DETROIT WAYNE INTEGRATED HEALTH NETWORK
QUALITY ASSURANCE PERFORMANCE IMPROVEMENT PLAN (QAPIP) DESCRIPTION
Fiscal Year 2023-2025

Approved:

Approved by Quality Improvement Steering Committee (QISC)	1/30/2024
Approved by Program Compliance Committee (PCC)	2/14/2024
Approved by Full Board of Directors	2/21/2024

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Introduction

The Detroit Wayne Integrated Health Network (DWIHN), a National Committee Quality Assurance (NCQA) accredited Managed Behavioral Health Organization (MBHO) 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) Description provides the structure and governance to guide the formal processes for evaluating and improving the quality and appropriateness of health care services and the health status of the populations we serve. The QAPIP describes the quality activities undertaken by DWIHN to promote and achieve excellence in all areas through continuous quality improvement.

The QAPIP demonstrates to members, advocates, community organizations and health care providers that it has a distinct competency as a high-performing, member-focused, quality-focused, and evidence-based efficient provider of behavioral health and substance use disorder services and is an essential partner in helping healthcare reform to succeed. It has the infrastructure necessary to improve the quality and safety of clinical care and services to our members and to oversee the Quality Improvement (QI) program.

The term of the QAPIP begins October 1, 2023, and ends September 30, 2025. Upon expiration of the term, the QAPIP shall remain in effect until DWIHN's Board of Directors approves a new QAPIP. QAPIP incorporates by reference all policies, and procedures necessary to operate as a Prepaid Inpatient Health Plan and Community Mental Health Services Program. The DWIHN's Board of Directors hereby approves all current and subsequent policies and procedures through the approval of the QAPIP.

Mission, Vision, and Values

The Mission and Vision Statement provides inspiration for DWIHN and describes what we aim to achieve mid-to-long term. Values are the core principles and define DWIHN culture and identity.

Mission

We are a healthcare safety net organization that provides access to a full array of integrated services that facilitate individuals to maximize their level of function and create opportunities for quality of life.

Vision

To be recognized as a national leader that improves the behavioral and physical health status of those we serve, through partnerships that provide programs promoting integrative holistic health and wellness.

Values

- We are an *advocate*, person-centered, family and community focused organization.
- We are an *innovative*, outcome, data-driven, and evidence-based organization.
- We respect the dignity and diversity of individuals, providers, staff, and communities.
- We are *inclusive*, culturally sensitive, and competent.
- We are fiscally responsible and accountable with the highest standards of integrity.
- We achieve our mission and vision through partnerships and collaboration.

Quality Assurance Performance Improvement Plan (QAPIP) Description

QAPIP provides the framework necessary to improve the quality, safety, and efficiency of clinical care. The QAPIP provides structure and governance to guide the formal processes for evaluating and improving the quality and appropriateness of health care services and the health status of the populations we serve. It also defines the authority, scope, and content of the QI program, including the roles and responsibilities of committees and individuals supporting program implementation. Member participation and involvement in the development and ongoing monitoring of DWIHN's QAPIP is critical.

The QAPIP contains the core functions of DWIHN's Board approved Strategic Plan, and the (6) pillars which serve as the foundation of the commitment of DWIHN to continuously improve the quality and safety of clinical care and quality of service. These functions will be conducted by DWIHN and its network of contracted service providers. It is the responsibility of DWIHN to ensure that the QAPIP meets the requirements of the Balanced Budget Act (BBA) of 1997, Public Law 105-33 and 42 Code of Federal Regulations (CFR) 438.358 of 2002. The QAPIP also reflects concepts and standards appropriate to the population of persons served under the Managed Specialty Supports and Services Waiver Program.

Scope of the QAPIP

The functional areas of the QAPIP are detailed through assigned Standing Committees. DWIHN has created committees to provide oversight and implementation of all quality improvement activities. The Compliance Committee focuses on regulatory compliance as well as corporate compliance issues to ensure service provision in network as required. The Improving Practices Leadership Team (IPLT) develops and monitors clinical service areas such as clinical practice guidelines, evidence-based practices, care integration processes, Home and Community-Based Services transition planning to ensure quality of clinical care, safety of clinical care, quality of service, and enhance members' experience. The Credentialing Committee focuses on ensuring network practitioners and providers have the appropriate qualifications to provide services to ensure safety and quality of clinical care. The Quality Improvement Steering Committee (QISC) focuses on performance indicator data, conducting and analyzing satisfaction survey data, oversight of performance improvement projects, and monitoring QI plans to ensure quality of services, and evaluate members' experience.

The Critical Sentinel Events Committee (CSEC) focuses on reviewing and monitoring critical and sentinel events to ensure safety of clinical care, and quality of service and Utilization Management Committee focuses on underutilization of services within the network to ensure quality and safety of clinical care and quality of service. The quality improvement activities are achieved through a complex infrastructure which includes key stakeholders and process owners, and cross-functional units and committees. It identifies the important processes and aspects of care, both clinical and non- clinical, required to ensure quality support and services for persons in the system. DWIHN requires all contracted Clinical Responsible Service Providers (CRSP) and substance use disorder providers to have a quality improvement plan relevant to the services they provide. DWIHN assures that all demographic groups, care settings and types of services are included in the scope of the QAPIP by including members, advocates, contracted service providers and community groups in the quality improvement process using a Continuous Quality Improvement (CQI) perspective.

DWIHN has an adequate organizational structure which allows for clear and appropriate administration and evaluation of the QAPIP. DWIHN's QISC is the decision-making body of the QAPIP and the evaluation which reports to PCC and to the full Board of Directors for review and approval. There is a designated senior official and Chief Medical Officer (CMO) responsible for the QAPIP implementation. There is active participation of providers and persons served in the QAPIP processes. The participating practitioners are external to the organization and part of the organization's network, providing input on process improvement, program planning, and program evaluation, through data collection and analysis. DWIHN believes the structure supports effective governance and aligns key strategic initiatives to ensure adequate guidance to help DWIHN reach goals and objectives.

Quality Improvement Program (QIP)

DWIHN's Quality Improvement Program is based on the principles of Continuous Performance Improvement (CPI) which are adopted and utilized throughout the organization. The Centers for Medicare and Medicaid Services (CMS) Medicaid Bureau mandates that QIP be a part of Pre-Paid Inpatient Health Plans. DWIHN has several contracts with the Michigan Department of Health and Human Services (MDHHS) for the provision of Managed Specialty Supports and Services (Medicaid), General Fund and waiver services for mental health and substance abuse and must comply with Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY19 Attachment P7.9.1 and CMHSP Managed Mental Health Supports and Services Contract FY19: Attachment C6.8.1.1 "Quality Assessment and Performance Improvement Programs for Specialty Pre-Paid Inpatient Health Plans" and the "Department of Community Health Michigan Mission Based Performance Indicators", the Balanced Budget Act, External Quality Review, and the Application for Renewal and Recommitment. DWIHN maintains a network-wide commitment to quality and industry best practices and standards as set forth by state and federal regulations, as well as accrediting organizations.

DWIHN partnered with the Network for Regional Healthcare Improvement (NRHI), that enabled DWIHN to be positioned as a national leader working to improve the behavioral and physical health status of those served, through partnerships that provide programs promoting integrative holistic health and wellness. DWIHN also rolled out a Certified Care Coordination platform coupled with HEDIS quality measures to the provider network working with health plans that enable true care coordination and interoperability. DWIHN Integrated Care staff attend monthly meetings with the State and Health Plans to share information. They also have separate meetings with some of the Medicaid Health Plans to share and discuss collaboration. In addition, DWIHN is collaborating on two quality improvement projects with the Medicaid Health Plans-one on Diabetes Screening of Bipolar and Schizophrenic members on antipsychotic medications and Compliance with Antidepressant Medications.

DWIHN's QI staff are highly skilled, experienced professionals who are required to have ongoing training and participate in regularly scheduled case consultations with the DWIHN Chief Medical Officer. DWIHN is committed to increasing competency and the quality of services through continuous staff development activities.

QI Staff Members' Assigned Activities and Professional Qualifications:

1. Board of Directors (BOD):
   - The BOD primary responsibility is to provide leadership, governance, and oversight of the region. The Board is a policy setting body, the fiduciary of the Medicaid funds.
2. Chief Medical Officer (CMO):
   - 5 years of experience working in a state or community psychiatric hospital or outpatient setting, as a direct provider of mental health services.
   - At least 5 years of administrative experience as CMO in a Mental Health Program with experience in: policy writing; accreditation activities, staff development; peer review management of direct report staff (i.e., nurses, social workers, etc.).
   - Prior experience working with State and Community Hospitals.
   - Prior Managed Care experience, and with the implementation of Evidence-Based Practices in psychiatry.
   - Completed medical school at an accredited university.
   - Completed an internship and psychiatric residency at an accredited program.
   - Thorough and up to date knowledge of psychiatric and medical practice.
   - At least three years' experience with peer and utilization review in a community mental health setting.
   - Active participation in professional organizations such as the American Psychiatric Association, the Michigan Psychiatric Society, and the American Association of Community Psychiatrists, Wayne County Medical Society, Michigan State Medical Society, Detroit Medical Society.
   - Must have a valid Michigan License to practice as a physician, and Michigan. controlled substance license. Additionally, the candidate must have a valid and current Drug Enforcement Authority Registration. Board certification by American Board of Psychiatry and Neurology as an adult psychiatrist is preferred not required.

Responsibilities include:

- Chairing the Quality Improvement Steering Committee.
- Chairing the Peer Review Committee & Improving practice Leadership Team (IPLT).
- Active Participation in the Sentinel Events Committee Activities.
- Active Participation in the Review of Death Committee.
- Active Participation in the Executive Leadership Team (as needed).
- Review policies, procedures, and protocols for the delivery of psychiatric and medical services.
- Co-facilitate advisory committees of Chief Medical Officers of Providers to meet on a regular basis and provide input into psychiatric and medical standards, policies, procedures, and protocols.
- Provide technical assistance and psychiatric input where needed regarding development of services, policies, and procedures.
- Provides leadership, support, and direction for development of clinical and cost-effective programs which improve member access, reduce gaps in care, enhance customer satisfaction, lower costs, and maximize positive health outcomes.
- Serve as clinical consultant to contractors and their sub-contractors on difficult cases.
- Work collaboratively with other agency areas to increase effectiveness of medical administration programs and promote the integration of all clinical programs.
- Provide consultation on the activities of DWIHN to advance workforce development, best, promising and evidence-based practices and integration of physical and mental health care.
- Function as a liaison with local, state, and national psychiatric and medical organizations for the purpose of information and networking to keep the Board of Directors and staff aware of trends in psychiatric and medical practice, research, training, and issues.

- Present to the Board of Directors and board subcommittee meetings (as needed).

3. Psychiatrist
    - Must have a valid Michigan License to practice as a physician, and Michigan controlled substance license. Additionally, they must have a valid and current Drug Enforcement Authority Registration. Board certification by the American Board of Psychiatry and Neurology as an adult psychiatrist is preferred but not require.
    - Must have completed a Psychiatric Residency approved by Accreditation Council for Graduate Medical Education (ACGME).
    - Five (5) years of experience working in a state or community psychiatric hospital or outpatient setting, as a direct provider of mental health services.
    - At least five (5) years of administrative experience as Medical Director in a Mental Health Program with experience in: policy writing; accreditation activities, staff development; peer review management of direct report staff (i.e., nurses, social workers, etc.).
    - Reviews Behavior Treatment cases including consultation on Behavior Treatment services to the network providers.
    - Participates in Behavior Treatment Review Advisory Committees.

4. Director of Quality Improvement
    - Master's Degree in a social work, psychology, counseling, or human service field.
    - Minimum of 10 (ten) years full-time paid experience in the areas of Quality with ongoing responsibility for supervising ten or more staff and managing projects within a health care environment.
    - Responsible for the development and continual updating of all UM processes, policies, and procedures within department.
    - Provides supervision and implements development plans for all QI staff.
    - Makes recommendations regarding staffing, hiring, training and allocation of resources.
    - Oversees the monitoring activities of services across all covered populations.
    - Develops quality improvement processes and ensures accreditation and regulatory requirements are met.
    - Leads multidisciplinary case reviews, to recommend/develop alternative treatment plans for complicated consumer cases.
    - Conducts analysis of internal and external reports to ensure compliance with contract, accreditation, and regulatory requirements.
    - Collaborates with other departments and agencies.
    - Sets yearly QI goals for department.
    - Represents DWIHN as assigned, in collaborative meetings or presentations with DCH, Board Association, and contracted entities.
    - Responsible for Agency reporting requirements.
    - Prepares annual QI program evaluation and Work Plan.

5. Quality Administrator – Performance Monitoring
    - Master's degree in social work, Psychology, Counseling, Nursing (a bachelor's degree will be accepted), Quality Management, Business Administration, the Human Services, the Social Services or a related field with clinical licensure and credentials, if applicable.
    - A Valid State of Michigan clinical licensure: RN, LMSW, LMHC, LPC, LLP or PhD.
    - Credentialing qualification in at least one of the following: Qualified Mental Health Professional (QMHP), Qualified Intellectual Disabilities Professional (QIDP), Qualified Children Mental Health Professional (QCMHP); Substance Abuse Treatment Specialist (SATS).
    - Minimum of five (5) years' experience working in mental health services.
    - Provides supervision and implements development plans for all QI staff.
    - Oversees the on-going performance monitoring activities to monitor usage of services across all covered populations.
    - Knowledge and skills in community based behavioral health care and case management preferred.
    - Works collaboratively with other DWIHN departments to implement and improve the utilization management program at DWIHN.
    - Participates in meetings, committees, and collaboration internally and externally.
    - Develops written and timely reports as requested.
    - Provides timely reporting of pertinent observations and system challenges which may directly impact the achievement of expected outcomes.

6. Provider Network Quality Improvement Administrator
    - Bachelor's degree social work or human service fields, valid Michigan license required.
    - Minimum of five (5) years' experience working in mental health services.
    - Co-chair of QISC committee.
    - Provides supervision and implements development plans for all QI staff.
    - Oversees the on-going performance improvement activities to monitor usage of services across all covered populations.
    - Knowledge and skills in community based behavioral health care and case management preferred.
    - Works collaboratively with other DWIHN departments to implement and improve the utilization management program at DWIHN.
    - Participates in meetings, committees, and collaboration internally and externally.
    - Develops written and timely reports as requested.
    - Provides timely reporting of pertinent observations and system challenges which may directly impact the achievement of expected outcomes.

7. Clinical Specialist Psychologist (Behavior Treatment)
    - Master's degree in psychology with license as Psychologist in the State of Michigan.
    - Conduct quarterly reviews analyses of data from the Behavior Treatment Review Committee where intrusive or restrictive techniques have been approved for use with members and where physical management or 911 calls to law enforcement have been used in an emergency behavioral crisis.
    - Review techniques permitted by the Technical Requirement for Behavior Treatment Plans and have been approved during person-centered planning by the member or his/her guardian, may be used with members.
    - Review data numbers of interventions and length of time the interventions were used per individual.
    - Chairing the Quality Improvement Steering Committee Worked with MDHHS BTPRC on MDHHS BTPRC FAQ document.
    - Preparing for the systemwide upcoming Behavior Treatment Training for DWIHN CAP for

MDHHS HSW Review.

- Ongoing Individual consultations with DWIHN departments (UM, ORR, Residential, Children's).
- Review the referred cases for the SEC/PRC meeting.

8. Clinical Specialist Performance Monitor
    - Master's degree in nursing or social work preferred. Bachelor's degree in psychology, social work, or related human services required. Certification as an addiction drug counselor (CADC) or certification as advanced addiction drug counselor (CAADC) or an approved development plan by the Michigan Certification Board for addiction professional (MCBAP) required.
    - Oversees and monitors the development and implementation of the quality improvement program.
    - Develops and implements the quality improvement plan in accordance with the QAPIP of the organization, federal and state laws/regulations, and accreditation standards.
    - Performs analytical monitoring of contractors and providers.
    - Monitors Medicaid and contractual agreements.
    - Monitors Medicaid Verification Claims and Michigan Mission Based Performance Indictors (MMBPI) data.
    - Develops performance improvement targets for quality, service, and the efficiency of the organization.
    - Implements changes targeted at system improvement.
    - Measures and evaluates attainment of results.
    - Provides consulting, technical, and clinical assistance.
    - Implements systematic improvements.
    - Ensures assigned service providers maintain quality services.
    - Assures improvement activities are documented and reported.
    - Analyzes, updates, and modifies standard operating procedures and processes to continually improve QI services.
    - Plans, organizes, manages, and leads work processes of the quality improvement program.
    - Performs statistical analysis and data analysis.
    - Monitors systems and procedures.
    - Conducts work simplification and measurement studies.
    - Prepares operations and procedures manuals.
    - Monitors compliance of SUD Treatment and Prevention providers within the DWIHN provider network.
    - Works with providers to improve the quality of care and services.
    - Assists with the NCQA accreditation process.
    - Sets standards, conducts performance assessments, and conducts remote and on-site monitoring of providers in the network.
    - Participates in MDHHS audits and site visits.
    - Develops and implements corrective action and improvement plans.
    - Oversees new program and Medicaid Enrollment reviews which involves site visits to ensure that new programs or programs requiring Medicaid enrollment meet the minimum requirements for participation in the DWIHN network.
    - Creates reports regarding - initial communication, review findings, Plans of Correction (POC) and POC monitoring and follow-up for DWIHN providers.
    - Completes or assists co-workers with reviews i.e. (Clinical Reviews, Investigations and Claims Reviews).

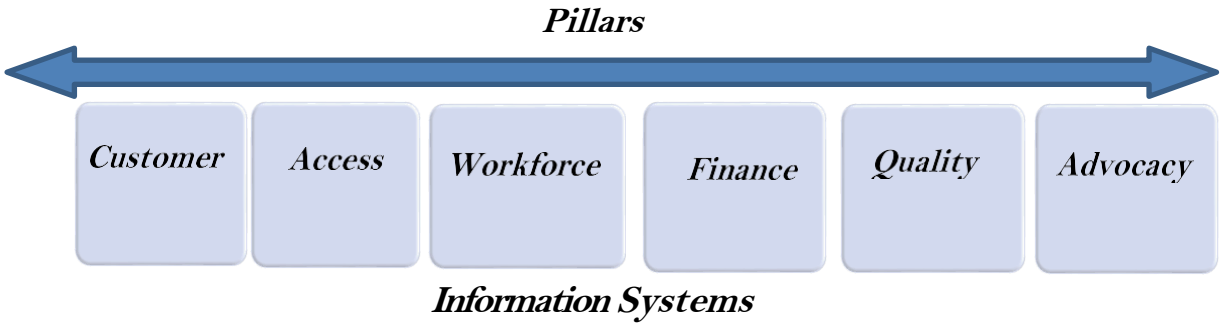
- Attends SUD and other provider meetings.
- Reviews data for trends and creates monthly reporting including reporting data into the Cascade software database.
- Communicates with providers by responding to phone calls and e-mail requests, providing training, and providing technical assistance.
- Performs related duties as assigned.

9. Clinical Specialist Performance Improvement (Critical/Sentinel Event)
   - Master's degree in nursing or social work preferred. Bachelor's degree in psychology, social work, or related human services required. Review of Critical/Sentinel Events to determine if the incident meets the criteria and definitions for a critical event, critical incidents, risk events, sentinel event, or media events and is related to a practice or standard of care.
   - Review to classify a critical event or incident as either a) sentinel event, or b) non-sentinel event.
   - Develop and update the "MH-WIN Procedural Guidance Manual for Reporting Critical Incidents/Events, Sentinel Events and Death Reporting Process".
   - Documentation and reporting of high profile, media-reported and urgent incidents that meet the critical incident criteria.
   - Develop Critical/Sentinel event face-to-face training for the provider network for accessing the Critical/Sentinel Event Module.
   - Reporting of ALL deaths (expected and unexpected) along with the appropriate information to MDHSS within 24 hours of knowledge.
   - Responsible for closure of assigned deaths in the MH-WIN Module.
   - Review of investigations of records and information concerning the member including, but not limited to, the review of Individual Plans of Service (IPOS), progress notes, psychiatric evaluations, Behavior Management Plans, records of dispute resolutions, grievances and appeals, and recipient rights complaints.
   - Maintain all materials as confidential and distribute only as necessary to perform the peer review function.
   - Ensure that all information related to the Critical Event be uploaded in MH-WIN using the Critical Event/Sentinel Event Module into the "All Scanned Documents" tab.
   - Review Critical and Sentinel Events to include analysis and reporting of member experience and satisfaction with services provided allowing for integration with the Customer Experience process.

10. Clinical Specialist Performance Improvement (Registered Nurse)
    - Bachelor's degree in nursing with certification as Registered Nurse in the State of Michigan.
    - Must meet credentialing qualification in at least one of the following: Qualified Mental Health Professional (QMHP), Qualified Intellectual Disabilities Professional (QIDP), Qualified Children Mental Health Professional (QCMHP).
    - Three (3) years of work experience in behavioral healthcare, two years of progressively responsible experience in a community mental health setting, two years in clinical practice.
    - Review of Critical/Sentinel Events to determine if the incident meets the criteria and definitions for a critical event, critical incidents, risk events, sentinel event, or media events and is related to a practice or standard of care.
    - Review to classify a critical event or incident as either a) sentinel event, or b) non-sentinel event.
    - Develop and update the "MH-WIN Procedural Guidance Manual for Reporting Critical Incidents/Events, Sentinel Events and Death Reporting Process".
    - Documentation and reporting of high profile, media-reported and urgent incidents that meet the critical incident criteria.
    - Develop Critical/Sentinel event face-to-face training for the provider network for accessing the Critical/Sentinel Event Module.
    - Reporting of ALL deaths (expected and unexpected) along with the appropriate information to MDHSS within 24 hours of knowledge.
    - Responsible for closure of assigned deaths in the MH-WIN Module.
    - Review of investigations of records and information concerning the member including, but not limited to, the review of Individual Plans of Service (IPOS), progress notes, psychiatric evaluations, Behavior Management Plans, records of dispute resolutions, grievances and appeals, and recipient rights complaints.
    - Follow-up with providers for completion of root cause analysis or investigation, a) the findings shall include actions that will minimize the further occurrence of the sentinel event (per CMS approval and MDHHS current contractual requirement); or b) a written explanation providing the rational for not pursuing an intervention. A corrective action plan or intervention must identify objective, measurable actions; who will implement the plan of action; a timeframe for the implementation; and how the implementation of the plan will be monitored or evaluated and submitted to DWIHN.
    - Completes appropriate documentation in clinical systems (MHWIN) in compliance with regulatory and accreditation standards.
    - Participates on committees or special projects as needed.

Quality Improvement Program (QIP) Governance

The DWIHN Strategic Plan is an overarching process that works toward common goals, establish agreements around intended outcomes/results, and assess and adjust the organization's direction in response to a changing environment. The QIP provides a systematic approach to assessing services and improving them on a priority basis. DWIHN's approach to quality improvement is based on the following six pillars. The six pillars are the focus areas that help realize the vision and a call to action with Information Systems as the foundation for supporting success across each of the pillars.



DWIHN's ability to understand and meet the unique health needs of our members is supported by our capabilities to effectively access, integrate, and analyze data. We have built and continue to invest in our members and technology to support industry-leading capabilities in data analytics. DWIHN's understanding of health care analytics and statistics enables us to develop and adjust standard methodologies to achieve targeted accurate results.

Cultural and Linguistic Needs

DWIHN's objectives for serving a culturally and linguistically diverse membership is a commitment to innovation, affordability, professional competence, continuous learning, teamwork, and collaboration. The racial and ethnic disparities in behavioral health care have been well documented. Data analysis has demonstrated that racial and ethnic disparities contribute to lower HEDIS effectiveness of care scores. DWIHN seeks to improve the overall care of members by identifying racial and ethnic composition so that potential health care disparities can be identified. This is accomplished by systematic monitoring and evaluation of provided services and by actively pursuing opportunities for improvement. DWIHN includes the following principles into its QIP:

- The importance of culture
- The assessment of cross-cultural relations
- Expansion of cultural knowledge, and
- The adaptation of services to meet the specific needs of our members.

DWIHN and its Provider Network shall demonstrate an ongoing commitment to linguistic and cultural competence that ensures access and meaningful participation for all individuals receiving behavioral health services. 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 relationship of language and culture to the delivery of support and services. Professional 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, etc.

DWIHN Medversant software captures the capacity to recruit providers of diverse racial and ethnic background by documenting the provider's self-identified ethnicity, culture, and race (if provided). The software also includes a question about other languages spoken by providers to indicate their linguistic diversity – this information can also be found in the provider e- directory and provider directory for informational purposes to members. In addition, to ensure a competent work force of qualified practitioners, DWIHN utilizes Detroit Wayne Connect (DWC) for ongoing cultural diversity training. DWIHN monitors the delivery of care and services in relation to the provision of culturally competent services through review of Staff Training Records, Member Satisfaction Surveys and Provider Satisfaction Surveys.

Credentialing and Re-Credentialing

The QAPIP contains written procedures to determine whether physicians and other health care professionals, who are licensed by the state and who are employees of the provider network or under contract with DWIHN, are qualified to perform their services. QAPIP also has written policies and procedures to ensure that non-licensed providers of care or support are qualified to perform their jobs. DWIHN policies and procedures for credentialing process follows the MDHHS Credentialing and Re-Credentialing processes, and includes the organization's initial credentialing of practitioners, as well as its subsequent re-credentialing, re-certifying, and/or reappointment of practitioners. The qualifications of physicians and other licensed behavioral healthcare practitioners/professionals employed by or under contract with DWIHN are reviewed by DWIHN's Credentialing and Re- Credentialing policy and procedures. Within this framework, the DWIHN credentials all organizational providers under direct contract with DWIHN and its own CMHSP behavioral healthcare practitioners. All CMHs and SUD Treatment Providers will have Credentialing policies in place that are approved by DWIHN and that cover all behavioral health care practitioners.

Providers are also bound by DWIHN contract requirements and MDHHS standards to provide training for all new staff and periodic training and staff development activities for all staff. This requirement includes Recipient Rights training. Other specific training courses are designated for non-licensed staff to ensure competency skills. DWIHN and its Provider Network's Staff Training program will ensure, regardless of funding mechanism (e.g., voucher), that staff possess the appropriate qualifications as outlined in their job descriptions, including the qualifications for all the following: educational background; relevant work experience; cultural competence; and certification, registration, and licensure as required by law. A program shall train new personnel regarding their responsibilities, program policy, and operating procedures.

DWIHN Credentialing Unit conducts bi-annually reviews of the delegates (accredited Behavioral Health and Substance Use Disorder Providers and Credentialing Verification Organizations). DWIHN's Credentialing Review Procedure will include but are not limited to the following:

- Review of the delegate Credentialing Policy and Procedures,
- Review of the Minutes of the delegate's Credentialing Committee,
- Review of Credentialing/Recredentialing files for the period specified by DWIHN Credentialing Unit, and
- Review of other information (Delegate reports, evidence of monthly monitoring of sanctions, organizational sanctions, complaints, etc.

DWIHN auditing procedure for the electronic files in the primary source verification database (Medversant). The Data and documentation that is stored in Medversant is reviewed for accuracy, completeness, and quality during the credentialing and re-credentialing process by the Virtual Review Committee. Data in the Medversant is audited between credentialing cycles utilizing various data integrity reports and queries. Erroneous data is corrected in the application as it is identified to ensure credentialing data is correct and up to date. The DWIHN Credentialing Unit randomly selected 15% of the universe of files received by the Virtual Review Committee the previous month. The sample files are identified using the Medversant IDs and generated using the Microsoft Excel Randomization Function. The Credentialing Committee provides oversight of the auditing process. The findings summarized in the Monitoring/Audit Report will be presented to the Credentialing Committee and Quality Improvement Steering Committee. When poor quality issues are identified appropriate sanctions will occur from technical assistance to revocation of delegated credentialing function. The contracted providers shall train new staff regarding their responsibilities, program policy and operating procedures.

Framework for Quality Improvement

1. **F**ind a Process to Improve
2. **O**rganize to Improve
3. **C**larify Current Knowledge of the Process
4. **U**ncover Causes of Process Variation or Poor Quality
5. **S**tate Plan Do Study Act (PDSA)
    i. **P**lan the Improvement Process
    ii. **D**o the Improvement, Data Collection, and Analysis
    iii. **S**tudy the Results and Lessons Learned
    iv. **A**ct by Adopting, Adjusting, or Abandoning the Change

To ensure compliance of the QAPIP methodology, the use of quality improvement process management/improvement tools and techniques will consistently be included using the following four steps:

1. Identify - Determine what to improve.
2. Analyze - Understand the problem.
3. Develop - Hypothesize what changes will improve the problem.
4. Test/Improvement - Test the hypothesized solution to see if it yields improvement. Based on the results, decide whether to abandon, modify, or implement the solution.

Key cultural components also ensure the success of improvement efforts include leadership involvement, data informed practice, use of statistical tools, prevention over correction, and continuous quality improvement. Strong leadership, direction, and support of quality improvement activities by the governing body and CEO are key to performance improvement and audit readiness. This involvement of organizational leadership ensures that quality improvement initiatives are consistent with the DWIHN mission, vision, values, and strategic plan.

Successful QI processes create feedback loops, using data to inform practice and measure results. Fact- based decisions are likely to be correct decisions, for continuous improvement of care, tools and methods needed to foster knowledge and understanding. Processes must be continually reviewed and improved. Small incremental changes do make an impact, and providers can almost always find an opportunity to make things better.

Continuous Quality Improvement Activities

The Quality Program encompasses all aspects of care and service delivery. Components of DWIHN's quality improvement activities include but not limited to:

- Clinical components across the continuum of care from acute hospitalization to outpatient care.
- Organizational components of service delivery such as case management, discharge planning, prior authorizations, as well as other procedures or processes that affect care including access to care.
- Processes that impact our members or providers of care such as claims, interpreter services, enrollment, customer services, credentialing/recredentialing and utilization management.
- Member satisfaction.
- Member safety.

These quality improvement activities emerge from a systematic and organized framework for improvement. This framework, adopted by the leadership, is understood, accepted, and utilized throughout the system, as a result of continuous education and involvement of staff at all levels in performance improvement. Quality Improvement involves two primary activities:

- Measuring and assessing the performance of processes and services through the collection and analysis of data.
- Conducting quality improvement initiatives and acting where indicated, including the redesign of processes, design of new services, and/or improvement of existing services.

The Michigan Department of Health and Human Services (MDHHS) requires that DWIHN provide a written description of the QAPIP plan for approval by the Board of Directors. The contract with MDHHS requires DWIHN to annually conduct an effectiveness review of its QAPIP. The effectiveness review includes an analysis of whether there have been improvements in the quality of health care and services for members because of quality assessment and improvement activities and interventions carried out by DWIHN. The analysis takes into consideration trends in service delivery and health outcomes over time and includes monitoring of progress on performance goals and objectives.

QAPIP is also reviewed for effectiveness of the methods used to implement, monitor, and evaluate the quality improvement processes and for any necessary revisions and adjustments monthly. The review of the QAPIP includes members, providers, Quality Improvement Steering Committee (QISC), Program Compliance Committee (PCC) of the DWIHN's Board of Directors, and other stakeholders. Information on the effectiveness of DWIHN's QAPIP is provided annually to our stakeholders and to members upon request.

At a minimum, the QAPIP specifies the following elements:

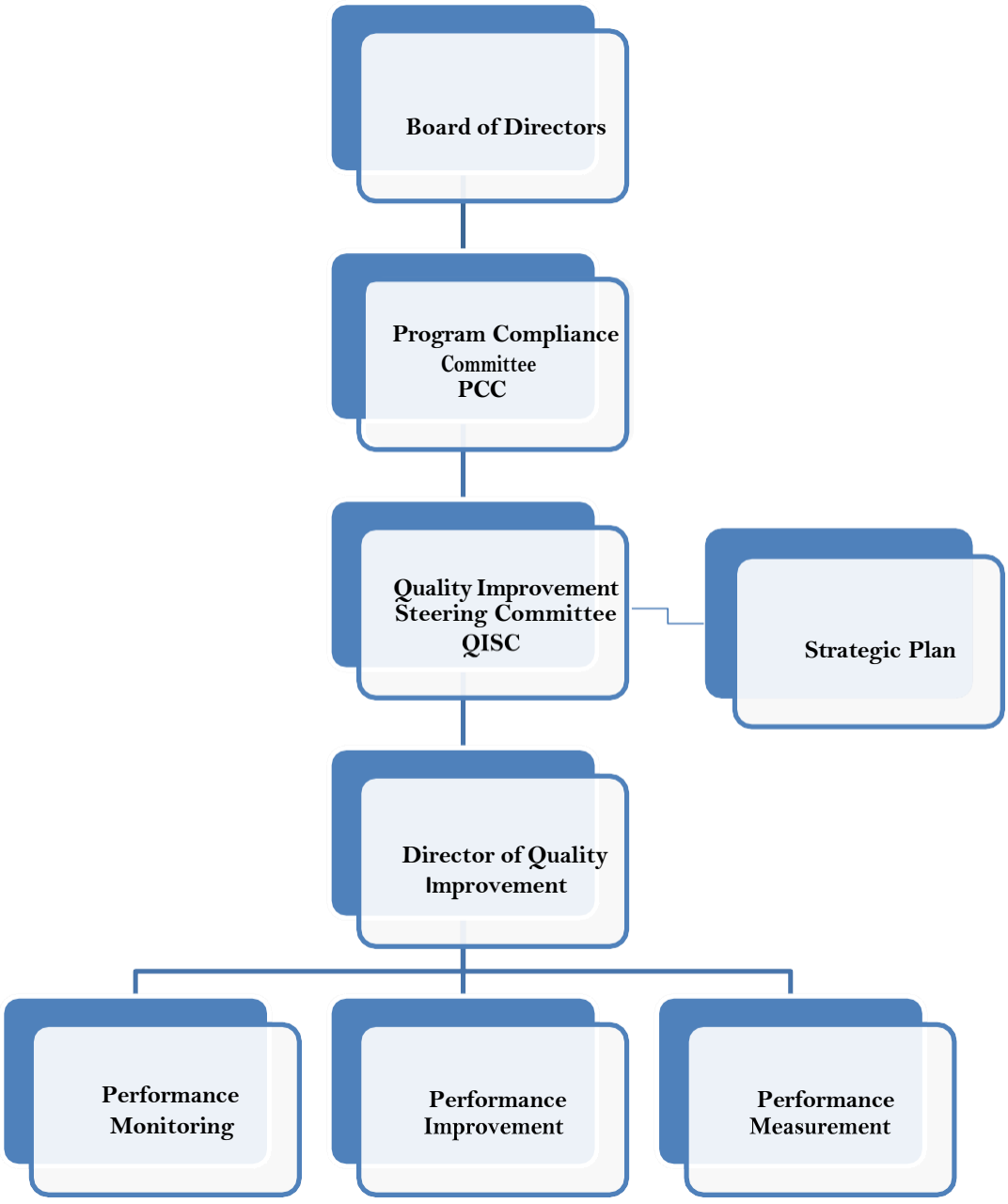
a. An adequate organizational structure that allows for clear and appropriate administration and evaluation of QAPIP.
b. Responsibilities of the governing body for monitoring, evaluation and making improvements to care.
c. Objectives and timelines for implementation and achievement.
d. Role of recipients of services and other stakeholders in the QAPIP plan.
e. Mechanisms or procedures used for adopting and communicating process and outcome improvements.
f. Description of a designated senior official responsible for QAPIP implementation.
g. Performance measures to address access, availability, quality, efficiency, and outcome of services, using standardized indicators based upon the systematic, ongoing collection and analysis of valid and reliable data.
h. Performance improvement projects that address clinical and non-clinical aspects of care that are directed as the state and the DWIHN established aspects of care. Clinical areas include high volume services, high-risk services and continuity and coordination of care. Non-clinical areas include grievances and appeals, complaints and access to and availability of services.
i. Process from the review and follow-up of Critical/ Sentinel Events and events that place members at risk of harm.
j. Periodic quantitative (i.e., survey) and qualitative (i.e., focus group) assessments of member experiences with services. These assessments must address issues of quality, availability, and accessibility of care.
k. Process for the incorporation of members receiving services into the review and analysis of the information obtained from quantitative and qualitative reviews.
l. Written procedures to determine whether physicians and other licensed health care professionals are qualified to perform their services.
m. Written procedures to ensure non-licensed providers of care or support are qualified to perform their jobs.
n. The organization's process for the initial credentialing and re-credentialing of providers.
o. Identification of staff training needs and provision of in-service training, continuing education, and staff development activities.
p. DWIHN process to verify whether services reimbursed by Medicaid were provided to enrollees by affiliates and service providers.

The Quality Improvement Unit reviews the response received regarding the effectiveness of the methods proposed or used to implement, monitor, and evaluate the quality improvement processes. The results and recommendations are incorporated in the QAPIP for the next fiscal year cycle.

DWIHN quality improvement goals are integrated and communicated throughout the organization with structured work plans, goals and objectives that are owned at the department level. Our organizational monitoring activities and reports are reviewed throughout the year to identify opportunities for needed changes and improvements. These activities, in addition to ongoing improvement projects, form the basis of the organization's work plan and support all services offered by DWIHN.

Leadership and Structure

Leadership. The key to the success of the Continuous Quality Improvement (CQI) process is leadership. Consistent with a total quality Improvement philosophy, the following is the structure of the organization in which the Quality Improvement Unit resides.



Governing Body

DWIHN's Program Compliance Committee (PCC) is the governing body for the QAPIP plan. PCC formally reviews on a periodic basis a written report on the operation of the QAPIP activities. PCC delegates direct oversight of all QI functions to the Quality Improvement Steering Committee (QISC), which serves as the oversight body and has responsibilities for the day-to-day management of the QI program. PCC annually reviews the specific goals and objectives of DWIHN, including a description of the services provided. This includes, but is not limited to, the QAPIP, Year End Evaluation, and periodic review of quality improvement progress reports. The Director of Quality Improvement provides monthly and quarterly reports on QI activities to PCC. As the governing body, PCC, with recommendations from appropriate clinical personnel, acts on all major contracts and other arrangements affecting the delivery of health care services. PCC actively supports the Quality Improvement Program as demonstrated by ongoing involvement in the policy making process of the organization. The final approval of the QAPIP is retained by DWIHN's Full Board of Directors.

Director of Quality Improvement

The Director of Quality Improvement has the overall responsibility for implementation of the QAPIP. Under the Director of Quality Improvement's leadership, an integrated interdivisional approach to improving DWIHN services and systems is undertaken. The Director of Quality Improvement is also responsible for the following:

1. Assisting staff in understanding and participating in the Continuous Quality Improvement (CQI) process.
2. Establishing regular communication throughout DWIHN's network about CQI issues, problems, status, and progress.
3. Assisting the PCC Committee and the Full Board of Director's understanding of the CQI process.
4. Developing and implementing a data collection system that yields real-time meaningful data for needs assessment, program planning, outcome evaluations and operationalizing quality improvement opportunities.
5. Pursuing opportunities for partnership between DWIHN and other public and private entities involved in quality improvement efforts.
6. Participating in quality improvement teams and work groups at DWIHN and state levels.
7. Assisting in the Strategic Planning process.
8. Developing a DWIHN Audit Ready philosophy.
9. Standardized protocols for ensuring appropriate use for telehealth services, appropriate billing codes and quality measures.

Quality Improvement (QI) Unit

The QI Unit is responsible for performing quality improvement functions assuring that program improvements are occurring within the Pre-Paid Inpatient Health Program (PIHP) and the Community Mental Health Services Program (CMHSP). The QI unit provides support for all departments in the organization for quality improvement projects.

The QI Unit operates in partnership with stakeholders, members, advocates, contracted providers, and DWIHN staff. The QI Unit achieves the scope of continuous quality improvement through three functions: performance monitoring, performance measurement and performance improvement.

Performance Improvement

Performance Improvement is a formal approach to the analysis of performance and systematic efforts to prevent, reduce or eliminate waste, and problems that will lead to improvement in service quality. The Performance Improvement component ensures guidance is provided to the system through the provisions of policy directives. This approach is system-wide and addresses DWIHN and its service provider network. All service providers are required to have certain policies in place which mirror DWIHN's policies. The policies address those areas that are contractually mandated in the contract with MDHHS and describe the process for ensuring compliance. DWIHN's policies undergo a public comment period before becoming final. This process allows stakeholders to comment and provide feedback on proposed policies. In addition, approved policies are reviewed and disseminated to DWIHN service provider network via Quality and Provider meetings. Approved policies are located on DWIHN's website.

To meet the regulatory requirements for MDHHS and NCQA, DWIHN conducts Performance Improvement Projects (PIPs) that are approved through the Improving Practices Leadership Team (IPLT) and the Quality Improvement Steering Committee (QISC). The QISC provides oversight to the Performance Improvement Projects. The purpose of each PIPs is to achieve through ongoing measurements, demonstrable and sustained improvement in both clinical and non-clinical services that will have beneficial health outcomes and member satisfaction. The clinical areas include, but are not limited to high-volume services, high-risk services and continuity and coordination of care. Non- clinical areas include, but are not limited to appeals, grievances, trends, and patterns of substantiated recipient rights complaints as well as access and availability of services. The methodology DWIHN works to improve clinical issues involves the following:

- Collecting data appropriate for the clinical issues
- Conduct quantitative and qualitative analysis of data that compares results against goals.
- Identifying opportunities for improvement.
- Implementing interventions to improve performance.
- Measuring the effectiveness of interventions.

Performance Improvement Projects (PIP)
Clinical/Non-Clinical PIPs

DWIHN have engaged in at least two (2) projects during the waiver renewal period.

- Improve children and adults within DWIHN provider network with follow-up services within 30 days after discharge from a psychiatric inpatient hospital. This study topic aligns with the Performance Bonus Incentive metric "Follow-up After Hospitalization for Mental Illness within 30 days". The PIP performance targets have been set to exceed performance standards.
- Increase the Number of New Habilitation Supports Waiver Program Enrolled Members and Improve the Utilization Rate of Habilitation Supports Waiver Program Slots that are allocated to DWIHN from the MDHHS. Refer to the FY2022 Workplan for the listing of additional Performance Improvement Projects.

Once the performance of a selected process has been measured, assessed, and analyzed, the information gathered by the above performance measures is used to identify DWIHN's defined continuous quality improvement initiative to be undertaken. The decision to undertake the initiative is based upon DWIHN priorities. The purpose of an initiative is to improve the performance of existing services or to design new ones. The models utilized for analysis Focus-Plan-Do-Study-Act (PDSA) and the Ishikawa Fishbone Diagram.

DWIHN requires its provider network to participate in the PIPs related to their respective programs and services. The Substance Use Disorder Providers and the Clinical Responsible Service Providers (CRSP) are expected to participate in DWIHN's PIP related to their programs and services. DWIHN Quality Improvement (QI) unit directly oversees and monitors all functions within the QI unit. No QI activities are delegated to another entity. However, it is the expectation of DWIHN that providers conduct PIPs based on their own self-assessment of need, risk, frequency, and performance of their settings. DWIHN's contract with MDHHS requires a State mandated performance improvement activity as well as activities identified by IPLT and QISC.

Oversight of the quality improvement infrastructure is achieved through collaboration with members, advocates, providers, DWIHN's Chief Medical Officer, and other stakeholders. Planned, systematic activities are implemented so that quality requirements for community mental health services are fulfilled by DWIHN and contracted service providers.

In partnership with stakeholders Quality Improvement activities include:

- Assessment of needs, quality of services, accessibility of care, availability of care, outcomes of services provided and beneficiary experiences with services.
- Evaluation of systems, programs, and services.
- Collect performance data utilizing effective quantitative metrics that are specific, measurable, actionable, relevant, and timely for Michigan Mission Based Performance Indicator System, MDHHS and DWIHN Performance Improvement Projects, QAPIP Status/Outcomes, Satisfaction Surveys (Member and Provider), Standardized HCPCS Code Utilization, Medicaid, and Other Claim Verification, MDHHS and DWIHN Needs Assessments, and Network Policies.
- Identification of positive and negative process trends.
- Analysis of causes of positive and negative statistical variation and outliers.
- Identification of opportunities for improvement.

- Determination of goals and objectives.
- Decision making and planning.
- Stakeholder education/information sharing.
- information and technical assistance regarding the quality improvement issues, trends, techniques, and proposed outcomes.
- Implementation of performance improvement activities.
- Measure and monitor progress toward goal achievement.
- Evaluate outcomes and modify performance improvement process as needed.
- Implementation of standardized performance improvement activities.
- Strategic and annual planning.

Some of the tools and techniques used in the continuous quality improvement process include Problem Solving Methodology, Process Mapping, Force Field Analysis, Cause and Effect Diagrams, Brainstorming, Pareto Analysis, Control Charts, Check Sheets, Bar Charts, Scatter Diagrams, Matrix Analysis, Tally Charts, and Ishikawa Fishbone Diagram.

Quality Assurance and Improvement functions include informing practitioners, providers, members, and the Governing body of assessment results, and facilitates a process of evaluating the effectiveness of the assessments and outlining systematic action steps to follow-up on findings.

The Leaders support QI activities through the planned coordination and communication of the results of measurement activities related to QI initiatives and overall efforts to continually improve the quality of care provided. This sharing of QI data and information is an important leadership function. Leaders, through a planned and shared communication approach, ensure the Board of Directors, staff, members, and families have knowledge of and input into ongoing QI initiatives as a means of continually improving performance.

This planned communication may take place through the following methods:

- Storyboards and/or posters displayed in common areas.
- Recipients participating in QI Committee reporting back to recipient groups.
- Sharing of the annual QI Plan evaluation.
- Newsletters and or handouts.
- Dashboards
- DWIHN website

Critical/Sentinel, Unexpected Deaths, and Risk Reporting

DWIHN Reporting of Consumer Critical Events, Sentinel Events, and Death policy establishes the guidelines for reporting and reviewing possible Sentinel Events and/or Critical Incidents. DWIHN analyzes, at least quarterly, the critical incidents, sentinel events, and risk events to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents. DWIHN has a process for analyzing additional critical events that put individuals at risk of harm. This analysis is used to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents. These events minimally include: actions taken by individuals who receive services that cause harm to themselves; actions taken by individuals who receive services that cause harm; two or more unscheduled admissions to a medical hospital (not due to planned surgery or the natural course of a chronic illness, such as when an individual has a terminal illness) within a 12 months; police calls by staff of specialized residential treatment providers or other provider agency staff for assistance with an individual during a behavioral crisis situation regardless of whether contacting police is addressed in a behavioral treatment plan; and emergency use of physical management by staff in response to a behavioral crisis. (See Critical Sentinel Event Flow Chart Appendix 1 pg.58).

The Sentinel Event Committee/Peer Review (SEC/PRC) Committee reports Sentinel Event findings for review and analysis, and document follow-up and system improvement efforts, as required by MDHHS practice guidelines. The SEC/PRC Committee also conducts review and analysis of sentinel event reports submitted by the CRSP/SUD Providers. The SEC/PRC submits no less than annually to the Governing Body a periodic summary and recommendations for action response and disposition. The SEC/PEC committee may require follow-up action on the part of the provider in the form of a Corrective Action Plan / Improvement Plan or Root Cause Analysis (RCA)

The QI Department may convene the SEC/PRC Committee ten (10) times per year to review cases in the five (5) reportable category areas as required by MDHHS, and other cases identified by the Chief Medical Officer and/or SEC/PEC Committee members. The identified reportable categories for members include Suicide; Non-Suicide Deaths; Arrest of Member; Emergency Medical Treatment due to injury or Medication Errors. The QI Department is responsible for tracking trends and patterns through this review process. The QI Department also provides annual data reports based on monthly and quarterly reviews of events. The reports are forwarded through the QISC, PCC, and to the full Board of Directors for review and approval.

DWIHN Critical Incident Reporting System captures information on specific reportable events which include but not limited to suicide, non-suicide death, emergency medical treatment due to injury or medication error, hospitalization due to injury or medication error, and arrest of member. The population on which these events must be reported differs slightly by type of event. The SEC/PEC ensures that all critical incidents, sentinel events, and risk events are analyzed to determine what action needs to be taken to remediate the problem or situation and prevent the occurrence of additional events and incidents.

Each Clinically Responsible Service Provider (CRSP) is responsible to enter the Critical Event, Critical Incident, Sentinel Event, and Risk Events into the Critical/Sentinel Event Module in MH-WIN for members actively receiving services in their organization within 24 hours of knowledge of the event. The Residential Treatment Providers are responsible for submitting and notifying CRSP timely of events involving members and must provide hospital documentation or police reports when applicable. DWIHN has expanded reporting to include data for each CRSP and the SEC/PRC trends and patterns with recommendations. SEC/PRC is represented by the Chief Medical Officer, clinicians, and administrative staff members of DWIHN.

All unexpected deaths of Medicaid beneficiaries who at the time of their death were receiving specialty supports and services are reviewed by the CRSP Provider. Refer to DWIHN policy on Reporting of Consumer Critical Event, Sentinel Events and Death Reporting for specific review and procedures.

DWIHN requires all contracted CRSP to have Behavior Treatment Plan Review Committee (BTPRC). As an option, the network providers and Mental Health CRSP may collaborate on developing and operating a joint BTPRC. It is DWIHN's expectation that it is the responsibility of the providers joining as partners in the BTPRC and CRSP to ensure that the joint BTPRC will provide the required review of proposed Behavior Treatment Plan (BTP) in real-time or during emergent situations. DWIHN contracted CRSP (Mental Health) monitor and ensured their implementation of Behavior Treatment policies and procedures.

The QAPIP quarterly review analysis of data for reporting to the QISC and PCC from the BTPRC intrusive or restrictive techniques that have been approved for use with members and where physical management or 911 contacts with law enforcement have been used in an emergency behavioral crisis. DWIHN also submits quarterly data analysis reports on system-wide trends of BTP to MDHHS. Data includes numbers of interventions and length of time the interventions were used per person. The techniques that have been approved during person-centered planning by the beneficiary or his/her guardian and are supported by current peer-reviewed psychological and psychiatric literature may be used with members.

Member Experience and Services

QAPIP is designed to improve the quality of care and service provided to members. Issues of quality, availability, and accessibility of care are evaluated through periodic quantitative (e.g., surveys) and qualitative (e.g., focus groups) assessments of member experiences with services. The assessments will be representative of the people served and support offered. The survey instruments used include the Experience of Care and Health Outcomes (ECHO) survey for (Adult/Children) and the National Core Indicators (NCI) survey (I/DD Population).

The QAPIP annual review analysis and data from the ECHO and NCI surveys are forwarded to the QISC, PCC and the full Board of Directors for review and approval. DWIHN and its Providers uses the assessment results to improve services for members. Processes found to be effective and positive will be continued, while those with questionable efficacy or low member satisfaction will be revised using the following methodology:

- Take specific action on individual cases as appropriate.
- Identifies and investigates sources of dissatisfaction.
- Outlines systemic action steps to follow-up on the findings.
- Informs practitioners, providers, recipient of service and the governing body of assessment results.

Long-Term Services and Supports (LTSS)

QAPIP includes mechanisms to assess the quality and appropriateness of care furnished to members receiving LTSS. The process includes an assessment of care between care settings and a comparison of services and support received with those set forth in the member's individual plan of service. Members receiving long-term supports or services (e.g., customers receiving case management or supports coordination), are included in the Quality Improvement process, as survey participants, as members of Consumer Advisory Councils, and as members of the DWIHN's Board. In this way members are incorporated into the review and analysis of information obtained from quantitative and qualitative methods. The LTSS cases or persons with special needs are tracked and reported on the MDHHS OBRA dashboard as established in response to the provisions of the federal Omnibus Budget Reconciliation Act (OBRA) of 1987, which amended the Medicaid program requirements for all nursing facilities. DWIHN Integrated Health Care unit has monthly meetings with the providers and quarterly meetings with MDHHS as required to discuss monthly and quarterly analysis of DWIHN's LTSS activities.

DWIHN continually evaluates its oversight of "vulnerable" individuals to determine opportunities for improving the health care and outcomes of members. DWIHN will continue to work with MDHHS to develop uniform methods for targeted monitoring of vulnerable individuals as well as review and approve corrective action plans that result from identified areas of non-compliance and follow-up on the implementation of the plans at the appropriate interval. Reports of the annual monitoring and plans of correction shall be subject to MDHHS review.

The QAPIP describes the process for the adoption, development, implementation and continuous monitoring and evaluation of practice guidelines when there are nationally accepted or mutually agreed upon clinical standards, evidence-based practices, practice-based evidence, best practices, and promising practices that are relevant to the individual served. The clinical protocols and practice guidelines are utilized as a tool to determine eligibility for services and assist in making determinations regarding continued necessity of care. DWIHN refers to these protocols and guidelines to determine medically necessary supports, services, or treatment for those we serve. DWIHN develops its clinical practice guidelines from scientific evidence, professional standards and/or a consensus of board-certified health care professionals in the field. Wherever possible, guidelines are derived from nationally recognized sources and are evidence- based on their foundation. For any DWIHN developed clinical guidelines, a literature search is conducted, including a search for established practice guidelines from national organizations and professional associations. With the support of the Improving Practices Leadership Team (IPLT) and the direction of the Chief Medical Officer develops and maintains up to date clinical Practice Guidelines that are well researched and well documented in the literature for DWIHN's provider network.

The following criteria are considered when establishing priorities for adopting Clinical Practice Guidelines relevant to the membership: the incidence or prevalence of the diagnosis or condition, the degree of variability in treatment approaches or outcomes for the diagnosis or condition, the availability of scientific and medical literature related to the effectiveness of various treatment approaches. The final step occurs when the guidelines are posted on DWIHN website for provider use and access. Additionally, all providers utilize the practice guidelines to assist in ongoing treatment decisions and methods of behavioral health care.

Public review and comment are also an integral piece of the developmental process. Following a series of clinical trainings and postings on the DWIHN website of the most updated clinical protocols and practice guidelines, implementation takes place via the proposed policies process. DWIHN may choose to send the draft version of the clinical practice guidelines to contract providers who treat the condition for feedback. The IPLT has ultimate responsibility for ensuring effective, evidence-based practice which is accomplished by the development or adoption of robust clinical guidelines. All clinical practice guidelines must be presented to DWIHN's IPLT for approval.

DWIHN staff under direction of the Chief Medical Officer assumes responsibility for continuous monitoring and updating of all practice guidelines and clinical protocols, regarding the latest literature, state/federal rules and regulations, and most effective standards of care. The Clinical Practice Guidelines are reviewed and updated at least every two (2) years or more frequently if national guidelines change during that two (2) year period. DWIHN expects its contracted practitioners to adopt these guidelines in their practice and encourages the use of evidence-based practices but recognizes the inability of the guidelines to address all individual circumstances. DWIHN monitors providers compliance with clinical guidelines through reports, treatment chart reviews, and/or process indicators. DWIHN supports its members in self- management of their conditions by making practice guidelines available on their website and through specific quality improvement initiatives/activities.

Verification of Services

The QAPIP addresses how DWIHN verifies whether services reimbursed by Medicaid were furnished to members by affiliates (as applicable) providers and subcontractors. The Individual Plan of Services (IPOS) is the conduit in which the Claims Verification process begins. DWIHN conducts claims verification reviews of randomly selected contracted providers encompassing all funding streams (MI-HEALTH LINK, Medicaid, SUD, Autism, Grants and General Fund) through desk audits, compliance investigations and on-site provider reviews. Bi-annually, DWIHN generates a statistically sound random sample, obtained from a pool of "Paid Encounters/Claims". The review sample size complies with the Office of Inspector General (OIG) minimum sampling standards. All program and clinical case records must comply with DWIHN's policy and procedures, existing requirements, and state guidelines as defined by MDHHS. Annually, DWIHN submits a report to MDHHS which contains its methodology for verification and its findings from the process, as well as providing any follow up actions that were taken because of the findings.

Verification for service includes testing of data elements from the individual claims/encounters to ensure the proper code is used for billing; the code is approved under the contract; the eligibility of the member on the date of service; that the service provided is part of the members IPOS (and provided in the authorized amount, scope and duration); the service date and time; services were provided by a qualified individual and falls within the scope of the code billed/paid; the amount billed/paid does not exceed the contract amount; and appropriate modifiers were used following the HCPCS guidelines.

Provider Network

DWIHN annually monitors its provider network including any affiliates and subcontractors to which it has delegated managed care functions, including service and support provision. The process includes review and follow-up on any provider network monitoring of its subcontractors. The standards used to assess contractors are the applicable sections of the Social Security Act, the Code of Federal Regulations (CFR), the Center for Medicare and Medicaid (CMS), MDHHS Operations Manuals, Michigan's Medicaid State Plan, and the Michigan Medicaid Provider Manual.

In an ever-changing economy, quality services and supports that result in positive outcomes for persons that receive services in a cost-effective manner are crucial. DWIHN continues to move toward a system that ensures accountability and transparency relative to service quality and cost. As a result, DWIHN's QI Unit will continue to develop, train, and implement a standardized system in which to measure performance and outcomes. These measurements will ensure accountability and transparency relative to the quality of services and cost. DWIHN's QI Unit directly oversees all monitoring functions, which includes but is not limited to onsite, virtual and provider self-monitoring. These monitoring measures are a component of the CQI process.

This process is designed to provide an organized documented process for assuring that eligible Detroit and Wayne County residents are receiving quality services for members with Serious Mental Illness, Severe Emotional Disturbance, Substance Use Disorders, Intellectual Developmental Disabilities, and Co-Occurring Disorders that are both medically necessary and appropriate standards of care while achieving the member desired outcomes.

DWIHN has adopted a performance monitoring process to support a CQI practice in an on-going effort to improve services through consistent evaluation, resulting in process/procedure/program refinements by on-going monitoring improvements as seen in Figure 1.

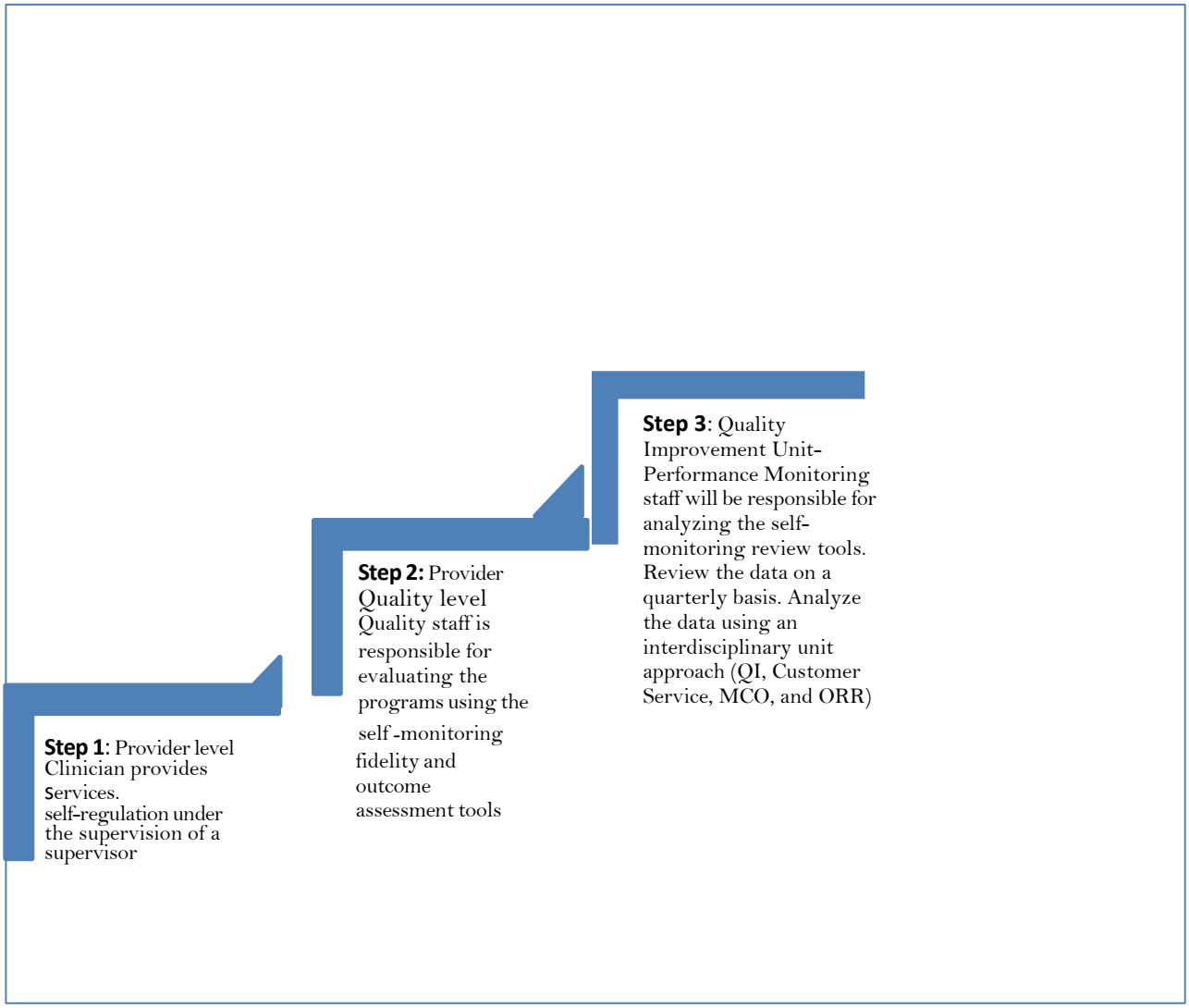
Figure 1.

The Performance Monitoring Plan is geared to improve quality and measure our performance in the delivery of service and compliance with required standards. This plan requires the involvement, skills, expertise, and input from DWIHN's Service Provider Network and internal staff. Requiring self-regulation and monitoring by all partners (DWIHN, Contracted Providers, Practitioner and Members).

As part of the monitoring process, DWIHN developed multiple levels using a standardized self-monitoring/self-regulating approach. This multilevel monitoring approach begins at the service provider level and cascades up to DWIHN's Quality Improvement Team. The "Monitoring Process" standardized tools assist in the documentation to ensure that:

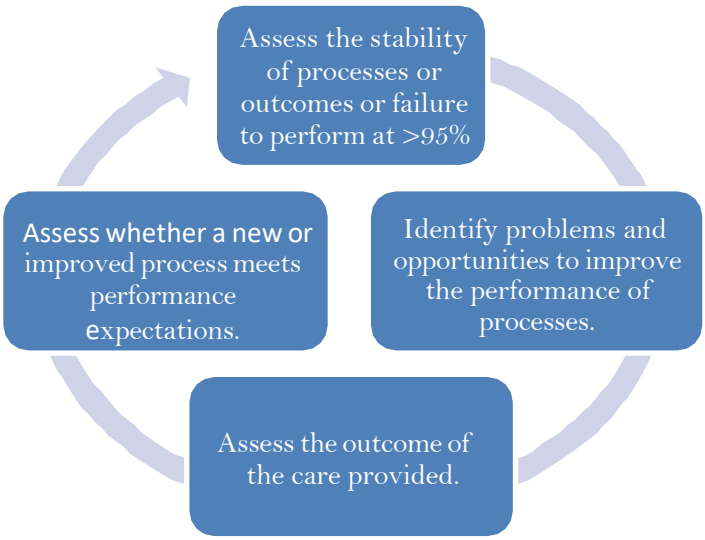
- Actions and/or process requirements are not open to different interpretations.
- The process is made easier to understand.
- Non-value-added steps are eliminated.
- Effectiveness and efficiency are increased.
- The process can be benchmarked to determine if it is excellent or to set new performance goals.
- DWIHN and Contracted Provider staff can collect evidence relying on process conformity to increase validity and reliability in findings.

Process Steps of Performance Monitoring Pathway (defined by QI)

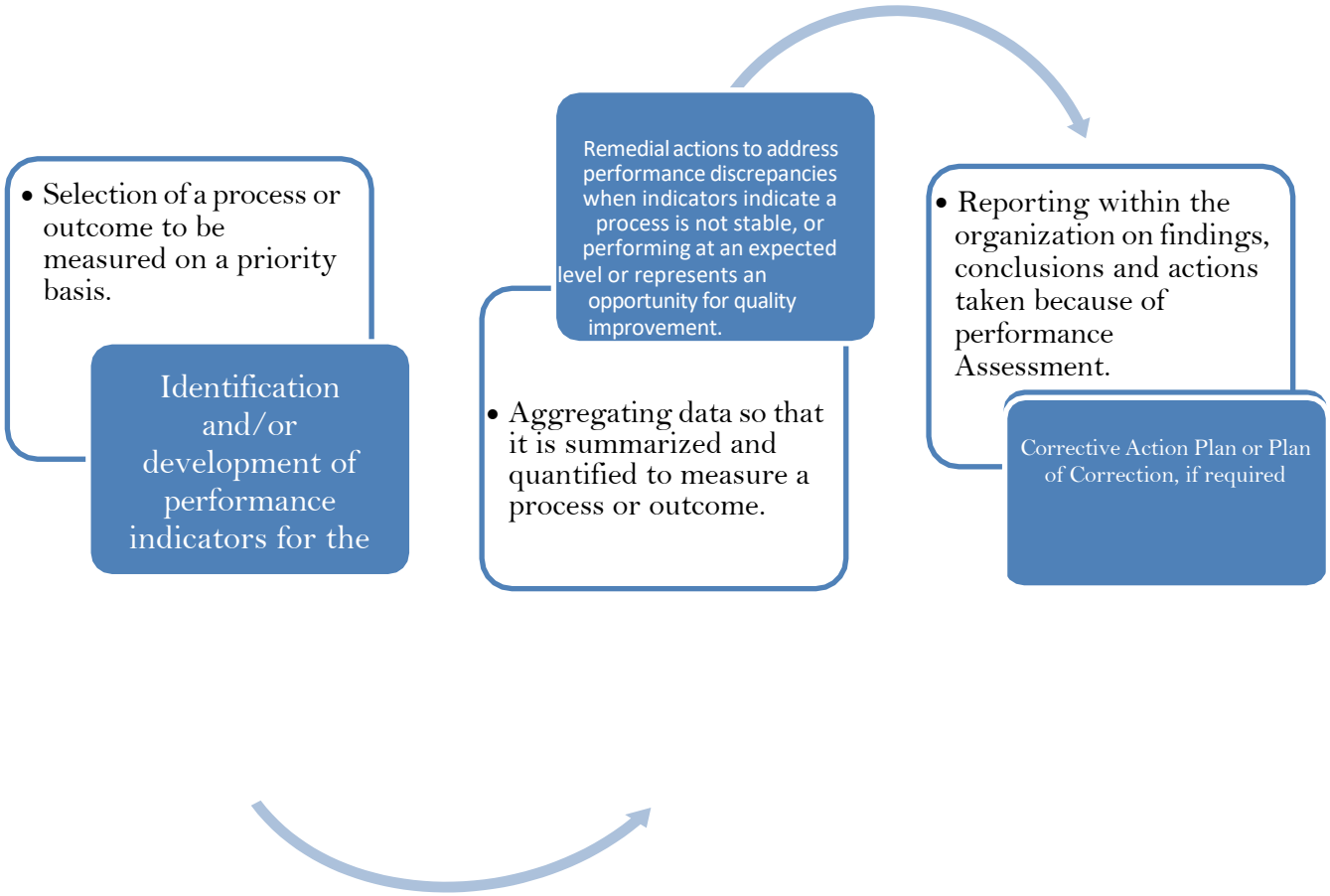


Performance Measures

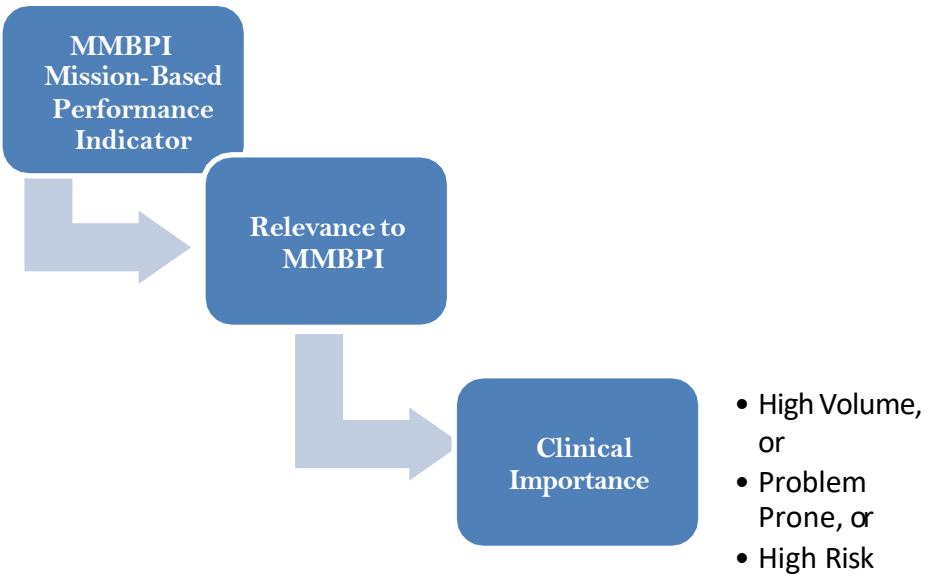
Performance measures are a critical component of the PDSA cycle. Performance Measures is the process of regularly assessing the data results produced by a program. The ***purpose*** of measurement and assessment is to:



Measurement and assessment ***involve***:

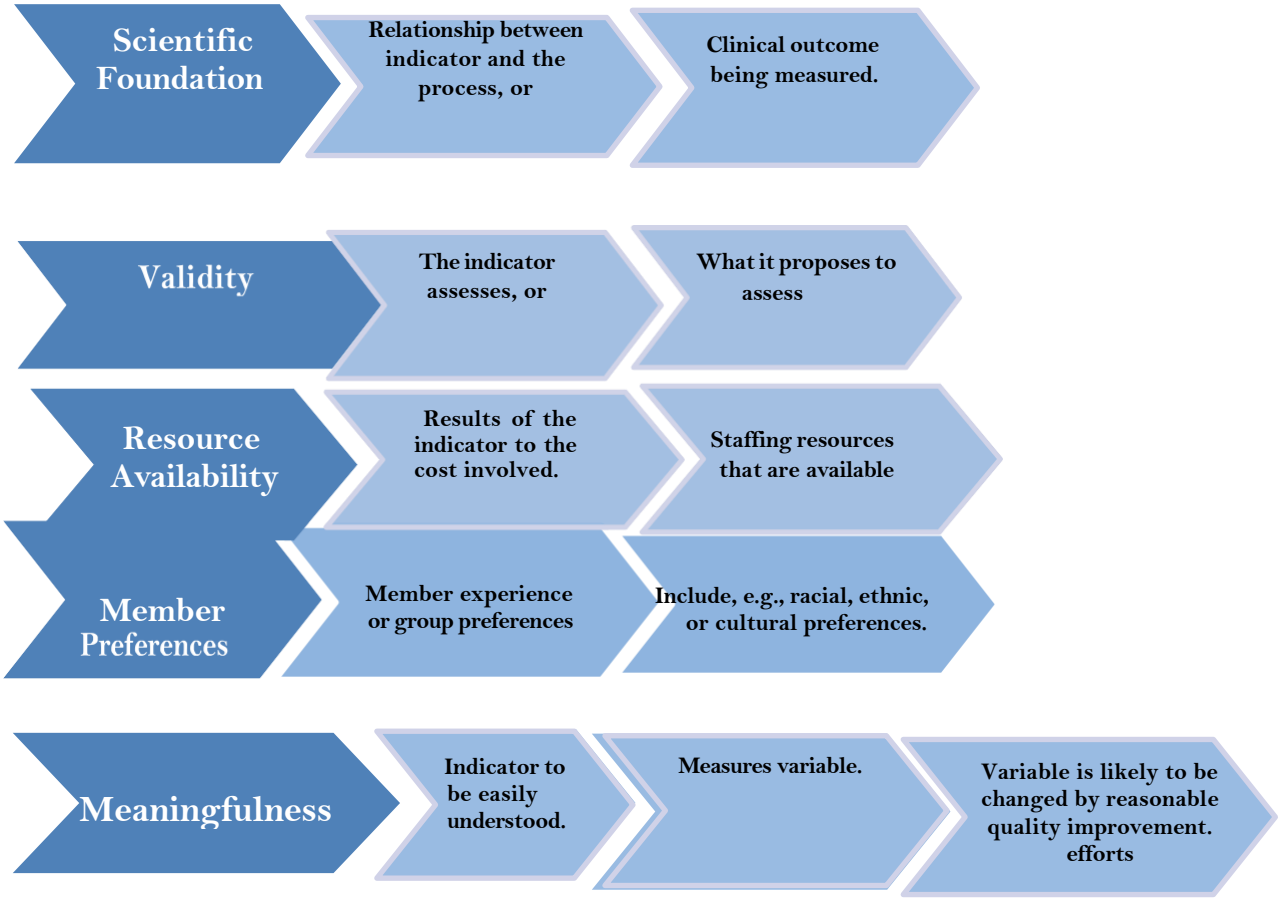


Selection of a Performance Indicator



Characteristics of a Performance Indicator:

Factors to consider in determining which indicator to use include:



Measure of Service	
Name	***Michigan Mission Based Performance Indicators (MMBPI)***
Definition	*This includes the indicators found in the MDHHS Code Book***.**
Data Collection	*The data is collected through MH-WIN, and the remainder is calculated by MDHHS.*
Assessment Frequency	*The Quality Improvement Steering Committee will review data associated with the indicator monthly and submit to MDHHS Quarterly.*
Measure of Service	
Name	***Member Grievances***
Definition	*An expression of dissatisfaction with any aspect of the operations or activities by the Service Provider or DWIHN.*
Data Collection	*Primarily collected through MHWIN.*
Assessment Frequency	*The Customer Service Committee will review Grievance, Appeals and other Customer Service-related issues on a Quarterly basis.*
Measure of Service	
Name	***Member Satisfaction***
Definition	*Measure of how services meet or exceed member expectation*
Data Collection	*MH-WIN, Survey, Member Questionnaire*
Assessment Frequency	*The Customer Service Committee will review Grievance, Appeals and other Customer Service-related issues on a Quarterly basis.*
Measure of Service	
Name	***Clinical Practice Improvement (CPI)***
Definition	*CPI adopts evidence-based and nationally recognized standards of care clinical practice guidelines based on the needs of the people we serve.*
Data Collection	*Through Provider Data, MH-WIN and available to members and providers on DWIHN's website.*
Assessment Frequency	*CPI guidelines are reviewed annually and approved by the Chief Medical Officer and Clinical Officer. Improving Practices Leadership Team (IPLT) meetings are used to discuss, approve, and disseminate the guidelines.*

Measure of Service	
Name	***Finance***
Definition	*Ensure financial solvency of DWIHN and Network Providers*
Data Collection	*Site Reviews, Audits, Financial Reports*
Assessment Frequency	*The Cost Utilization Committee will analyze spending, trends, and makes recommendations for the system based on Strategic Initiatives, Market Forecasts, and historical data on a Quarterly basis or as needed.*
Measure of Service	
Name	***Crisis Services (CS)***
Definition	*CS ensure access to care for members via DWIHN's full array of services within the Crisis Continuum Service System.*
Data Collection	*MMBPI, Performance Monitoring, MH-WIN*
Assessment Frequency	*The Quality Improvement Steering Committee will review requests for service and recidivist data on a Monthly and Quarterly basis.*
Measure of Service	
Name	***7 Day Follow-up***
Definition	*Ensure appointments are scheduled and attended by members*
Data Collection	*Performance Indicator Module in MH-WIN*
Assessment Frequency	*The Quality Improvement Steering Committee will review data associated with this indicator on a Monthly and Quarterly basis.*
Measure of Service	
Name	***30 Day Follow-up***
Definition	*Ensure appointments are scheduled with Mental Health Professionals and attended by Members.*
Data Collection	*MH-WIN, Performance Monitoring*
Assessment Frequency	*The Quality Improvement Steering Committee will review data associated with this measure on a Monthly and Quarterly basis.*

Measure of Service	
Name	***Critical Event/Sentinel Event/Death Reporting***
Definition	*The reporting of all actual or alleged incidents or situations that create a significant risk or substantial harm to the physical or mental health, safety, or wellbeing of the members within DWIHN's service delivery area.*
Data Collection	*MH-WIN*
Assessment Frequency	*The Sentinel Event Committee/ Peer Review Committees will review data uses a **three-tiered** system of peer review activity information associated with this measure on a Monthly and Quarterly basis.*
Measure of Service	
Name	***Advocacy***
Definition	*Identify ways to improve community inclusion and integration.*
Data Collection	*MH-WIN, Site Review, Performance Monitoring, HCBS*
Assessment Frequency	*The Quality Improvement Steering Committee and Constituents Voice will review data associated with this measure on a Monthly and quarterly basis.*

Performance Indicators Assessment

The Assessment of the Performance Indicators is accomplished by comparing actual performance on an indicator with:

- Self over time
- Pre-established standards, goals or expected levels of performance.
- Information concerning evidence-based practices.
- Other systems or similar service providers

Specific, measurable, actionable, relevant, and timely data is a critical element of Quality Improvement operations. Quality Improvement unit staff is engaged in on-going processes for identification of data process deficiencies and opportunities to improve accuracy and completeness of the DWIHN's datasets in MH-WIN and in the state's data warehouse.

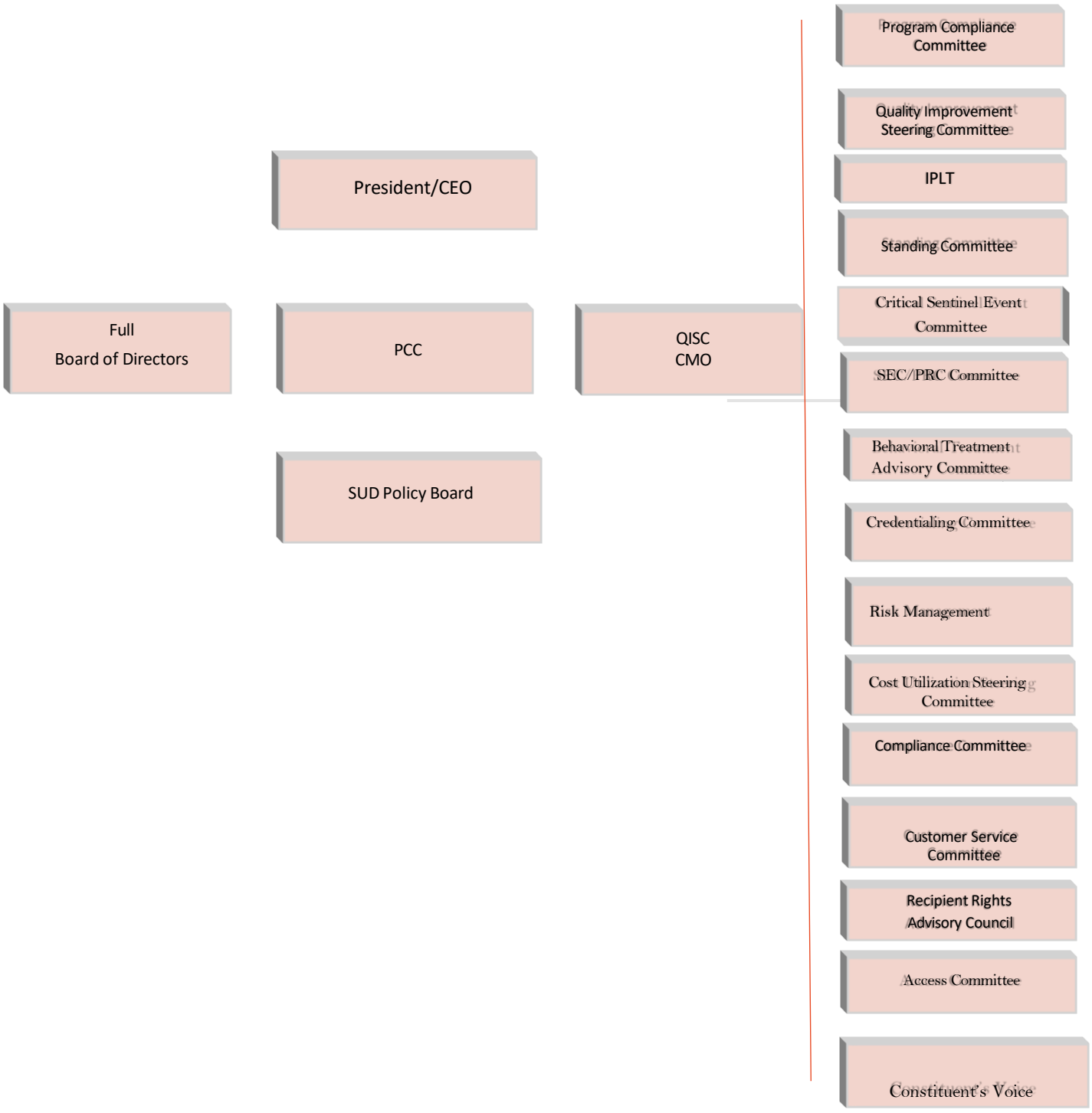
The Quality Improvement Unit has responsibility for oversight of the Michigan Mission Based Performance Indicator (MMBPI) System data. Standardized indicators, based on the systematic, on-going collection and analysis of valid and reliable data are utilized. Performance measures utilized have been established by MDHHS in the areas of access, efficiency, and outcome. This data is reported to MDHHS according to established timelines and formats. Data is also reported quarterly to various factions of the quality Improvement infrastructure (i.e., Program Compliance Committee, Quality Improvement Steering Committee, Quality Operations Technical Assistance Workgroup, etc.).

Behavioral Treatment Review

DWIHN has delegated all contracted Mental Health (MH) Clinically Responsible Service Providers (CRSP) to have the Behavioral Treatment (BT) review process in place. The Behavior Treatment Plan Review Committee (BTPRC) requirements are included in the CRSP written contract. To date, DWIHN has a total of twenty (20) BTPRCs that are conducted at the MH CRSP. The QAPIP quarterly reviews analyses of data from the BTPRC where intrusive or restrictive techniques have been approved for use with members and where physical management or 911 calls to law enforcement have been used in an emergency behavioral crisis. The length of time physical management interventions is also used per individual in its aggregated analysis. The techniques permitted by the Technical Requirement for Behavior Treatment Plans and have been approved during person-centered planning by the member or his/her guardian, may be used with members. The data shall include the numbers of interventions and the length of time the interventions were used per individual. The data tracks and analyzes the length of time of each intervention. The Committee also reviews the implementation of the BTPRC procedures and evaluates each committee's overall effectiveness and corrective action as necessary. The Committee compares system-wide key indicators such as psychiatric hospitalization, behavior stabilization, and reductions or increases in the use of behavior treatment plans.

Committee Structure

To promote quality throughout DWIHN's organization, DWIHN has created committees to provide oversight and implementation of all quality improvement activities. The quality improvement activities are achieved through a complex infrastructure which includes key stakeholders and process owners, and cross-functional units and committees. Due to the Covid-19 global pandemic, committees have been utilizing virtual meeting platforms. The structure is depicted below:



Research Advisory Committee (RAC)

Program Compliance Committee (PCC)
The Program Compliance Committee (PCC) is a committee of the Board of Directors and provides leadership for the Quality Improvement process through supporting and guiding implementation of quality improvement activities at DWIHN; and reviewing for changes, evaluating, need for Board Actions and approving the QAPIP Description biennial, the QAPIP Evaluation and Work Plan annually.

Membership:
DWIHN's PCC Committee consists of members of the Board of Directors. The Vice President of Clinical Operations is the liaison to the committee. Meeting notices are posted in public places and on DWIHN's website. Meetings are open to the public.

Function of the Committee:
The committee monitors the effectiveness of the QAPIP and make recommendations on the following:

- Annual evaluation of the effectiveness of the QAPIP and recommends approval of reports to the Board.
- System-wide trends and patterns of key indicators.
- Opportunities for improvement.
- Studies in areas identified from data review as having the potential for affecting the outcomes of care and related quality concerns.
- Policies and Procedures.
- System-wide attainment of goal(s) and objective(s).
- Developing and approving the QAPIP description and evaluation.
- Establishing measurable objectives based upon priorities identified using established criteria for improving the quality and safety of clinic services.
- Developing indicators of quality on a priority basis.
- Periodically assessing information based on the indicators, acting as evidenced through quality improvement initiatives to solve problems and pursue opportunities to improve quality.
- Establishing and supporting specific quality improvement initiatives.
- Reporting to the Full Board of Directors on quality improvement activities on a regular basis.
- Review of program operations.
- Recommend Board Actions to the Full Board of Directors.

Quality Improvement Steering Committee (QISC)
DWIHN's Quality Improvement Steering Committee (QISC) is an advisory group with responsibility for ensuring system-wide representation in the planning, implementation, support, and evaluation of DWIHN's continuous quality improvement program. The QISC provides ongoing operational leadership of continuous quality improvement activities for DWIHN. It meets at least monthly or not less than nine (9) times per year. The QISC provides leadership in practice improvement projects and serves as a vehicle to communicate and coordinate quality improvement efforts throughout the quality Improvement program structure.

Membership:
Membership includes the Chief Medical Officer, directors of DWIHN's units or designee, chairperson of the committees within the Quality Improvement structure or designee, members, advocates, and Contracted Providers of services to members with Serious Mental Illness, Severe Emotional Disturbance, Substance Use Disorders, Intellectual Developmental Disabilities, and Co-Occurring Disorders.

Function of the Committee:
- Establish and annually review committee operational guidelines, such as confidentiality, meeting frequency, management of information requests, number of members required for a quorum, membership, etc.
- Establish committee goals and timelines for progress and achievement.
- Participate in the development and review of quarterly/annual reports to the Program Compliance Committee and the Full Board of Directors regarding the Quality Improvement System.
- Annually review and evaluate the effectiveness of the Quality Assessment Performance Improvement Program.

- Oversee a circular communication process to ensure that all involved constituencies, including the Board of Directors, DWIHN staff, and members, providers and other stakeholders are a part of the Quality Improvement Process.
- Provide recommendations and feedback on process improvement, program implementation, program results and program continuation or termination.
- Examine quantitative and qualitative aggregate data at predetermined and critical decision-making points and recommend courses of action.
- Review reports from regulatory DWIHN reviews.
- Review of DWIHN improvement plans and make recommendations based on these reviews.
- Monitor progress and completion of plans of correction in response to recommended remedial actions identified for the DWIHN or by regulatory organizations.
- Review quality Improvement operating procedures and propose changes in procedures as needed.
- Oversee a process for establishing, continuing, or terminating subcommittees, standing committees, improvement teams, task groups and work groups.
- Identify training needs and opportunities for staff development in the quality Improvement process.
- Identify future trends and make recommendations for next steps.
- Develop standardized forms required for the work of the Steering Committee.
- Initiate and participate in recognition and acknowledgement of successes in quality Improvement for the DWIHN and the community mental health system.
- Leadership in practice improvement projects.

Improving Practices Leadership Team (IPLT)

DWIHN endeavors include implementation and support of Best and Evidence-Based Practices (EBP). The purpose of the Improving Practices Leadership Team (IPLT) is to oversee and monitor these practices. IPLT is charged with developing work plans, coordinating the regional training and technical assistance plan, working to integrate data collection, developing financing strategies and mechanisms, assuring program fidelity, evaluating the impact of the practices, and monitoring clinical outcomes.

Membership:

The IPLT committee is chaired by the Clinical Officer and Chief Medical Officer that includes Improving Practice Leadership Specialists in the following areas:

- Individuals with Serious Mental Illness (SMI)
- Children with Serious Emotional Disturbance (SED)
- Individuals with Intellectual and/or Developmental Disabilities (I/DD)
- Individuals with Substance Use Disorders (SUD)
- Quality Improvement
- Finance
- Data Evaluation
- Member employed by the system.
- Family Member of a child receiving PIHP services Peer support specialist.
- An identified program leader for each practice being implemented.
- Identified program leader for peer-directed or peer-operated services.

Function of the Committee:

Develop and communicate a strategy that is tailored to the context and the roles, capabilities, and interests of the stakeholder groups involved in the public mental health system:

- Identify and mobilize program leaders or change agents within the organization to implement the activities required to achieve the desired outcomes.
- Develop an on-going process to maximize opportunities and overcome obstacles.
- Monitor outcomes and adjust processes based on learning from experience.
- Align relevant persons, organizations, and systems to participate in the transformation process.
- Support Membership of a Member/Certified Peer Support to represent the PIHP/CMHSP on the Recovery Council of Michigan.
- Assess parties' experience with change.
- Establish effective communication systems.
- Ensure effective leadership capabilities.
- Enable structures and process capabilities.
- Improve cultural capacity.
- Demonstrate their progress in system transformation by implementing evidence based, promising and new and emerging practices.

Standing Committee
DWIHN's quality Improvement system consists of standing committees that oversee on-monitoring, peer evaluation, and improvement functions, including receipt and review of data related to their identified areas of responsibility. This structure is designed to improve quality of care to members, improve operations of providers and promote efficient and effective internal operations. Standing Committees may be assigned quality indicators to use in monitoring aspects of care and service or may establish indicators for which data will be collected and monitored.

The standing committees consist of qualified representatives of DWIHN units, providers and in some cases, stakeholders, and members. The committees define aspects of services and support to be monitored for opportunities to improve, based on priorities established in the MDHHS contract and on the needs of high-risk members and high volume/problem-prone programs. Results from DWIHN's Performance Indicators System, which is an extension of the MDHHS data collection program, are a key source for identification of aspects to be monitored. The committees develop plans by which data for their scope of responsibility will be reviewed and opportunities for improvement identified. QI staff work with the committees and assure that the principles of data based continuous quality improvement are followed. The standing committees monitor improvements that are implemented for effectiveness and improved outcomes.

Standing committees identify and recommend needs for quality improvement teams, as appropriate, and may bring in outside resources, if needed, to facilitate the work of teams and to facilitate involvement of internal staff, providers, members, stakeholders, and various outside groups, as needed. The standing committees are:

Sentinel Events Committee/Peer Review Committee (SEC/PRC)
The Critical/Sentinel Event process involves the reporting of all actual or alleged incidents or situations that create a significant risk or substantial harm to the physical or mental health, safety, or wellbeing of the members within DWIHN's service delivery area. Incidents include, at a minimum, member deaths*, arrests, hospitalizations for injuries or medication errors. The SEC/PRC retains the right to make the final decision whether an incident is a Critical or Sentinel Event. As applicable, when necessary to respond to questions/concerns of the SEC/PRC will request others to attend. All Peer Review clinical activities are privileged, confidential and are in accordance with state and federal laws and regulations that govern Peer Review activities.

All unexpected* deaths of Member who at the time of their deaths were receiving specialty supports and services must be reviewed and must include:

- Screens of individual deaths with standard information (e.g., coroner's report, death certificate).
- Involvement of medical personnel in mortality reviews.
- Documentation of the mortality review process, findings, and recommendations.
- Use of mortality information to address quality of care.
- Aggregation of mortality data over time to identify possible trends.

* Unexpected deaths include those that resulted from suicide, homicide, an undiagnosed condition, accidental, or suspicious for possible abuse or neglect. As applicable, when necessary to respond to questions/concerns of the DRC other persons will be requested to attend.

SEC/PRC Membership includes but is not limited to:

- Chief Medical Officer/Designee
- Quality Performance Improvement Team/Manager/Director
- Utilization Management
- Managed Care Operations
- Substance Use Disorders Initiatives
- Office of Recipient Rights
- Children's Initiatives
- Clinical Performance Improvement

Function of the Committee:

The mission and goal of the SEC/PRC is to ensure the Contracted Providers and/or Clinically Responsible Service Providers (CRSP) conduct a thorough review of incidents with an action plan to remediate or reduce the risk of the incident reoccurring.

SEC/PRC also ensures that a thorough review of the Member's death has been conducted by the Member's respective Service Provider, CRSP, Recipient Rights and Clinical Practice Improvement Units. All reviews are conducted in accordance with DWIHN's Death Reporting Policy and procedures, state and federal laws and regulations that govern death review activities.

The SEC/PRC uses a **three-tiered** system of peer review activity. In the **first tier**, the Critical and Sentinel Events are reviewed by Quality Performance Improvement Team (QPIT) for standard-of-care and scope of service issues. Requests for additional documents, completeness of the information are forwarded to the CRSP with notification to DWIHN Department leaders as appropriate.

In the **second tier**, the Critical/Sentinel Events are reviewed by DWIHN's SEC/PRC Committee. Findings from the SEC/PRC can include requests for additional information, corrective action plans, or Recipient Rights, Compliance or Contract action referrals. Repeated deficits or failures to correct identified deficits may result in recommendations for performance sanctions as defined by DWIHN policy, procedures, and contracts.

In the **third tier**, the data collection is reviewed by the QPIT for policy updates and implementation, patterns, trends, compliance, education and improvement and presentation to DWIHN Program Compliance Committee of the Board of Directors.

Behavioral Treatment Advisory Committee (BTAC)

DWIHN's Behavioral Treatment Advisory Committee is charged with oversight of nineteen (19) Behavioral Treatment Plan Review Committees (BTPRC) in the network. The BTAC is a contractual obligation of DWIHN to Michigan Department of Health and Human Services (MDHHS). The BTAC takes the lead in implementing a systematic approach to monitor service providers and compliance with the MDHHS standards for BTPRC. The BTAC reviews system wide BTPRC trends and patterns compared to key indicators such as psychiatric hospitalization, behavior stabilization, reductions or increases in the use of interventions, crisis plans, and behavior treatment plans. The BTAC members are appointed for a term of two years. The total number of BTAC members is sixteen for FY2023-2025. The representatives from the network providers are invited for the case validation review process at the BTAC as part of continuous quality improvement at the PIHP level. The committee submits quarterly BTPRC data analysis reports to MDHHS.

Membership:

- The committee consists of DWIHN's Chief Medical Officer, DWIHN Consultant Physician, licensed psychologist, Members,
  DWIHN staff, provider representatives and Office of Recipient Rights (ORR).
- The representative of DWIHN's ORR is required to attend BTPRC meetings.
- Each of the providers' BTPRC consists of a licensed psychologist, a physician/psychiatrist and DWIHN's ORR.

Function of the Committee:

DWIHN's BTAC provides oversight and monitoring of Behavior Treatment Plan Review Committees (BTPRC) to ensure compliance with MDHHS Technical requirements and collects data and information on implementation issues including:

- Types of challenging behaviors resulting in use of law enforcement
- Types of interventions used.
- Revising and Updating DWIHN Policy on Behavior Treatment Plans
- Frequency and duration of interventions used (Restrictive and Intrusive)
- Frequency of review of behavior treatment plans.
- Number of Critical/Sentinel Events involving challenging behaviors.
- Root Cause Analysis Reviews along with Sentinel Events Committee
- Percent of care staff at all levels trained in behavior management (i.e., positive behavior management, the culture of gentle teaching, management of challenging behaviors, etc.).
- Number of behavior management related ORR complaints.

Credentialing Committee
The purpose of the committee is to delineate and describe the functions and oversight of DWIHN's Credentialing Verification Organization (CVO) and the responsibilities of the Service Providers, and to implement credentialing/re-credentialing functions. The Credentialing Committee is mandated by the PIHP agreement with MDHHS. The Committee ensures that DWIHN has a workforce that is appropriately prepared to provide the services that receive Medicaid and Medicare funding. The Committee guidelines comply with 45 CFR 438.214 Provider Selection.

Function of the Committee:
The Committee reviews the completed files that have been primary source verified (education, licensure, certifications, work history, malpractice history, current malpractice insurance, Medicare, and Medicaid exclusions) by an NCQA accredited Credentialing Verification Organization, approves clean files and denies files that do not meet the requirements. The Committee also provides oversight to the CVO and monitors exclusion and preclusion databases monthly. All Committee members sign an attestation agreeing to keep the information confidential and to not discriminate against practitioners and providers during their decisions.

In compliance with MDHHS' Credentialing and Re-credentialing processes, DWIHN has established written policies and procedures for ensuring appropriate credentialing and re-credentialing of the provider network. Quality Improvement monitors the provider network qualification of staff to ensure compliance with federal, state, and local regulations. Performance monitoring is completed no less than annually through an established process to ensure providers of care or support are qualified to perform their jobs.

Membership:
- Chief Medical Officer
- Behavioral Health and Substance Use Disorder Providers
- DWIHN Staff

Risk Management
The purpose of the committee is to review incidents involving Member and the provider system under the protection of protected information. The Risk Management Committee is an ad- hoc committee and meets as required.

Membership:
- Vice President of Finance
- Chief Medical Officer
- Executive Vice President of Operations
- Vice President of Compliance
- Others as needed.

Function of the Committee:
- Continuously improve member safety and minimize and/or prevent the occurrence of errors, events, and system breakdowns leading to harm to patients, staff, volunteers, visitors, and others through proactive risk management and patient safety activities.
- Minimize adverse effects of errors, events, and system breakdowns when they do occur.
- Minimize losses to the organization overall by proactively identifying, analyzing, preventing, and controlling potential clinical, business, and operational risks.

Cost Utilization Steering Committee
The utilization, standards, access etc. to clinical services, Cost Utilization looks at where our spending is occurring, analyzes the trends, and makes recommendations for the system based on Strategic Initiatives, Market Forecasts, and our historical data.

Membership:
- Vice President of Finance
- Chief Medical Officer
- Executive Vice President of Operations
- Vice President of Compliance
- Vice President of IT Services

Function of the committee:
- To receive data from the Cost Integrity Group (CIG), Procedure Code Work Group, along with the contractual expectations.
- Review the needs for improved clinical outcomes (UM/QM/CPI data or input), state mandates (such as EBPs).
- Finds ways to fund necessary functions or services. It contemplates state funding (revenue) and network funding (costs), and fund source management along with cost and utilization data integrity and even system processes.
- As a steering committee it would set the priorities for managing our funding to achieve our operating expectations.

Compliance Committee
The Compliance Committee is an organization-wide operations compliance committee. The Compliance Committee shall meet, at a minimum, each quarter during the fiscal year. The Vice President of Compliance can schedule additional meetings as deemed necessary.

Membership:

- Vice President of Compliance
- Executive Vice President of Operations
- Vice President of Legal Affairs
- Vice President of Finance
- Chief Medical Officer

Function of the Committee:

- Assist the Vice President of Compliance with risk assessment and the need for and design of compliance reviews within the organization.
- Advise the Vice President of Compliance on training needs within the organization and assist. in arranging for and conducting such compliance training.
- Assist the Vice President of Compliance with developing organizational policies. supporting the Compliance Plan.
- Assist the Vice President of Compliance with implementation of the Compliance Plan.
- Assist the Vice President of Compliance with evaluation of the effectiveness of the Compliance Plan.
- Refer all matters to the Program Compliance Committee (PCC) and the Board for review that relate to the following:
  - Violations that require notification to federal, state, and/or local agencies.
  - Violations that have an economic impact (i.e., budgetary) on the Network and/or require funds to be returned to federal or state agencies.
  - Any other information that the Compliance Committee deems appropriate for Board notification.

Customer Service Committee
The purpose of this committee is to provide procedural and operational guidance on Customer Service mandated standards and functions, to DWIHN, Service Providers,
the Access Center, Crisis services vendor, and entities that are contracted to provide Customer Service on behalf of DWIHN. The Customer Service Committee meets on a quarterly basis.

Membership:
DWIHN Staff:

- Customer Service Director
- Customer Service Administrator
- Customer Service Due Process Manager and Grievance and Appeals staff.
- Member Engagement Manager
- Access Center Director

Service Provider Staff:

- Customer Services Management
- Grievance, and Appeal staff
- Quality Department staff
- Others as needed.

Function of the Committee:
The quarterly meetings are facilitated by DWIHN's Customer Service Department to coordinate with the Customer Service, Grievance and Appeals management at the Service Provider levels that addresses DWIHN Customer Service, Grievance, Appeals and other Customer Service-related updates and issues. It also provides a venue to network and share programs, processes and upcoming events that are occurring in their respective networks.

Recipient Rights Advisory Council (RRAC)

The RRAC is mandated by the Michigan Mental Health Code (MCL 330.1757). The RRAC meets bi-monthly, on the first Monday of every odd-numbered month, from 1:00 – 3:00. The meetings are governed by the Open Meetings Act and the public is welcome to attend.

Membership:

Is broadly based to best represent the varied perspectives of the CMHSP's geographical area. At least 1/3 of the Membership shall be primary Member or family Member, and of that 1/3, at least ½ shall be primary Member.

Function of the committee:

- Protect the Office of Recipient Rights (ORR) from pressures that could interfere with the impartial, even-handed, and thorough performance of its functions.
- Serve in an advisory capacity to the executive director and the director of ORR Other specific functions.
- Review the process for funding ORR.
- Recommend candidates for the position of Director of ORR to the Executive Director.
- Consult with the Executive Director regarding any proposed dismissal of the Director of ORR.
- Receive education and training in ORR policies and procedures.
- Review the Semi-Annual report submitted to the MDHHS.
- Review the Annual report submitted to MDHHS.
- Provide "Goals for ORR" and "Recommendations for ORR" for the Annual Report.
- The RRAC also serves as the Recipient Rights Appeals Committee.

Access Committee (AC)

The Access Committee provides oversight to ensure DWIHN has programming to provide the full array of Behavioral Health Services for the following populations: Adults, Children, I/DD, SMI/SEI, SED, SUD, and Autism. The Access Committee is responsible for the inter-departmental review, recommendation, and movement of additional providers, service-delivery locations, and/or services forward into the Credentialing Process those that are deemed necessary to meet the needs of individuals being served by DWIHN.

The Access Committee also ensures compliance with appointment availability and timeliness standards set by our Regulatory agencies. i.e., MDHHS' Access Standards policy, External Quality Review (EQR) Checklist and Standards, 42 CFR §438.206(c)(1) (i-vi) *Contract Schedule A–1(E)(7)(a)***.** The Access Committee is charged with developing strategies and working within the organization to provide oversight for the timeliness standards. Data along with operational obstacles, and strategies to address challenges will be discussed and action steps will be developed to ensure availability and access to care.

Recommendations would include documentation and implementations of provider expectations, consequences when those expectations are not met around access standards, ensuring the development of quality-of-care monitoring, and establishing additional monitoring mechanisms around access standards. i.e., monitoring access complaints received, % of availability of appointments within an established standard, etc.

Membership includes but not limited to:

- Chief Medical Officer
- Clinical Officer
- Clinical Practice Improvement
- Managed Care Operations
- Quality Improvement
- Utilization Management
- Integrated Health Care
- Substance Use Disorders
- Customer Services
- Director of Crisis Services

Function of the committee:

- Improved and increased member access.
- Improved operational workflows.
- Enhanced data monitoring and compliance with all Regulatory agencies.
- Improved organizational strategic initiatives and organizational operational alignment.
- Review data reporting on appointment type slots availability per provider.
- Review quality access reports on how provider organizations are meeting the access standards and measuring initiatives and implemented strategies to address challenges will be discussed and action steps will be developed to ensure availability.

Research Advisory Committee (RAC)

The purpose of the committee is to act as a collaborative body to encourage the development of research and evaluation proposals within the framework of a research agenda informed by DWIHN's strategic priorities. The RAC shall meet at least quarterly or as often as necessary to Carry out its charge.

Function of the committee:

- Provide recommendations regarding research and evaluation projects presented to the RAC.
- Encourage and promote the utilization of research-based practice.
- Ensure that evaluation proposals follows the process of obtaining informed consent by complying with the requirements of 45 CFR 46.116 and the documentation of informed consent comply with 45 CFR 46.117.

Membership:

- The DWIHN Chief Clinical Officer will appoint members to the RAC at the recommendation of the Committee Co-Chairs and/or other Committee members. One Co-Chair shall be the DWIHN Chief Medical Officer.
- The RAC will be comprised of members with a variety of skills, expertise, and experiences, representing DWIHN, its Direct Contractors, service recipients, and other stakeholders, including research and funding communities.

Constituent's Voice

The Constituents' Voice (also known as the "CV") is a DWIHN Member advisory group. The body is charged with advising the Network, and specific to driving policies and agendas that facilitate community inclusion.

Membership:

The diverse group of Member advocates and secondary members meets monthly. Generally, meetings are held on the Third Friday of each month from 10:00am -12:00pm. Presently, meetings are hybrid, some are in person at a location announced in advance, all meetings offer platform attendance currently via Zoom.

Function of the Constituent's Voice:

The CV is an advisory committee for the DWIHN CEO. Their mission and focus are to offer recommendations on community/member issues and participate in dialogue with other DWIHN staff for the purpose of adding member feedback to policy, programming, or other functions of the system.

The CV hosts a myriad of events to educate the community about DWIHN services and other topics which promote stigma-busting agenda and focuses on community inclusion. One of the CV's signature events is the Annual Dreams Come True Mini-grant project which offers member applicants the opportunity to apply for $500 to assist them in reaching personal goals that also aides them in their recovery journey. The CV also sponsors and participates in various advocacy and civic efforts. Events include the annual MACMHB's Walk-A-Mile in My Shoes Rally in Lansing, Michigan and their Voter Education Registration and Participation (VERP) program which is an initiative the encourages voter education for all members, and particularly to advocate voter rights for people with disabilities.

Quality Improvement Teams, Ad Hoc Committees and Workgroup

DWIHN may identify opportunities for improvement that do not fit into the existing standing committee structure. Ad hoc teams, workgroups and quality circles are appointed for a limited period for a specific task by the Quality Improvement Steering Committee, Quality Improvement or a Standing Committee based on organizational need. Reports from the various Committee(s), Ad hoc team(s), DWIHN Unit(s) and workgroup(s) will include outcome measures and are forwarded to the Quality Improvement Steering Committee (QISC).

Utilization Management (UM)

The Utilization Management (UM) program is an integral part of DWIHN's QAPIP. DWIHN is required to have a written Utilization Management Program Description which includes procedures to evaluate medical necessity, criteria used, information sources and the process used to review approve the provision of medical services. The UM program has mechanisms to identify and correct under-utilization as well as over- utilization. Prospective (preauthorization), concurrent and retrospective procedures are established and include:

- Review, deny or reduce service decisions.
- Efforts to obtain all necessary information, including pertinent clinical information and consultation with the treating physician as appropriate.
- The reasons for the decisions are clearly documented and available to the member.
- Well-publicized and readily available appeals mechanisms for both providers and service recipients, and notification of denial.
- Decisions and appeals made in a timely manner as required by the exigencies of situation.
- Mechanisms to evaluate the effects of the program using data on member satisfaction, provider satisfaction, or other appropriate measures.

To ensure the above goals are achieved, DWIHN UM department has developed a comprehensive UM Program Description Plan for the provider network to ensure that these standards are met. The activities conducted to detect underutilization (for example, various service utilization reports, performance measures, adherence to CPGs, provider/member profiling, appeals and grievances, financial reports, etc.) includes analyze over and underutilization data on a scheduled and ad-hoc basis and report results at least annually to UM Committee for further review and action. Refer to the UM Program Description Plan for specific processes and procedures implemented.

Practice Guidelines

DWIHN developed its Clinical Practice Guidelines from scientific evidence, professional standards and/or a consensus of board-certified health care professionals in the field. Wherever possible, guidelines are derived from nationally recognized sources and are evidence-based in their foundation. For any DWIHN developed clinical guidelines, a literature search is conducted, including a search for established practice guidelines from national organizations and professional associations. DWIHN sends the draft version of the Clinical Practice Guidelines to be adopted, to contracted providers who treat the condition for feedback. Providers have 21 days to complete the peer review of the clinical practice guidelines via policy stat. DWIHN keeps a written record of all comments. Comments will be addressed by the facilitator/co-facilitator in the Improving Practices Leadership Team (IPLT) meetings if a need to address has been identified. A rationale will be provided for comments not addressed.

DWIHN's Improving Practices Leadership Team (IPLT) has ultimate responsibility for ensuring effective, evidence-based practice which is accomplished by the development or adoption of robust clinical guidelines. The IPLT consists of subject matter experts from DWIHN's internal and external subspecialty populations as well as members with lived experience. IPLT members are asked to be included in the adoption of the Practice Guidelines, collaborate on its development, review, and provide feedback. All clinical practice guidelines are presented to DWIHN's IPLT for approval. The clinical practice guidelines are reviewed and updated at least annually or more frequently if national guidelines change during that period. Communication of the Clinical Practice Guidelines occurs through posting of the Clinical Practice Guidelines on the DWIHN website via the policy manual. Also, DWIHN supports its members in self-management of their conditions by making practice guidelines available on the website and through specific quality improvement initiatives/activities.

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	10%
Information Technology	Information Technology	50%
Practitioner Participation	Provider Network	100%

Quality Improvement Evaluation

The Quality Improvement evaluation is completed at the end of each fiscal year. The annual evaluation is conducted by DWIHN and submitted to MDHHS and kept on file at DWIHN, along with the QAPIP description. These documents will be reviewed by Health Services Advisory Group (HSAG) and MDHHS as part of the certification process. The evaluation summarizes the goals and objectives of DWIHN's Quality Improvement Work Plan. The Quality Improvement Work Plan specifies quality improvement activities DWIHN will undertake in the upcoming year. The plan includes goals and objectives based on the strengths and weaknesses identified in the previous year's evaluation and issues identified in the analysis of quality metrics. The Work Plan is the mechanism for tracking quality improvement activities and is updated as needed to assess the progress of initiatives. The foundation of the Work Plan addresses the following NCQA focus areas:

- Quality and safety of clinical care
- Quality of service
- Member Experience
- Yearly goals and objectives
- Planned Activities
- Monitoring of previously identified issues
- Evaluation/outcomes
- Time frame for each activity's completion
- The staff member responsible for each activity
- Evaluation of the QI program

The Quality Improvement Work Plan is reviewed and approved by the Program Compliance Committee (PCC) and the Full Board of Directors annually.

Goals for Fiscal Year 2024

- Achieve NCQA re-accreditation.
- Continued efforts related to becoming a Certified Community Behavioral Health Clinic (CCBHC).
- Continued efforts on children services the Mobile Crisis Response for Children and Intensive Crisis Stabilization.
- 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 in the network.
- Consistently maintain a 95% enrollment rate of the HAB waiver slots as required by MDHHS.
- Ensure members receive timely access to a full array of behavioral Health Services.
- Improve member and provider satisfaction.
- Ensure a high-quality trained network through credentialing, peer review, and contracting processes.
- Continue to collaborate with providers to share ideas and implement strategies to improve care coordination and quality of service.
- Lead system-wide culture change committed to reducing suicide.
- 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.
- Continue 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.
- 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.
- 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.

Appendix 1

SENTINEL EVENT COMMITTEE/ PEER REVIEW COMMITTEE PROCESS

The Quality Performance Improvement Team is comprised of licensed a social worker, counselor, registered nurses, and a psychologist. Daily this time is reviewing all events entered into MH-WIN by ALL contracted providers in the DWIHN network. These reviews look at all documents for the member including but not limited to : IPOS, Crisis Plans, Behavior Tx Plans, Progress Notes, Urgent Care Documents, Recipient Rights Reports, Police/Fire/EMS Reports (as available) and CPS/APS reports.

PROCESS – PAGE 2

The review process: QPIT Review → Missing Information notification to CRSP Provider to upload within deadline → Final review of QPIT (possible closure at this point for health-related events) → SEC/PRC Review (Sentinel/Risk Events) recommendations for remediation by case and within system, systemic impact identified, trends, recommended training topics, etc.

QAPIP Work Plan
FY 2023 - 2024 (October 1, 2023, through September 30, 2024)

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**						
I.1	ECHO Annual Satisfaction Surveys (Adult and Children)	Director of Customer Service	The 2023 ECHO® Survey (Children and Adult) results will be collated, reviewed, analyzed and reported by April of 2024.	The target goal is to improve Treatment of Care issues, Access to Care, Timeliness and Appropriateness of Care, Members Perception Increased Improvement of Health, Cultural Competency of Care and various nuances related to the Relationship between the Member and the Practitioner for both Children and Adults.	No previously identified issues during FY2023, this goal will be a continuation in FY2024.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2024 will be presented to QISC and PCC in Quarter 3 of FY-2024.

QAPIP Work Plan
FY 2023 - 2024 (October 1, 2023, through September 30, 2024)

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	Provider and Practitioner Satisfaction Survey	Director of Strategic Operations, Director of Managed Care Operations (MCO)	In FY 2024 Q4 results of the Provider Satisfaction surveys will be collated, reviewed, analyzed for comparison between FY2023 and FY2024. The 2024 Practitioner Satisfaction Survey results will be collated, reviewed, analyzed and reported by November of 2024.	The target goal is to increase Provider and Practitioner survey responses by 5% or higher.	Previously identified issues. Provider Satisfaction survey questions were modified in FY2022, baseline data was collected during FY2023 a comparison of the data from the baseline period will be conducted during FY2024. This goal will be a continuation FY2023.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2024 will be presented to QISC and PCC in Quarter 1 of FY2025.

QAPIP Work Plan
FY 2023 - 2024 (October 1, 2023, through September 30, 2024)

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	Grievance/Appeals	Director of Customer Service	FY 2023-2024 (October 1, 2023 through September 30, 2024) results will be collated, reviewed, analyzed and reported by Q2 of January 2025.	The target goal is to improve outcomes by resolving grievances and appeals within the required time frame.	No previously identified issues during FY2023, this goal will be a continuation in FY2024.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2024 will be presented to QISC and PCC in Quarter 1 of FY-2025.
I.4	Timeliness of Utilization Management Decisions	Director of Utilization Management	FY 2023-2024 (October 1, 2023 through September 30, 2024) 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 FY2023, this goal will be a continuation in FY2024.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2024 will be presented to QISC and PCC in Quarter 1 of FY-2025.

QAPIP Work Plan
FY 2023 - 2024 (October 1, 2023, through September 30, 2024)

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.5	Practice Guidelines	Chief Medical Officer	FY 2023-2024 (October 1, 2023 through September 30, 2024). 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 for feedback through reports, clinical record reviews, and/or process indicators.	No previously identified issues during FY2023, this goal will be a continuation in FY2024.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY2024 will be presented to QISC and PCC in Quarter 1 of FY-2025.
I.6	Cultural and Linguistic Needs	Director of Customer Service, Director of Managed Care Operations, Director of Quality Improvement Diversity, Equity & Inclusion Administrator	FY 2023-2024 (October 1, 2023 through September 30, 2024). 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.	No previously identified issues during FY2023, this goal will be a continuation in FY2024.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2024 will be presented to QISC and PCC in Quarter 1 of FY-2025.
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 2023 - 2024 (October 1, 2023, through September 30, 2024)

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 2023-2024 (October 1, 2023 through September 30, 2024). 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 FY2023, this goal will be a continuation in FY2024.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY2024 will be presented to QISC and PCC in Quarter 1 of FY-2025.
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 2023-2024 (October 1, 2023 through September 30, 2024). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to meet or exceed performance standard. Standard is 57% or above.	No previously identified issues during FY2023, this goal will be a continuation in FY2024.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY2024 will be presented to QISC and PCC in Quarter 1 of FY-2025.

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 2023-2024 (October 1, 2023 through September 30, 2024). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to meet or exceed performance standard. Standard is 83% or above.	No previously identified issues during FY2023, this goal will be a continuation in FY2024.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2024 will be presented to QISC and PCC in Quarter 1 of FY-2025.

QAPIP Work Plan
FY 2023 - 2024 (October 1, 2023, through September 30, 2024)

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.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 2023-2024 (October 1, 2023 through September 30, 2024). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to meet or exceed performance standard. Standard is 95% or above.	Previously identified issue target goal not met for Children Q4 (89.29%). This goal will be a continuation in FY2024.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2024 will be presented to QISC and PCC in Quarter 1 of FY-2025.
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 2023-2024 (October 1, 2023 through September 30, 2024). 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 FY2023, this goal will be a continuation in FY2024.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2024 will be presented to QISC and PCC in Quarter 1 of FY-2025.
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 2023-2024 (October 1, 2023 through September 30, 2024). 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 target goal not met Adults Q2 (15.71%);Q3 (17.71%), Q4 (16.09%). This goal will be a continuation goal in FY2024.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2024 will be presented to QISC and PCC in Quarter 1 of FY-2025.

QAPIP Work Plan
FY 2023 - 2024 (October 1, 2023, through September 30, 2024)

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 2023-2024 (October 1, 2023 through September 30, 2024) results will be collated, reviewed, analyzed and reported by Q1 of February 2025.	The target goals are to improve medical and behavioral health concerns and increase overall functional status by 5% 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 least 60 days and improve member satisfaction scores by 20%.	No previously identified issues during FY2023, this goal will be a continuation in FY2024.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2024 will be presented to QISC and PCC in Quarter 1 of FY-2025.

QAPIP Work Plan
FY 2023 - 2024 (October 1, 2023, through September 30, 2024)

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 2022-2023 (October 1, 2022, through September 30, 2023). Data reporting is collated, reviewed, and analyzed quarterly.	The target goal is to decrease amount 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 FY2024.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2024 will be presented to QISC and PCC in Quarter 1 of FY-2025.
Workforce Pillar							
Goal III. (Quality of Service)	**Develop and maintain a Competent Workforce through the Credentialing and Re- Credentialing Process**						

QAPIP Work Plan
FY 2023 - 2024 (October 1, 2023, through September 30, 2024)

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 Innovation and Community Engagement, Provider Network Administrator Credentialing, Director of Quality Improvement, Director of Clinical Practices Improvement, Director of Managed Care Operations	FY 2023-2024 (October 1, 2023, through September 30, 2024). 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 collaborative integrated healthcare system.	No previously identified issues during FY2023, this goal will be a continuation in FY2024.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 1 of FY-2025.
Finance Pillar							
Goal IV (Quality of Service)	**Maximize Efficiencies and Control Costs**						

QAPIP Work Plan
FY 2023 - 2024 (October 1, 2023, through September 30, 2024)

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 2023-2024 (October 1, 2023, through September 30, 2024). Data reporting is collated, reviewed, and analyzed Bi-quarterly (1st & 2nd Quarter (October 1, 2023 - March 31, 2024); (3rd & 4th Quarter April 1, 2024 - September 30, 2024).	The target goal is to review 100% of randomly selected Paid Encounters/Claims to eliminate Fraud, Waste and Abuse in the provider network.	No previously identified issues during FY2023, this goal will be a continuation in FY2024.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2024 will be presented to QISC and PCC in Quarter 1 of FY-2025.

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 2023-2024 (October 1, 2023, through September 30, 2024). Data reporting is collated, reviewed, and analyzed quarterly.	The target goal is to increase the number of provider reviews from FY2023 by 20% or higher to ensure Continuous Quality Improvement.	No previously identified issues during FY2023, this goal will be a continuation in FY2024.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2024 will be presented to QISC and PCC in Quarter 1 of FY-2025.

QAPIP Work Plan
FY 2023 - 2024 (October 1, 2023, through September 30, 2024)

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 2023-2024 (October 1, 2023, through September 30, 2024). Data reporting is collated, reviewed, and analyzed quarterly.	The target goal is to increase number of Residential Treatment Provider reviews from FY2023 by 10% or higher to ensure Continuous Quality Improvement.	No previously identified issues during FY2023, this goal will be a continuation in FY2024.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2024 will be presented to QISC and PCC in Quarter 1 of FY-2025.
V. 3	Long Term Supports Services (LTSS)	Director of Quality Improvement; Director of Customer Service	FY 2023-2024(October 1, 2023 through September 30, 2024). Data reporting is collated, reviewed, and analyzed quarterly.	Target goal is to ensure the incorporation of individuals receiving LTSS into the review and analysis of the information obtained from quantitative and qualitative methods; and evaluate the effects of activities implemented to improve satisfaction.	No previously identified issues during FY2023, this goal will be a continuation in FY2024.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
V.4	Provider Network Self-Monitoring (Inter-Rater Reliability)	Director of Quality Improvement	FY 2023-2024(October 1, 2023 through September 30, 2024). 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 15% or higher to ensure inter rater reliability.	No previously identified issues during FY2023, this goal will be a continuation in FY2024.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2024 will be presented to QISC and PCC in Quarter 1 of FY-2025.

QAPIP Work Plan
FY 2023 - 2024 (October 1, 2023, through September 30, 2024)

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	Autism Services	Director of Quality Improvement, Director of Children's Initiatives	FY 2023-2024 (October 1, 2023, through September 30, 2024). Data reporting is collated, reviewed, and analyzed quarterly.	The target goal is to maintain 100% review compliance	No previously identified issues during FY2023, this goal will be a continuation in FY2024.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2024 will be presented to QISC and PCC in Quarter 1 FY-2025.
V.6	Critical/Sentinel/ Unexpected Death and Risk Reporting	Director of Quality Improvement	FY 2023-2024 (October 1, 2023, through September 30, 2024). Data reporting is collated, reviewed, and analyzed quarterly.	The target goal is to meet MDHHS reporting requirements to ensure adherence to timeliness of data and reporting standards and to monitor for trends, to improve systems of care.	No previously identified issues during FY2023, this goal will be a continuation in FY2024.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2024 will be presented to QISC and PCC in Quarter 1 of FY-2025.
V.7	Behavior Treatment Review	Director of Quality Improvement, Chief Medical Officer	FY 2023-2024 (October 1, 2023, through September 30, 2024). 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.	No previously identified issues during FY2023, this goal will be a continuation in FY2024.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2024 will be presented to QISC and PCC in Quarter 1 of FY-2025.

(Quality of Clinical Care)	**Quality Improvement Projects (QIP's)**						

QAPIP Work Plan
FY 2023 - 2024 (October 1, 2023, through September 30, 2024)

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.8a	Improving the availability of a follow up appointment with a Mental Health Professional with-in 7 days after Hospitalization for Mental Illness.	Director of Integrated Health Care Director of Quality Improvement	FY 2022-2023 (October 1, 2022, through September 30, 2023). Data reporting is collated, reviewed, and analyzed quarterly. FY2023 Data not available until April 2024.	The target goal is to meet the comparison benchmark to MDHHS Children (70%), Adults. (58%) for FY2022.	Previously identified issues, targeted goals not met for Adults (18- 64) 30.39%; Adults (65 or older) 28.74% and Children 45.02%. This goal will be a continued.		Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2024 on the reporting measure. The Annual Evaluation Report for FY-2024 will be presented to QISC and PCC in Quarter 1 of FY-2025.
V.8b	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Director of Integrated Health Care Director of Quality Improvement	FY 2022-2023 (October 1, 2022, through September 30, 2023). Data reporting is collated, reviewed, and analyzed quarterly. FY2023 Data not available until April 2024.	The target goal is to meet the comparison benchmark of Quality Compass 85.09%.	Previously identified issue, targeted goal not met for FY2022 (47.05%). This goal will be a continued.		Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2024 on the reporting measure. The Annual Evaluation Report for FY-20234will be presented to QISC and PCC in Quarter 1 of FY-2025.

QAPIP Work Plan
FY 2023 - 2024 (October 1, 2023, through September 30, 2024)

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.8c	Antidepressant Medication Management for People with a New Episode of Major Depression	Director of Integrated Health Care, Director of Quality Improvement	FY 2022-2023 (October 1, 2022, through September 30, 2023). Data reporting is collated, reviewed, and analyzed quarterly. FY2023 Data not available until April 2024.	The target goal is to meet the comparison benchmark to MDHHS Chronic (63.41%); Acute (77.32%).	Previously identified issue. Targeted goal not met for FY2022 Acute (35.55%); Chronic (12.50%) This goal will be a continued.		Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2023 on the reporting measure. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
V.8d	Improving Diabetes Monitoring for People with Schizophrenia and Bipolar Disorder	Director of Integrated Health Care, Director of Quality Improvement	FY 2022-2023 (October 1, 2022, through September 30, 2023). Data reporting is collated, reviewed, and analyzed quarterly. FY2023 Data not available until April 2024.	The target goal is to meet the comparison benchmark to Quality Compass 86.36%	Previously identified issue. Targeted goal not met for FY2022 (73.43%). This goal will be a continued.		Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2023 on the reporting measure. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.

QAPIP Work Plan
FY 2023 - 2024 (October 1, 2023, through September 30, 2024)

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.8e	Reducing Risk of Hepatitis, C in SUD Members	Director of Integrated Health Care, Director of Quality Improvement	FY 2023-2024 (October 1, 2023, through September 30, 2024). Data reporting is collated, reviewed, and analyzed quarterly.	The target goal is to meet the comparison benchmark to MDHHS of 5%.	No previously identified issue. New goal for FY2024.		Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2023 on the reporting measure. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
V.8f	Wellness/MyStrength	Director of Adult Initiatives	FY 2023-2024 (October 1, 2023, through September 30, 2024). Data reporting is collated, reviewed, and analyzed quarterly.	The target goal is to meet the comparison benchmark of 75.0% or higher.	No previously identified issue. New goal for FY2024.		Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2023 on the reporting measure. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
V. 8g	Reducing the Call Abandonment Rate	Director of Call Center	FY 2023-2024 (October 1, 2023, through September 30, 2024). Data reporting is collated, reviewed, and analyzed quarterly.	The target goal is to meet the comparison benchmark is 5% or less.	No previously identified issue. New goal for FY2024.		Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2023 on the reporting measure. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.

QAPIP Work Plan
FY 2023 - 2024 (October 1, 2023, through September 30, 2024)

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. 8h	Children's Metabolic Screening for Children on Antipsychotics. (APM)	Director of Children's Initiative	FY 2023-2024 (October 1, 2023, through September 30, 2024). Data reporting is collated, reviewed, and analyzed quarterly.	The target goal is to meet the comparison benchmark of 38.0% or higher.	No previously identified issue. New goal for FY2024.		Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2023 on the reporting measure. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
V. 8i	Follow up for Children on ADHD medication.	Director of Children's Initiative	FY 2023-2024 (October 1, 2023, through September 30, 2024). Data reporting is collated, reviewed, and analyzed quarterly.	The target goal is to meet the comparison benchmark of 50% or higher.	No previously identified issue. New goal for FY2024.		Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2023 on the reporting measure. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
V. 8j	Reducing 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 days.	Director Of Quality Improvement	FY 2023-2024 (October 1, 2023, through September 30, 2024). Data reporting is collated, reviewed, and analyzed quarterly.	The target goal is to meet the comparison benchmark of 40% or higher.	No previously identified issue. New goal for FY2024.		Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2023 on the reporting measure. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.

QAPIP Work Plan
FY 2023 - 2024 (October 1, 2023, through September 30, 2024)

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.8k	Case Finding for Opiate Treatment	Director of Substance Use Disorder	FY 2023-2024 (October 1, 2022, through September 30, 2023). Data reporting is	The target goal is 79% or higher.	Previously identified issue. Targeted goal not met FY22. This goal will be continued.		Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2023 on the reporting measure. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
V.8l	PHQ-9 Implementation	Director of Clinical Practice Improvement	FY 2023-2024 (October 1, 2022, through September 30, 2023). Data reporting is collated, reviewed, and analyzed quarterly.	The target goal is 95% or higher.	No previously identified issue. Targeted goal met FY22 (99.1%).		Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2023 on the reporting measure. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
V.8m	PHQ-A Implementation	Director of Children's Initiative	FY 2023-2024 (October 1, 2022, through September 30, 2023). Data reporting is collated, reviewed, and analyzed quarterly.	The target goal is 100%	No previously identified issue. Targeted goal not met FY23 (99.2%). This goal will be continued.		Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2024 on the reporting measure. The Annual Evaluation Report for FY-2024 will be presented to QISC and PCC in Quarter 2 of FY-2024.

QAPIP Work Plan
FY 2023 - 2024 (October 1, 2023, through September 30, 2024)

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.8n	Decreasing Wait for Autism Services	Director of Children's initiative	FY 2023-2024 (October 1, 2023, through September 30, 2024). Data reporting is collated, reviewed, and analyzed quarterly.	The target goal is 100%	Previously identified issue. Targeted goal not met (67.5%). This goal will be continued.		Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2023 on the reporting measure. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
	Advocacy Pillar						
Goal VI.	**Increase Community Inclusion and Integration**						
VI.1	Home and Community Based Services (HCBS)	Director of Quality Improvement	FY 2023-2024 (October 1, 2023, through September 30, 2024). Data reporting is collated, reviewed, and analyzed quarterly.	The target goal not met; Provider network is not fully HCBS compliant to ensure quality of clinical care and service. Improve HCBS contractual requirements to 100% compliance.	Previously identified issue. Targeted goal not met for FY23. DWIHN must ensure all new providers of HCBS services are assessed and meet the final rule requirements. This goal will be continued in FY2024.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2024 will be presented to QISC and PCC in Quarter 2 of FY-2024.
Goal VII (Quality of Service)	**External Quality Reviews**						

QAPIP Work Plan
FY 2023 - 2024 (October 1, 2023, through September 30, 2024)

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.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, Innovation and Community Engagement, Provider Network Administrator Credentialing, Director of Integrated Health Care, Director of Human Resources	FY 2023-2024 (October 1, 2023, through September 30, 2024). 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 issues during FY2023.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2024 will be presented to QISC and PCC in Quarter 3 of FY-2024.

QAPIP Work Plan
FY 2023 - 2024 (October 1, 2023, through September 30, 2024)

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.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 Innovation and Community Engagement, Provider Network Administrator	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.		Submit quarterly reports to PCC on the recertification process. DWIHN will be revaluated for re-certification in January 2024.

QAPIP Work Plan
FY 2023 - 2024 (October 1, 2023, through September 30, 2024)

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.3	Health Services Advisory Group (HSAG)- Validation of Performance Projects (PIP)	Director of Quality Improvement	FY 2023-2024 (October 1, 2023, through September 30, 2024). 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.	No previously identified issues, Targeted goal met during FY23. DWIHN received 100% compliance for barriers, interventions and for the data analysis for submission requirements. This goal will be a continued.		Submit quarterly reports to PCC on performance outcomes. The Annual Evaluation Report for FY-2024 will be presented to QISC and PCC in Quarter 3 of FY-2025.

QAPIP Work Plan
FY 2023 - 2024 (October 1, 2023, through September 30, 2024)

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.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 Innovation and Community Engagement, Provider Network Administrator Credentialing, Director of Integrated Health Care, Director of Human Resources	FY 2023-2024 (October 1, 2023, through September 30, 2025). Reports and collated, reviewed and analyzed during the required look back period.	Previously identified issues. The target goal is to complete plans of action from (Year 1) and (Year 2) to address each deficiency identified during the Compliance Review in (Year 3) of August 2024.	No Previously identified issues, Targeted goal met during FY2023. This goal will be continued.		Submit quarterly reports to PCC on performance outcomes. The Annual Evaluation Report for FY-2024 will be presented to QISC and PCC in Quarter 4 of FY-2025.

QAPIP Work Plan
FY 2023 - 2024 (October 1, 2023, through September 30, 2024)

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 2023-2024 (October 1, 2023, through September 30, 2024). 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. Targeted goal met during FY23.This goal will be a continued.		Submit quarterly reports to PCC on performance outcomes. The Annual Evaluation Report for FY-2024 will be presented to QISC and PCC in Quarter 3 of FY-2025.

QAPIP Work Plan
FY 2023 - 2024 (October 1, 2023, through September 30, 2024)

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 Assessment	Director of Quality Improvement, Director of Managed Care Operations, Director of Customer Service, Director of Recipient Rights, Deputy Chief Financial Officer, Director of Innovation and Community Engagement, Provider Network Administrator Credentialing, Director of Integrated Health Care, Director of Human Resources	FY 2023-2024 (October 1, 2023, through September 30, 2024). Reports and collated, reviewed, and analyzed during the required look back period.	The target goal is to prioritize and implement planned actions as identified by our stakeholders, members, and the provider network.	No previously identified issues, Targeted goal met during FY2023.This goal will be a continued.		Submit quarterly reports to PCC on performance outcomes. The Annual Evaluation Report for FY-2024 will be presented to QISC and PCC in Quarter 2 of FY-2025.
End							