (a) and 10 (b) - Percentage of readmissions (Children and Adults) to inpatient psychiatric unit within 30 days of discharge.	Director of Quality Improvement	FY 2021-2022 (October 1, 2021 through September 30, 2022). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to meet or exceed performance standard. Standard is 15% or less.	Previously identified issues. Targeted goal not met with Recidivism for adults in over 3 years.	**Target goal partially met.** Results: FY2022 standard met for the children population. Standard not met for the adult population for three out of four quarters Q2 (16.31%), Q3 (17.79%), Q4 (15.89%). Total population rate (15.43%). This will be a continuation goal for FY2023.	Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.

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FY 2021 - 2022 (October 1, 2021 through September 30, 2022)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
II.7	Complex Case Management	Director of Integrated Health Care	FY 2021-2022 (October 1, 2021 through September 30, 2022) results will be collated, reviewed, analyzed and reported by February 2023.	The target goals are to improve medical and behavioral health concerns and increase overall functional status by 10% in PHQ scores, provide early intervention for members appropriate for Complex Case Management to prevent recurrent crisis or hospitalizations, increase participation in the number of members who attended two out-patient behavioral health services within 60 days of starting CCM services who were open for at	No previously identified issues during FY2021.	**Target goal met.** Improve medical and/or behavioral health concerns, overall 10% improvement in PHQ scores, overall 10% reduction in Emergency Department (ED) utilization and an overall 10% reduction in hospital admissions from 90 days prior to receiving CCM services to 90 days after receiving CCM services for members at closure who were enrolled for at least 60 days and a 80% or greater member satisfaction scores for members at closure who have received CCM services. This will be	Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.

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QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
II.8	Crisis Intervention Services	Director of Utilization Management, Director of Crisis Services	FY 2021-2022 (October 1, 2021 through September 30, 2022). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to decrease number of re-hospitalization within 30 days of discharge to 15% or less for Adults.	Previously identified issues. Targeted goal not met with Recidivism for the adult population for three out of four quarters. This is a continuation goal from FY2022.	**Target goal partially met.** FY2022 standard met for the children population. Standard not met for the adult population for three out of four quarters Q2 (16.31%), Q3 (17.79%), Q4 (15.89%). Total population rate (15.43%). This will be a continuation goal for FY2023**.**	Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.
Workforce Pillar							
Goal III. (Quality of Service)	**Develop and maintain a Competent Workforce through the Credentialing and Re-Credentialing Process**						

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FY 2021 - 2022 (October 1, 2021 through September 30, 2022)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
III.1	Maintain Competent Workforce	Director of Workforce Development, Provider Network Administrator Credentialing, Director of Quality Improvement, Director of Clinical Practices Improvement, Director of Managed Care Operations	FY 2021-2022 (October 1, 2021 through September 30, 2022). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to ensure a competent workforce through performance reviews by evaluating job performance and competency, and maintaining and expanding a centralized training program for allied health professionals. Focusing on the development of new professionals is integral to achieving a	No previously identified issues during FY2021.	**Target goal met.** DWIHN continues to provide continuing education platforms for stakeholders of the behavioral health workforce through Detroit Wayne Connect live and online courses. SUD Trainings are also available on Improving MI Practices posted at www.dwihn.org. This will be a continuation goal for FY2023.	Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.
Finance Pillar							
Goal IV (Quality of Service)	**Maximize Efficiencies and Control Costs**						

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
IV.1	Verification of Services	Director of Quality Improvement, Corporate Compliance Officer	FY 2021-2022 (October 1, 2021 through September 30, 2022). Data reporting is collated, reviewed and analyzed Bi-Quarterly.	The target goal is to review 100% of randomly selected Paid Encounters/Claims to eliminate Fraud, Waste and Abuse in the network by identifying patterns and trends of behavioral health	Previously identified issue. Targeted goal not met in FY21, A total of 2,371 claims were randomly selected for verification. Of those claims 1,260 were reviewed and validated for 51.03%.	**Target goal met.** For FY2022, reviewed and validated 3,524 claims, which is a 35.75% increase from the previous FY2021 (1,260). This will be a continuation goal for FY2023.	Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.
Quality Pillar							
Goal V (Safety of Clinical Care)	**Improve Quality Performance, Member Safety and Member Rights system-wide**						
V.1	Provider Network Performance Monitoring - Clinically Responsible Service Provider (CRSP)	Director of Quality Improvement	FY 2021-2022 (October 1, 2021 through September 30, 2022). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to increase number of reviewed providers from FY2021 on regulatory audits by 15% to ensure performance	Previously identified issue targeted goal not met during FY2021 by 15% or higher to ensure Continuous Quality Improvement. This will be a continuation goal for FY2022.	**Target goal met.** DWIHN saw an increase in provider reviews by 26%. This will be a continuation goal for FY2023.	Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.

QAPIP Work Plan

FY 2021 - 2022 (October 1, 2021 through September 30, 2022)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V.2	Residential Treatment Providers	Director of Quality Improvement	FY 2021-2022 (October 1, 2021 through September 30, 2022). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to increase the number of Residential Treatment Providers reviews from FY2021 by 15% to ensure continuous quality improvement.	Previously identified issue targeted goal not met during FY21 to increase the Residential Treatment providers reviews by 15% or higher. This will be a continuation goal for FY2022.	**Target goal met.** DWIHN saw an increase in residential treatment provider reviews, which is a 40.5 percentage increase compared to FY2021.This will be a continuation goal for FY2023.	Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.
V.3	Provider Network Self-Monitoring (Inter-Rater Reliability)	Director of Quality Improvement	FY 2021-2022 (October 1, 2021 through September 30, 2022). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to increase Provider's participation in Self-Monitoring reviews from the previous year by 20%.	Previously identified issue. Targeted goal not met during FY21; less than 40% of providers completed self-monitoring reviews. This will be a continuation goal for FY2022.	Target goal met. DWIHN saw an slight increase in Provider self-monitoring reviews compared to FY21. This will be a continuation goal for FY2023.	Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.
V.4	Autism Services	Director of Quality Improvement, Director of Children's Initiatives	FY 2021-2022 (October 1, 2021 through September 30, 2022). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to increase number of reviewed providers from FY2021 on regulatory audits to ensure performance	No previously identified issues.	**Target goal met.** All ABA providers were reviewed during FY2022. This will be a continuation goal for FY2023.	Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 FY-2023.

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QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V.5	Critical/Sentinel/Unexpected Death and Risk Reporting	Director of Quality Improvement, Deputy Chief Information Officer	FY 2021-2022 (October 1, 2021 through September 30, 2022). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to meet MDHHS reporting requirements and monitor the safety of clinical care of members.	Previously identified issue. Targeted goal not meet in meeting MDHHS reporting requirements in FY2021 . This will be a continuation goal for FY2022.	**Target goal met.** All five (5) reportable areas were reported to MDHHS timely in FY22. This will be a continuation goal for FY2023.	Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.
V.6	Behavior Treatment Review	Director of Quality Improvement, Chief Medical Officer	FY 2021-2022 (October 1, 2021 through September 30, 2022). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to meet the BTPRCs Technical Requirements set by MDHHS through reviews of randomly selected cases. Threshold 95% or above.	Previously identified issue is not meeting the MDHHS (BTPRC) reporting requirements in FY21. This will be a continuation goal for FY2022.	**Target goal met.** In FY22, DWIHN BTPRC reviewed 1,495 members on Behavior Treatment Plans which is an increase of 334 (28.76%) from the previous year. This will be a continuation goal for FY2023.	Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.
(Quality of Clinical Care)	**Quality Improvement Projects (QIP's)**						

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V.7a	Improving the availability of a follow up appointment with a Mental Health Professional with-in 7 and 30 days after Hospitalization for Mental Illness.	Director of Integrated Health Care, Director of Quality Improvement	FY 2021-2022 (October 1, 2021 through September 30, 2022) Data reporting is collated, reviewed and analyzed quarterly.	The target goal is 45% (Adults) or higher in improving the availability of a follow up appointment with a Mental Health Professional within 7. The target goal is 58% or higher (Adults) 30 days after	Previously identified issue. Targeted goal of 45% or higher not met for the 7day follow-up (Adult) ; rate was 28.33% for FY2021. Target goal of 58% or higher not met for the 30 day follow-up (Adult); rate was 46.67%.	**Target goal not met for 7 day or 30 day follow-up**. This will be a continuation goal for FY2023.	Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2022 on the reporting measure. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.
V.7b	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Director of Integrated Health Care, Director of Quality Improvement	FY 2021-2022 (October 1, 2021 through September 30, 2022). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is 68.00% 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	No previously identified issues during FY2021.	**Target goal not met**. In FY2021 results have trended down to 46.92%. This is a 32.42 percentage point decrease. This will be a continuation goal for FY2023.	Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2022 on the reporting measure. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.

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V.7c	Antidepressant Medication Management for People with a New Episode of Major Depression	Director of Integrated Health Care, Director of Quality Improvement	FY 2021-2022 (October 1, 2021 through September 30, 2022). Data reporting is collated, reviewed and analyzed quarterly.	The target 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	Previously identified issue failed to meet the goal for FY 2021 (46.42%)	**Target goal not met.** Results was 13.36%. This is an 8.3 percentage point decrease compared FY2020. This will be a continuation goal for FY2023.	Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2022 on the reporting measure. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.
V.7d	Improving Diabetes Monitoring for People with Schizophrenia and Bipolar Disorder	Director of Integrated Health Care, Director of Quality Improvement	FY 2021-2022 (October 1, 2021 through September 30, 2022). Data reporting is collated, reviewed and analyzed quarterly.	The target 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	Previously identified issue failed to meet the goal for FY 2021 (64.86%)	**Target goal not met.** DWIHN results for 2021 was 64.86%, this is a 0.48 percentage point increase compared to FY2020. The goal of 80% was not achieved. This will be a continuation goal for FY2023.	Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2022 on the reporting measure. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.

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QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V.7e	Coordination of Care	Director of Integrated Health Care, Director of Utilization Management, Director of Quality Improvement	FY 2021-2022 (October 1, 2021 through September 30, 2022). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is 95% or higher for review of randomly selected cases through the performance monitoring process for compliance.	Previously identified issues failed to meet the goal for FY 2021 (82%).	**Target goal not met.** 68.8% for Quarters 1-3. Quarter 4 data will be available in Q3 of FY2023. This will be a continuation goal for FY2023.	Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2022 on the reporting measure. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.
V.7f	Case Finding for Opiate Treatment	Director of Substance Use Disorder	FY 2021-2022 (October 1, 2021 through September 30, 2022). Data reporting is collated, reviewed	The target goal is 79% or higher.	Previously identified issue targeted goal not met during FY2021 (55%).	**Target goal not met.** 60%, Goal at 79%. This will be a continuation goal for FY2023.	Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2022 on the reporting measure. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.
V.7g	PHQ-9 Implementation	Director of Clinical Practice Improvement	FY 2021-2022 (October 1, 2021 through September 30, 2022). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is 95% or higher.	Previously identified issue targeted goal not met during FY2021.	**Target goal met** at 99.1%. This will be a continuation goal for FY2023.	Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2022 on the reporting measure. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.
V.7h	PHQ-A Implementation	Director of Children's Initiative	FY 2021-2022 (October 1, 2021 through September 30, 2022). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is 95% or higher.	Previously identified issue targeted goal not met (75%) during FY2021.	**Target goal met** at 99.2%. This will be a continuation goal for FY2023.	Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2022 on the reporting measure. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.

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V.7i	Decreasing Wait for Autism Services	Director of Children's initiative	FY 2021-2022 (October 1, 2021 through September 30, 2022). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is 95% or higher.	No previously identified issue during FY2021.	**Target goal not met** at 67.50%. This will be a continuation goal for FY2023.	Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2022 on the reporting measure. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.
	Advocacy Pillar						
Goal VI.	**Increase Community Inclusion and Integration**						
VI.1	Home and Community Based Services (HCBS)	Director of Quality Improvement	FY 2021-2022 (October 1, 2021 through September 30, 2022). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is 100% compliance of the Network with the HCBS requirements.	Previously identified issue targeted goal not met during FY2021.	**Target goal not met.** This will be a continuation goal for FY2023.	Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.
Goal VII (Quality of Service)	**External Quality Reviews**						

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VII.1	MDHHS Annual 1915 © Waiver Review	Director of Quality Improvement, Director of Managed Care Operations, Director of Customer Service, Director of Recipient Rights , Deputy Chief Financial Officer, Director of Workforce, Provider Network Administrator Credentialing, Director of Integrated Health Care, Director of Human Resources	FY 2021-2022 (October 1, 2021 through September 30, 2022). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to achieve 95% or above in the Waiver compliance review.	No previously identified issue during FY2021.	**Target goal met.** In FY2022, DWIHN received full compliance with the implementation of the plan of correction. The follow-up review involved evaluation of the current status of the Corrective Action Plans, submitted by DWIHN, in response to the Full Site Review that was conducted March 14 through April 22, 2022. This will be a continuation goal for FY2023.	Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.

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VII.2	NCQA Accreditation	Director of Quality Improvement, Director of Managed Care Operations, Director of Customer Service, Director of Recipient Rights , Deputy Chief Financial Officer, Director of Workforce, Provider Network Administrator Credentialing, Director of Integrated	January 1, 2022-January 1, 2024. Reports and collated, reviewed and analyzed during the required look back period.	The target goal is to achieve recertification in FY2024.	No previously identified issues during FY21.	DWIHN will be revaluated for re-certification in January 2024. This will be a continuation goal for FY2023.	Submit quarterly reports to PCC on the recertification process. DWIHN will be revaluated for re-certification in January 2024.

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VII.3	Health Services Advisory Group (HSAG)-Validation of Performance Projects (PIP)	Director of Quality Improvement	FY 2021-2022 (October 1, 2021 through September 30, 2022). Reports and collated, reviewed and analyzed during the required look back period.	The target goal is to verifies whether DWIHN's new PIP (reduce racial and ethnic disparity with African Americans for the percentage of discharges from a psychiatric inpatient unit that were seen for follow-up care within 7 day) used a sound methodology in the design, implementation, analysis, and reporting.	Previously identified issue; targeted selected goal of 80% not met (64.86%) in FY2021. The goal should represent a statistically significant increase over the baseline performance.	**Target goal met**. In FY2022 validation, DWIHN initiated the PIP topic: Reducing the Racial Disparity of African Americans Seen for Follow-Up Care Within 7-Days of Discharge from a Psychiatric Inpatient Unit and received a 100% compliance score. This will be a continuation goal for FY2023.	Submit quarterly reports to PCC on performance outcomes. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.

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VII.3a	Health Services Advisory Group (HSAG)-Compliance Review	Director of Quality Improvement, Director of Managed Care Operations, Director of Customer Service, Director of Recipient Rights , Deputy Chief Financial Officer, Director of Workforce, Provider Network Administrator Credentialing, Director of Integrated Health Care, Director of Human Resources	FY 2021-2022 (October 1, 2021 through September 30, 2022). Reports and collated, reviewed and analyzed during the required look back period.	The target goal is to complete plans of action from (Year 1) to address each deficiency identified during the Compliance Review.	Previously identified issue; targeted goal not met in FY2021; achieved an overall score 77.0%.	**Target goal partially met.** In FY2022, DWIHN achieved an overall compliance review score of 83 percent compared to 77 percent in FY2021. The areas with the greatest opportunity for improvement were related to Provider Selection, Grievance and Appeal Systems, Sub-contractual Relationships and Delegation, Practice Guidelines, Health Information Systems, and Quality Assessment and Performance Improvement Program, as these areas received performance scores below 90%. This will be a continuation goal for FY2023.	Submit quarterly reports to PCC on performance outcomes. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.

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FY 2021 - 2022 (October 1, 2021 through September 30, 2022)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
VII.3b.	Health Services Advisory Group (HSAG) - Performance Measure Validation (PMV)	Director of Quality Improvement, IT Administrator, Claims Administrator	FY 2021-2022 (October 1, 2021 through September 30, 2022). Reports and collated, reviewed and analyzed during the required look back period.	The target goal is to achieve 95% or above.	No previously identified issues during FY2021; Targeted goal met with no plan of correction.	**Target goal met.** In FY2022, DWIHN received a full compliance score of 100% with no Plan of Correction (POC), for the second consecutive year. This will be a continuation goal for FY2023.	Submit quarterly reports to PCC on performance outcomes. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.

QAPIP Work Plan
FY 2021 - 2022 (October 1, 2021 through September 30, 2022)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
VII.4	Annual Needs Assessme	Director of Quality Improvement, Director of Managed Care Operations, Director of Customer Service, Director of Recipient Rights , Deputy Chief Financial Officer, Director of Workforce, Provider Network Administrator Credentialing, Director of Integrated Health Care, Director of Human Resources	FY 2021-2022 (October 1, 2021 through September 30, 2022). Reports and collated, reviewed and analyzed during the required look back period.	The target goal is to prioritized and implement planned actions identified in Needs Assessment.	No previously identified issues during FY2021.	**Target goal met.** DWIHN prioritized and implemented planned actions. This will be a continuation goal for FY2023.	Submit quarterly reports to PCC on performance outcomes. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.

QAPIP Work Plan

FY 2021 - 2022 (October 1, 2021 through September 30, 2022)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
VII. 5	QAPIP Description: The QAPIP Description is written according to MDHHS and NCQA guidelines. The QAPIP Description scope, goals, objectives and structure are written to assure regulatory compliance.	Director of Quality Improvement	Complete written QAPIP Description for FY2023-2025 by February 2024. Reviewed Annually	No previous issues identified in FY2022	No previously issues requiring follow-up.	Target Goal: All MDHHS and NCQA requirements are met 95% or greater.	Present QAPIP Description to QISC, PCC and Full Board (Q2-FY2022).
VII. 6	QAPIP Evaluation The Evaluation is developed annually.	Director of Quality Improvement	Annual (FY2022)	The Target Goal is to Collate analyze and report annually by February 2023. Annual results to be shared with stakeholders and members.	Previous issues identified during FY2022: Not all QI goals were met during FY2022.	**Target Goal** Partially Met: Goals that were not met or partially met will be continued in FY(2023)	Present QAPIP Evaluation to QISC, PCC and Full Board annual (Q2-FY2023)
VII. 7	QAPIP Work Plan The QI workplan is developed after review of previous year's work plan. The work plan is evaluated and updated on an ongoing basis to reflect the status of all QI goals.	Director of Quality Improvement	The QAPIP work plan will be developed by FY2022.	Target Goal is that the work plan will include all MDHHS and NCQA requirements. Annual results to be shared with stakeholders and members.	Previous issues identified during FY2022. Goal completion rate for FY2022 was 70%. Threshold is 95% or higher.	**Target Goal** Partially Met: FY2022 (70%) Completion Rate. Threshold 95% or higher	Present QAPIP Work Plan to QISC, PCC and Full Board annual (Q2-FY2023).
END							