Detroit Wayne Integrated Health Network
Quality Assurance Performance Improvement Plan (QAPIP)
Evaluation Fiscal Year 2022-2023 and Work Plan

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Approved:

Approved by Quality Improvement Steering Committee (QISC)	1/30/24
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Executive Summary

The Detroit Wayne Integrated Health Network (DWIHN) is the Pre-Paid Inpatient Health Plan (PIHP) and Community Mental Health Service Provider (CMHSP) for Detroit and Wayne County. DWIHN is the largest community mental health service provider in the State of Michigan. The Quality Assurance Performance Improvement Plan (QAPIP) Evaluation is an annual document that assesses the results, Improvements, and outcomes DWIHN has made with respect to the Annual Work Plan for FY2023.

Description of Service Area

Wayne County is the most populous county in the State of Michigan. Wayne County is comprised of 34 cities and 9 townships covering roughly 673 miles. The municipality of Detroit had a 2022 estimated population of 620,376 which is a noted decrease of 12,068 from the previous fiscal year (632,444). Member populations receiving services through DWIHN are commonly referenced throughout this evaluation using the following abbreviations:

- MI Adults—Adults diagnosed with mental illness.
- SMI Adults—Adults diagnosed with serious mental illness. IDD
- Adults—Adults with intellectual developmental disability
- IDD Children—Children with intellectual developmental disability SUD
- – Adults diagnosed with substance use disorder.
- SED Children—Children diagnosed with serious emotional disturbance.
- ASD- autism spectrum disorders

Demographics

DWIHN provided services to an unduplicated count of 76,432 members during FY2023, which is an increase of 559 (0.734%). Of those served 47,966 (62.76%) received services through Medicaid funding, 19,232 (25.16%) received services through Healthy Michigan Plan funding, 7,332 (9.59%) received services through General Fund, 6.430 (8.41%) through SUD Block Grant, 6,433 (8.42%) through MI Health Link, 1,302 (1.70%) through State Disability Assistance (SDA) and 1,038 (1.36%) through Habilitation Supports Waiver. The percentage of adults who reported having an SMI in FY23 was 44,883 (58.72%), demonstrating an increase of (1.19%) from the previous year. Followed by 10,500 (13.74%) (SED), 13,764 (18.01%) (IDD), 1,399 (4.81%) (SUD), 2,094 (2.74%) (MI), 3,674 (Co-Occurring, and 93 (0.12%) unreported, which is a substantial decrease of unreported disability designation from the previous year (303). Of those served 42,566 (55.69%) were of African American descent. The Caucasian count was 23,005 (30.10%). The remaining (14.21%) were identified as other, two or more races, unreported, Asian, American Indian, Native Hawaiian, and Alaskan.

The largest group of individuals served are in the age group of 22-50 years old 34,146 (44.68%). Followed by the age group of 0-17 years old,16,953 (22.18%), and the age group of 51-64 years old, 15,124 (19.79%). The growth of persons served 65 and over continues to increase by (6.93%) from the previous year. Currently, our organization does not have a lot of data on the number of LGBTQ+ members in the population. However, there is strong evidence from recent research that members of the LGBTQ community are at a higher risk for experiencing mental health conditions — especially depression and anxiety disorders. LGBTQ+ adults are more than twice as likely as heterosexual adults to experience a mental health condition. Transgender individuals are nearly four times as likely as cisgender individuals (people whose gender identity corresponds with their birth sex) individuals to experience a mental health condition ***Data was extracted for this report on January 19, 2024.**

Customer Pillar

Member Experience with Services

DWIHN manages an annual Member Experience Survey, the selected ECHO® tool was developed by the Consumer Assessments of Healthcare Providers & Systems, known best as CAHPS. Utilizing Wayne State University School of Urban Planning to administer the blind surveys as a third party, increases the level of anonymity and more candid feedback from participants. Wayne State University is an R1 Research school that helps to provide critical scientific data from surveys. DWIHN has been able to utilize the ECHO® Adult and Children's Version since 2020, creating our ability to review and compare data annually and measure our progress over the past four (4) Fiscal Years. DWIHN was able to complete these surveys during FY 22 and FY 23. DWIHN looks at other sources of member experience as well including a crosswalk of trends between grievances, recipient rights violations, appeals, and other member feedback received by stakeholders. In the FY22/23 report survey participants for adults were nearly 800 participants and for the Children's it reached 1,143 respondents.

Quantitative Analysis and Trending of Measures

In a review of the annual ECHO® results, the DWIHN multi-disciplinary team dialogues and studies the outcomes and makes recommendations for planning interventions and improvements to optimize five major categories, including, but not exclusive of; 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. DWIHN has documented slight improvements in both the Adult and Children's population in review of the combined trends, with slight variations in the outcomes between the two.

Evaluation of Effectiveness

Below is the composite review of the global measures for both the adult and children's ECHO® respectively, over several years.

CATEGORY	FY 2022	FY 2021	FY 2020	FY 2017	STATUS
Overall Treatment	52%	51%	51%	46%	**UP + 6% Improved**
Seen Within 15 Minutes	49%	44%	36%	33%	**UP + 16% Improved**
Told About Meds and Side Effects	76%	79%	74%	75%	**UP + 1% Improved**
Engages Family in Treatment	55%	60%	60%	59%	Down -4%
Provides Information on Managing Condition	80%	75%	81%	78%	**UP + 2% Improved**
Information on Rights	88%	88%	88%	91%	**ABOVE 85%**
Member feels able to refuse treatment	78%	84%	81%	78%	NO GAIN
Confidence in Privacy	91%	93%	91%	91%	**ABOVE 90%**
Cultural Needs Met	76%	69%	69%	76%	NO GAIN
Perceived Improvement from Treatment	59%	57%	58%	52%	**UP + 7 % Improved**
Options on Treatment after benefits deplete	56%	56%	55%	48%	**UP + 8% Improved**
ECHO ADULT					**UP 40%**

CATEGORY	FY 2022	FY 2021	FY 2020	FY 2017	STATUS
Overall Treatment	49%	51%	51%	46%	**UP + 3% Improved**
Seen Within 15 Minutes	54%	44%	36%	33%	**UP + 21% Improved**
Told About Meds and Side Effects	75%	79%	74%	75%	NO GAIN
Engages Family in Treatment	82%	60%	60%	59%	**UP + 23% Improved**
Provides Information on Managing Condition	78%	75%	81%	78%	NO GAIN
Information on Rights	92%	88%	88%	91%	**ABOVE 90%**
Member feels able to refuse treatment	89%	84%	81%	78%	**UP + 9% Improved**
Confidence in Privacy	95%	93%	91%	91%	**AT 95%**
Cultural Needs Met	74%	69%	69%	76%	Down -2%
Perceived Improvement from Treatment	66 %	57%	58%	52%	**UP + 14 % Improved**
Options on Treatment after benefits deplete	56%	56%	55%	48%	**UP + 8% Improved**
ECHO Children's					**UP 78% total**

Opportunities for Improvement

DWIHN will further review and discuss in the Quality Improvement Steering Committee (QISC), adopted through changes that occur through interventions, process improvement planning, and implemented QAPIP process to ensure systemic change and the opportunity for better health outcomes for participating members.

National Core Indicators (NCI) Survey

On an annual basis, DWIHN participates in the National Core Indicator (NCI) Survey. The 2021 survey is reported in a collective summary which is conducted by Wayne State University Developmental Disabilities Institute, (WSU/DDI) on behalf of MDDHS. WSU/DDI aggregates the data of all participating PIHPs within the State of Michigan. Each year the survey commences around November and pre-survey data is collected from providers on behalf of consenting (participating) members. The State to date has not released the 2022 results of the NCI, however, the 2023 NCI has recently commenced as of November 2023 A Summary will be completed and will be offered for a preview by MDHHS and WSU/DDI at such time. DWIHN does not control or participate in the completion of this report.

Quantitative Analysis and Trending of Measures

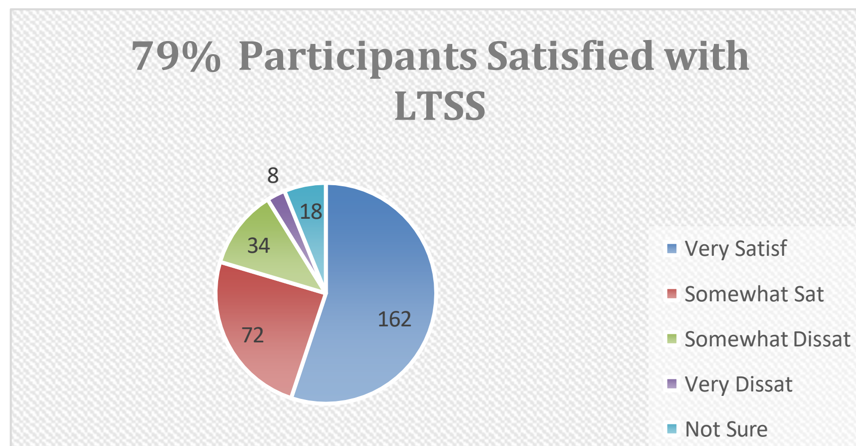
During FY2022, over 250 participants from Wayne County were asked to participate in the NCI Survey. The results of the NCI Survey include the total response of about 620 persons state-wide, therefore Wayne County plays a significant role in providing to MDHHS an overview of care related to IDD/DD Indicators to help align programming with strategies to improve overall care. While the actual survey summary does not drill down to the individual or (back) to DWIHN as a PHIP in 2024, DWIHN is planning to review the potential of asking participants of the NCI their level of satisfaction, as the NCI tool does not focus on satisfaction measurables, but rather information that offers indicators related to their level of service in long term supports. Though DWIHN and other PIHPs have requested local data aggregated data from the State related to NCI, they have declined consistently to provide results from individual surveys for any PIHPs or Counties.

Identified Barriers

The NCI is a specific survey that could identify the individuals and participants. The role DWIHN and other PIHPs play is to identify a pre-survey material that manages the pool from which the State surveys of the 298 Pre-survey Background packets we send to be interviewed for NCI we have no way of knowing who has participated in the surveys. The significance of this is that NCI is not an effective tool for measuring satisfaction. Its purpose is to provide statistical data for the State mostly on the effectiveness of programs rather than the success or satisfaction of individuals.

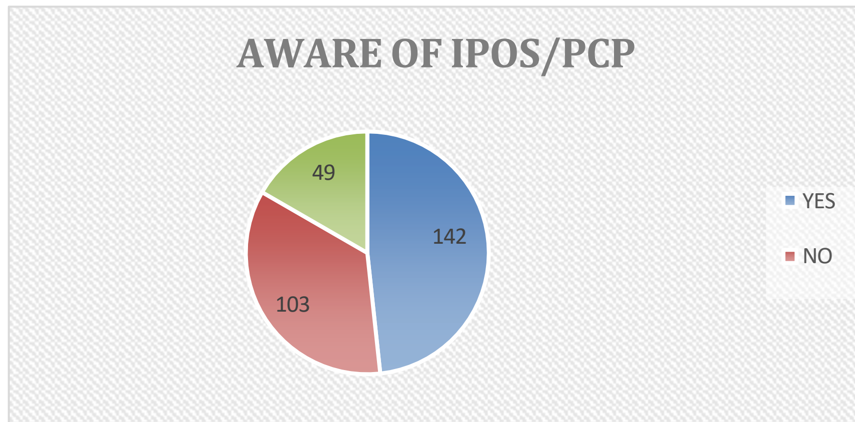
Long-Term Services and Supports (LTSS)

The Detroit Wayne Integrated Health Network, (DWIHN), staff took steps to review and explore the possibility there was a correlation between dissatisfaction with Long-Term Support Services, (LTSS), and the ability to understand and use the Person- Centered Planning, (PCP), Process in an impactful way. The team had speculated there may be a potential theory that members who were not satisfied with their LTSS care may also not be engaged thoroughly with their own PCP. The results of the initial survey conducted in July 2022 showed that the percentage of persons who were not confident that their PCP addressed their needs was relatively close to the same percentage of persons who reported they were dissatisfied with their services. This short proof study was intended as a follow-up to those persons who said they were dissatisfied. Overall, DWIHN findings concluded that most of the persons surveyed during this period were indeed satisfied with their services as demonstrated in the chart below.



Evaluation of Effectiveness

Nearly 80% of participants expressed satisfaction in the survey. The chart below also shows that a little more than half of the respondents said they were aware of their PCP and its role in the planning of their services. Interestingly, the total number of persons reporting they were ***not sure*** if they understood their PCP as a tool to achieve their goals, (103) of them responded they were not aware and 49 were not sure. The team considered that of the 49 who were uncertain of their PCP could potentially be reflective of the total 60 persons who said they were not satisfied with their LTSS program. DWIHN used the list of previous LTSS study participants and drilled down to contact a portion of respondents who said they were dissatisfied.



Identified Barriers

While the proof group is small the results seem even more compelling that there may be a correlation between the proper understanding of the individual's role and understanding of the power and use of their PCP to achieve goals and thus become more satisfied. The challenges faced were that the process was tedious and difficult to reach persons one on one, to follow up with the study, having to connect through multiple efforts, phone calls and messages to ensure that a person (member), was fully interested in participation of the follow-up study.

The options were the inability to reach Goals, feeling limited wanting to learn new things, unable to get the employment (JOB) they wanted, inability to live where they want (HOUSING), services do not offer a challenge, services not helping me to grow (GROWTH), other was not described. This group was represented only by the six members who were certain they were not satisfied; the four uncertain members were referred to other questions.

Opportunities for Improvement

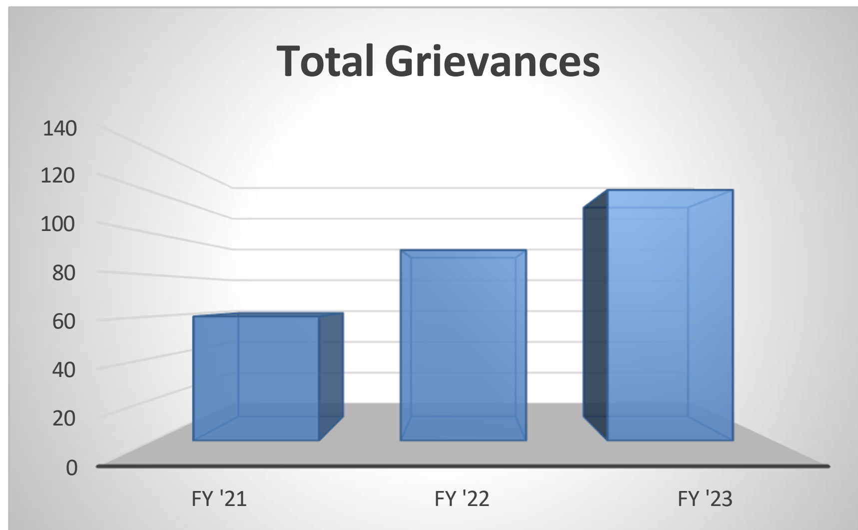
While this study is a mere glimpse into the implications of dissatisfaction of LTSS programming within the DWIHN system it appears that satisfaction remains at or around 80% of participants. A new survey which offers additional elements and factors to consider could be impactful, next steps regarding this will be discussed at the Quality Improvement Steering Committee. With consideration of the data offered in this proof survey, it is apparent that DWIHN members would benefit from more education related to their role and participation in their own Person-Centered Planning process. Potential one-on-one training for individuals would be most impactful. Efforts have already commenced by offering PCP Essential Training to Providers in April (2023), July 2023 and October 2023. These trainings have also been offered to Peers who work in the system. DWIHN staff will propose that the Persons have their PCP addressed more frequently at every opportunity and more education about the PCP become a part of a routine agenda at the monthly consumer member meetings. In addition, advocacy on Person-Centered Planning will be planned to LTSS Members via Virtual Trainings commencing in FY 2024, helping members to learn how to utilize the PCP process to empower and realize hopes and goals more fully will be the focus.

Member Grievance and Appeals

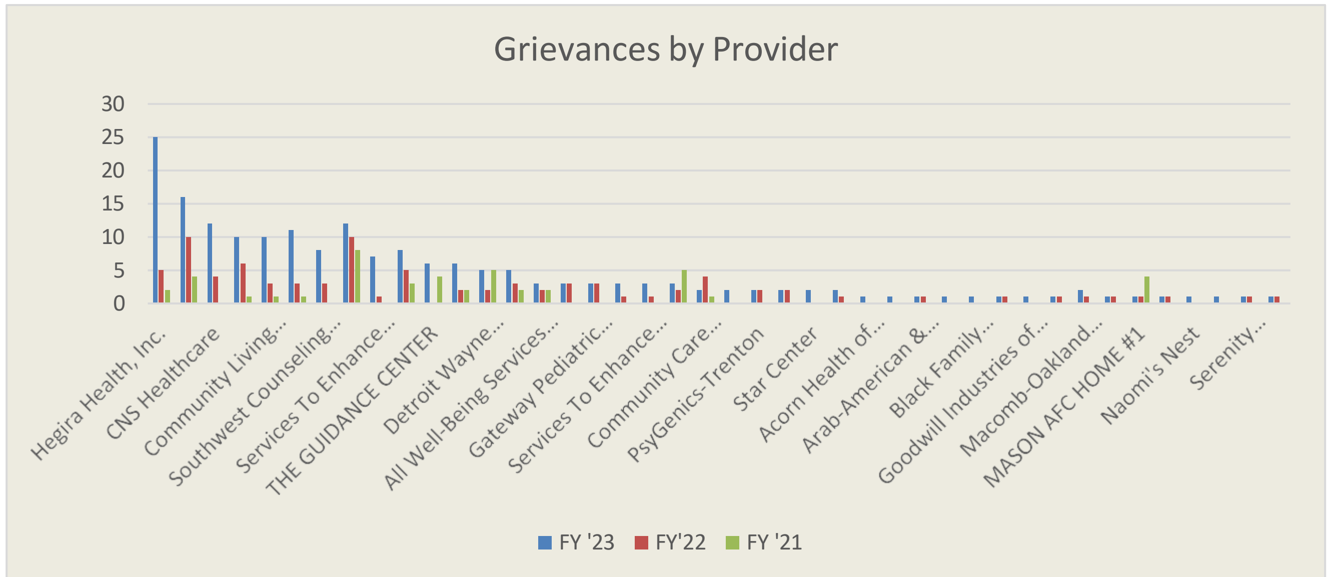
DWIHN's Customer Service completes an analysis of member experience trends and occurrences through review of Grievance data. DWIHN uses this data and other initiatives to determine priority actions and improvements to better engage members and stakeholders. Analyzing the data helps to forecast the direction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

Quantitative Analysis and Trending of Measures

The results described below include responses from members who received services in fiscal year 2023. There was a total of 273 grievances reported within the last three fiscal years. Grievances originated with either the Service Provider or DWIHN. As the graph below indicates the most grievances were reported in FY '23. Grievances increased by approximately 30% from FY '21 to FY '22, and 30% increased from FY '22 to FY '23. It is believed that due to more training offered to not only the Provider Network but to the members that we serve along with the constraints that have been placed on the provider network due to the aftermath of Covid, the number of grievances has increased.



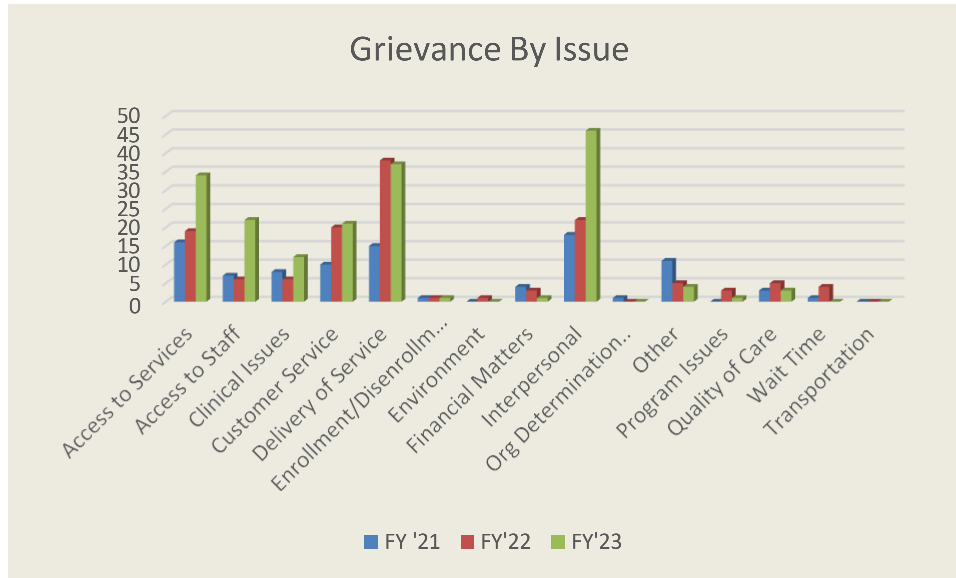
DWIHN has a network of approximately 1,558 providers. However, grievances were not reported against every provider. Although grievances were filed against several providers. For this report, members filed the most grievances against the providers as identified in the graph below.



Hegira Health accumulated the most grievances for the most recent fiscal year. Second place in total amount of grievances per provider was Lincoln Behavioral Services followed by Team Wellness and CNS Healthcare tied for third place. Grievances at Hegira saw a significant increase from 5 in 2022 to 25 in 2023. Lincoln Behavioral Services saw a slight increase going from 10 in 2022 to 16 in 2023. Team Wellness Center also saw a slight increase from 10 grievances in 2022 to 12 grievances in 2023. Another provider that saw a significant increase in the fiscal years is CNS Healthcare. This agency went from 4 grievances in FY' 22 to 12 grievances in 2023.

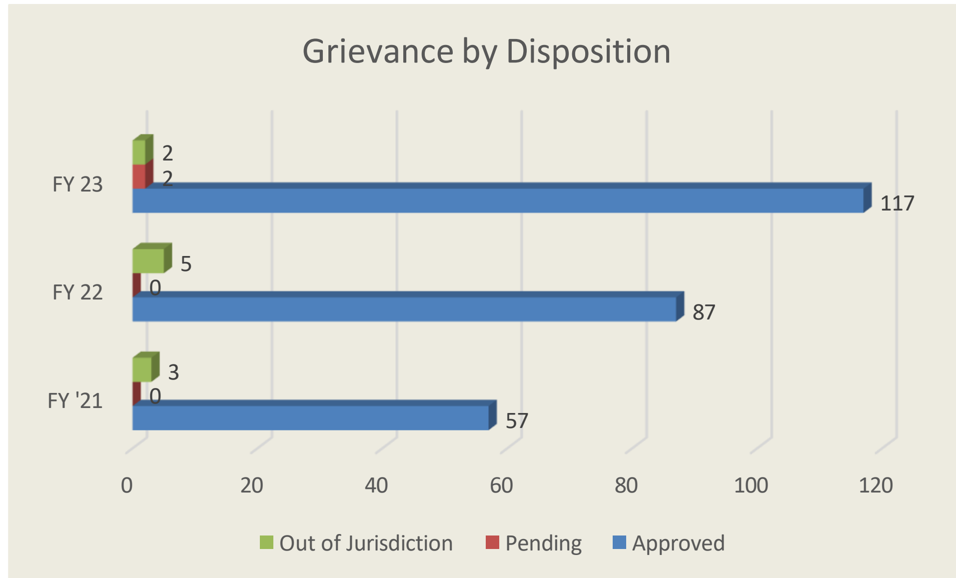
Evaluation of Effectiveness

The number of categories identified within a grievance can be significantly greater than the number of grievances received. However, a grievance is not considered resolved until all the categories within a grievance have been thoroughly investigated and considered appropriate for closure. DWIHN identifies grievance categories in alignment with MDHHS requirements as illustrated in the graph below. During FY '21 there were 60 grievances reported in which 96 issues were identified. FY '22 had a total of 92 grievances with 146 issues. In FY '23, there was a total of 121 grievances identified with 182 issues. FY' 23 numbers indicated Interpersonal (47), Delivery of Service (37) and Access to Service with a total of 34 issues. For the first time, Customer Service was not in the top 3 of Grievance issues although it remained high at 21 and Access to Services was 22. Thes 5 categories remain consistently in the top 5 grievances among members. There have been no transportation grievances in the past 3 years while the Wait time grievances decreased between fiscal years '22 and '23 going from 4 to 0.

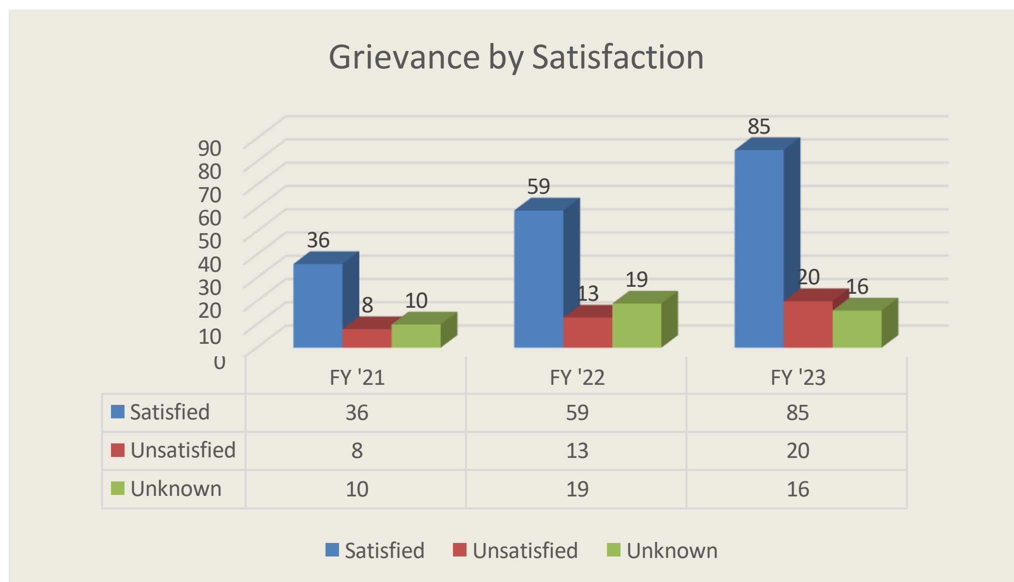


A total of 13* grievances were reported for the five ICOs over the last three fiscal years. Molina has consistently had the highest number of grievances reported. There were 2* grievances in FY '23, 4 in FY '22 and 3 in FY '21. The 13 grievances are included in the total number of grievances reported for each year and the same for the grievance categories. Medicaid grievances are required to be resolved within ninety (90) calendar days, non-Medicaid grievances must be resolved within sixty (60) calendar days and MI Health Link grievances must be resolved within thirty (30) calendar days. Medicaid grievances were resolved all within the 90-calendar day timeframe. All MI Health Link grievances were resolved within the 30-calendar day timeframe. Grievances for MI Health Link are counted through October 2023 for fiscal year 2023 as the ICO's fiscal year goes from January – December.

Of the 273 grievances reported over the last three fiscal years, 95.6% were resolved within the Customer Service unit at either the Service Provider or DWIHN. Those grievances were usually coordinated with other departments for resolution. There were 10 grievances received during the same time frame that were determined not to be in DWIHN jurisdiction and 2 pending grievances which accounts for 4.4%.



There were 273 grievances reported over the last three fiscal years (FY ’21, FY ’22 and FY ’23). 65% of the grievances were resolved satisfactorily (180). 41 grievances were marked unsatisfied with the outcome of their complaint. Unable to determine the satisfaction disposition for the remainder of the grievances due to either not responding to contact attempts or other factors is the result of the remaining 45 grievances.

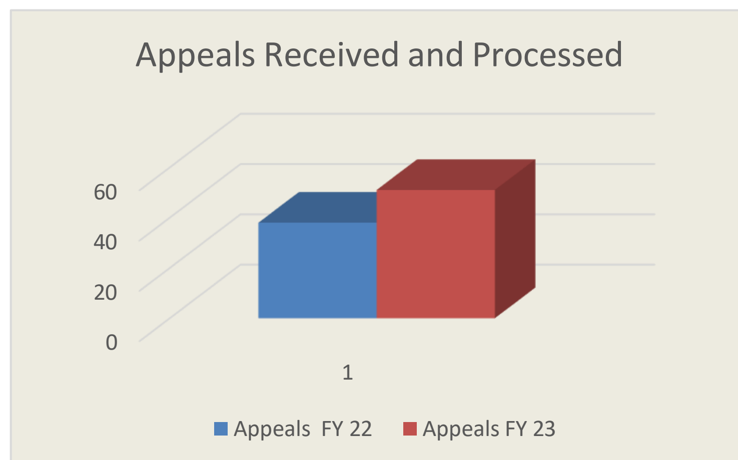


Identified Barriers
Overall, member ratings of quality, satisfaction, appropriateness, and outcomes were positive. This may be because consumers are still in services and their ultimate goals have not been attained. Most of the open-ended comments were positive. Members made a request for more flexibility with scheduling, including requests for weekend appointments and more reliable transportation. Face-to-face appointments became more evident in the most recent fiscal year which could be contributed to additional grievances being reported.

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

- Continuation of consistent and relevant training on the grievance process to members and providers alike to address issues related to interpersonal and customer service issues within the provider network. It may be warranted to explore additional training to address interpersonal and customer service issues being experienced within the population we serve.
- Develop initiatives with the cooperation of the Member Engagement division to provide outreach, education, advocacy, peer development, and surveying member experiences. The Due Process Summit is in the works for October of 2023, and we are looking to make this an annual event.
- Continue the Constituents' Voice Advisory Committee which addresses consumer legislative issues including the delivery of service, interpersonal relations, and customer service.
- Review and discuss grievance data with the Member Engagement Division which will allow for an additional avenue for evaluating member experiences.
- Continue to identify continuous quality improvement opportunities through use of patterns and trends of grievances reported.
- Continue to support members by resolving issues of dissatisfaction with DWIHN.
- Identify gaps in service provision and discuss with leadership to address needs as they develop.

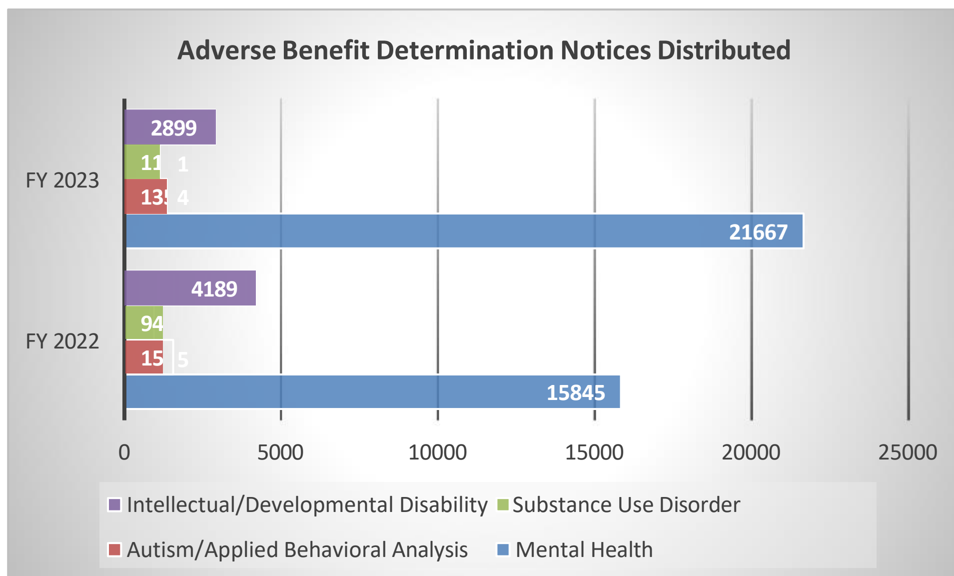
Member Appeals
In the arena of appeals, increases were seen as the unit processed 1,359 appeal related correspondence for Fiscal Year 2023 versus 595 appeals related correspondence in FY 2021/2022. The correspondence is inclusive of emails as well as phone calls. The increased correspondence can be attributed to the higher number of appeals and the amount of increased follow-up needed to resolve each case.



Quantitative Analysis and Trending of Measures

Actual appeal cases increased slightly with 51 appeals from 38 the previous fiscal year. The type of appeals filed are mostly administrative in nature as the trend continues that members receive notices of adverse benefit determination because of lack of engagement/contact with their Clinically Responsible Service Provider (CRSP).

The monitoring of 21,667 Mental Health based Adequate and Advance Adverse Benefit Determination Notices in FY 2022/2023 compared to 15,845 sent in FY2021/2022, which showed a significant increase. There was a decrease noted with 1,354 notices being provided to individuals receiving services related to the Applied Behavioral Analysis (ABA) benefit versus 1,555 ABDs the previous year. In the area of substance use disorder (SUD) notices, there was an increase for the second consecutive year. For the fiscal year 2023, the number of notices was 1,131 compared to 945 the previous year. There was a significant increase in the number of Adequate and Advance notices distributed in 2022/2023 (4,189) to 2,899 IDD related notices the previous year.



Identified Barriers

Overall, many member appeals received were resolved to the satisfaction of the appellant. Typically, this is due to the members being connected or reconnected with the services that were adversely affected largely because of the efforts of the Appeals Specialists effort to ensure members are receiving the appropriate service. It is of note that the member at times is unable to return to the site where they were originally receiving services due to staff constraints or interpersonal issues. However, the services can be provided in a different setting therefore satisfying the request. In reviewing the appeals, some barriers to receiving services include inadequate staffing, lack of transportation or inability to connect with the member after requesting an appeal to provide options for care. DWIHN has contracted with two transportation providers to try to address the lack of transportation for the members that are serviced. DWIHN continues to expand their provider network to accommodate the demand for services and alleviate the drain on the current provider system.

Opportunities for Improvement

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

- Continuation of consistent and relevant training on the appeals process to members and providers alike to address issues related to service provision.
- Develop initiatives with the cooperation of multiple DWIHN departments to provide outreach, education, advocacy, and surveying member experiences. The Due Process Summit has been scheduled for the fiscal year 2024 and the desire is to make this an annual event.
- Review and discuss appeals data with the other pertinent DWIHN divisions to allow for an additional avenue for evaluating member experiences.
- Continue to support members by resolving issues of adverse action with DWIHN. Identify gaps in service provision and discuss with leadership to address needs as they develop.

Provider and Practitioner Satisfaction Survey

DWIHN administered the Provider Satisfaction Survey for FY2023 during the months of April 1, 2023, and ended April 14, 2023, to measure provider experience with service access, service provision, treatment experiences and outcomes. The survey was delivered via email using Gov Delivery to 1502 DWIHN practitioners. There were 578 responses to the survey. All the respondents did not answer every question this created a variation in number of responses for each question.

The rating scale ranges from 1 -5 with Excellent being the highest rating utilized.

5 = Excellent-extremely good; outstanding
4 = Very Good -above average, exceptional
3 = Good- high standard; satisfactory capable
2 = Fair-acceptable, meets the minimum standard
1 = Poor -substandard, below par, low or inferior standard or quality
Not Applicable = Does not apply to your organization

Based on the survey methodology for categorizing responses in two types positive or negative the DWIHN results are identified as outlined:

- Excellent, Very Good, and Good are positive responses.
- Fair and Poor are negative responses.
- Completely Satisfied and Somewhat Satisfied are positive responses.
- Somewhat Dissatisfied and Completely Dissatisfied are negative responses.

Causal Analysis of Provider Survey Results

Overall, there were over 400 comments that were made by practitioner respondents. As illustrated below, most of the comments were favorable with DWIHN's communication of actions, clinical policies, concerns, and other notices to their organization.

How satisfied are you with the degree to which DWIHN's benefits assist members under your care. Number of Responses = 478

51	71	148	122	87
Excellent	Very Good	Good	Fair	Poor

How satisfied are you with DWIHN's communication of actions and policies and procedures to you and your organization. Number of Responses = 478

81	101	147	86	71
Excellent	Very Good	Good	Fair	Poor

In your specific role, how satisfied are you with the communications related to treatment, services, and supports among all Health Care Practitioners, Psychiatrists, and Support Personnel* within the system (*Definition of Support Personnel: Direct Care Workers, Coaches or Peer Support Specialists) Number of Responses = 482

76	117	157	76	56
Excellent	Very Good	Good	Fair	Poor

Cultural and Linguistic Needs

Creating a diverse and inclusive workplace culture is important because it has a positive impact on everything from employee recruitment and loyalty to innovation and performance. There are three fundamental indicators of inclusion in the workplace: equality, openness, and belonging. Equality refers to fairness and transparency in pay, recruitment, promotion, and access to resources. Openness refers to a workplace culture where people are treated with respect and without bias, discrimination, or microaggressions. And belonging refers to a sense of community that encourages people of all backgrounds to feel free to share their insights and talents—and to know that their input is valued by coworkers, managers, and their organization.

Evaluation of Effectiveness

Diversity, Equity, and Inclusion

DWIHN established a DEI Coalition made up of 24 Providers and Community Stakeholders. The Coalition was established to create an inclusive community that stands up for equity at all levels throughout the 75,000 people DWIHN served with behavioral health challenges throughout Wayne County and the staff that supports them. DWIHN's DEI newsletter was also implemented. This publication is sent out monthly to discuss different diversity topics and highlight members DEI events in the organization. Also, a DEI page was created on the official DWIHN website to seek employee insights and highlight diverse voices. In FY2022, DWIHN was awarded the Corp Magazine Overall Diversity Champion Award. DWIHN also partnered with the National Disability Institute on Disability/Diversity/Financial Empowerment and Wayne State University on Black Health & Racial Equity Symposium; topics included implicit bias, structural racism & health outcomes, and the digital divide.

Director of Diversity, Equity & Inclusion has been requested to serve on the Planning Committee on the 2023 WSU Detroit Community Health Equity Alliance (D-CHEA). Groups served include (but not limited to) Middle Eastern and North African (MENA) and Immigrant Health, LGBTQ Health, and Black Health and Racial Equity. D-CHEA will work to inform and develop initiatives to advance health equity with emphasis on Detroit's persistent poverty areas, where a substantial proportion of the neighborhood has lived in poverty for decades. The committee plans to collaborate to bring about community-level change towards health-promoting opportunities and behaviors.

Completion of DEI Pulse Survey – Baseline survey for DWIHN employees only. This survey was administered to gather information and insights related to diversity, equity, and inclusion within an organization. Surveys are a safe space and avenue for employees to share feedback about company culture. Employees want to see organizations take a clear and thoughtful approach to inclusion efforts. The Diversity, Equity & Inclusion Engagement Pulse allows organizations to gather feedback to inform their actions to create a more inclusive environment for all.

DEI Foundations Training Program launch (McLean & Co) September 2023 for DWIHN Management. This blended program (facilitated sessions, self-paced e-learning, and peer coaching) will ask participants to deepen their understanding of diversity, equity, and inclusion (DEI); further develop emotional intelligence; and adopt inclusive behaviors to influence change within teams and beyond. A combination of self- reflection, peer coaching, and live facilitated conversations with facilitators provides an opportunity to practice, refine, and develop management soft skills.

Practice Guidelines

DWIHN adopts evidence-based and nationally recognized standards of care clinical practice guidelines based on the needs of the people we serve. The clinical practice guidelines are reviewed 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. The practice guidelines are available to members and providers on DWIHN's website.

Evaluation of Effectiveness

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

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

Identified Barriers

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

Access Pillar

Mission Michigan Based Performance Indictors (MMBPI)

The Michigan Mission Based Performance Indicators data are a way of measuring how well Detroit Wayne Integrated Health Network (DWIHN) is helping the people we serve by meeting standards of care like timeliness; by reducing problems like hospitalizations; or by helping people improve their lives in other ways. There are five indicators that have been established by Michigan Department of Health and Human Services (MDHHS) that are the responsibility of the Pre-Paid Inpatient Health Plan (PIHP) to collect data and submit on a quarterly basis. The established standards for indicators #1 and #4 are (95% or above) and the standard for indicator #10 is (15% or less). Indicators #2a (The percentage of new persons during the period receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service) and indicator #3 (The percentage of new persons during the period starting any medically necessary on-going service within 14 days of completing a non-emergent biopsychosocial assessment) are indicators in which there are no established standard/benchmark set by MDHHS for FY2023.

In June 2023, MDHHS established a benchmark for FY2024. DWIHN's PI#2a benchmark will be 57% or above and PI#3 is 83.8% or above. This is for all IDD and MI services. These will take effect in the 1st Quarter 2024 (October 1st, 2023).

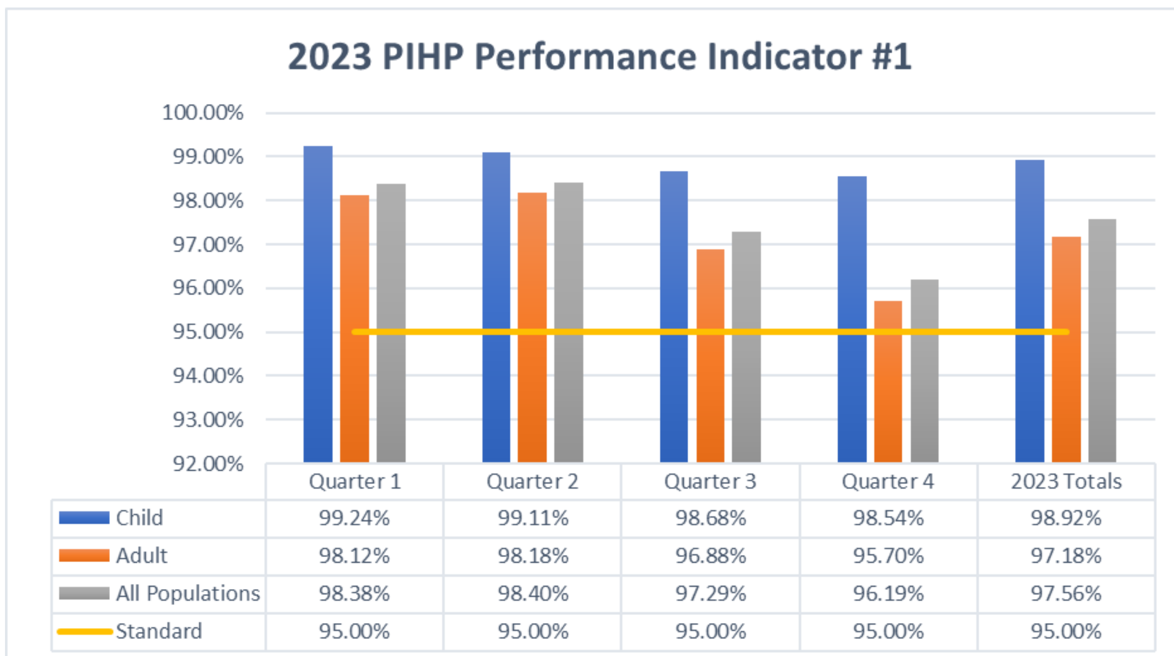
Qualitative Analysis and Trending of Measures

Indicator #1- Pre-Admission Screening within 3 hours

The percentage of persons during 2023 receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.

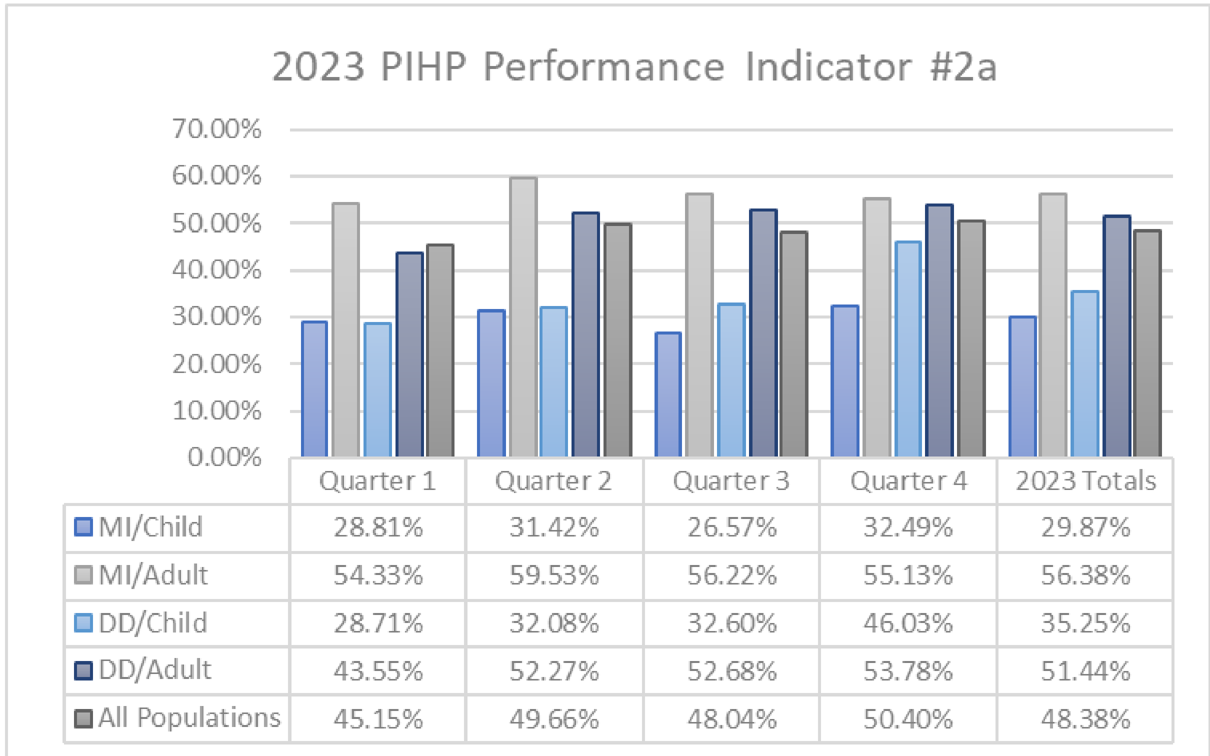
Goal: The goal is to attain and maintain performance standards as set by the MDHHS contract. Standard 95% or above.

Results: FY2023 standard met for all populations. Total population rate (97.56%).



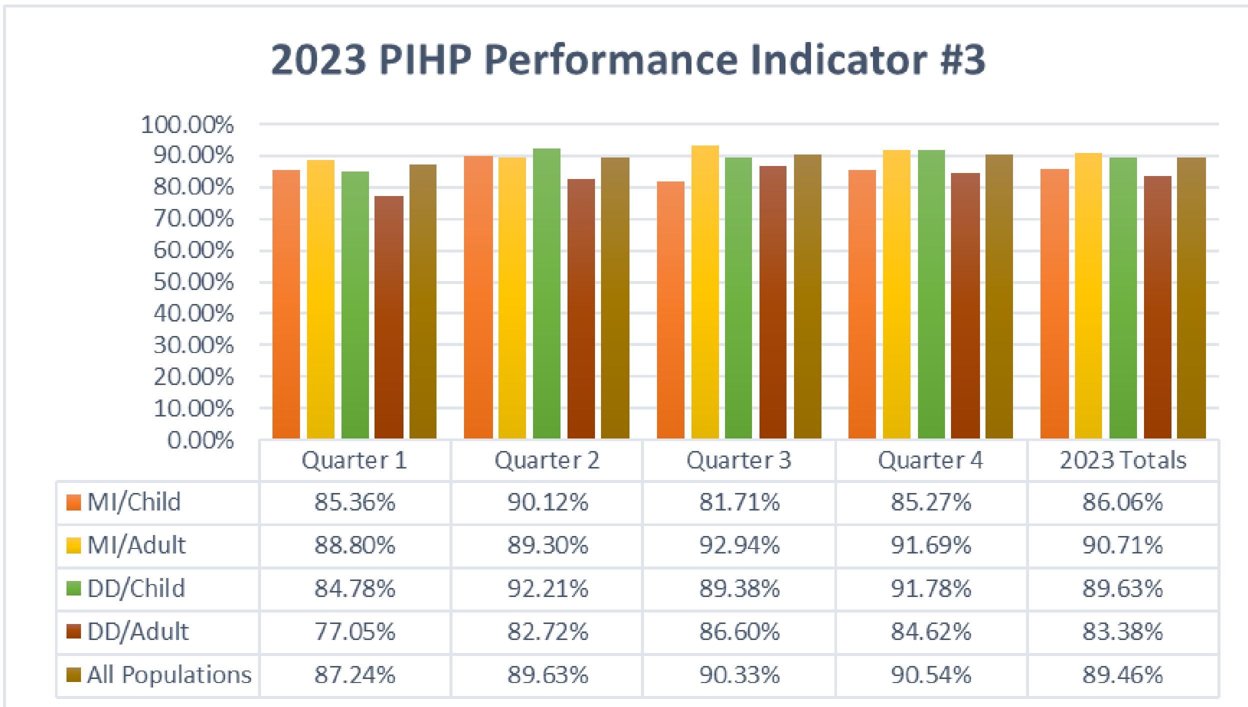
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2023 Totals
Child	99.24%	99.11%	98.68%	98.54%	98.92%
Adult	98.12%	98.18%	96.88%	95.70%	97.18%
All Populations	98.38%	98.40%	97.29%	96.19%	97.56%
Standard	95.00%	95.00%	95.00%	95.00%	95.00%

Indicator #2- Access/1st Request Timeliness
The percentage of persons during FY2023 receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service. This measure allows for no exceptions.
Goal: The goal is to attain and maintain performance standards as set by the MDHHS contract. MDHHS has not established a minimum threshold for this measure. The goal for FY2024 will be 57.0%.
Results: Q1 (45.15%), Q2 (49.66%), Q3 (48.04%) and Q4 (50.40%). Total population rate (48.38%). No sub-population met the FY2023 goal. Total population rate for FY2023 was 48.38%.



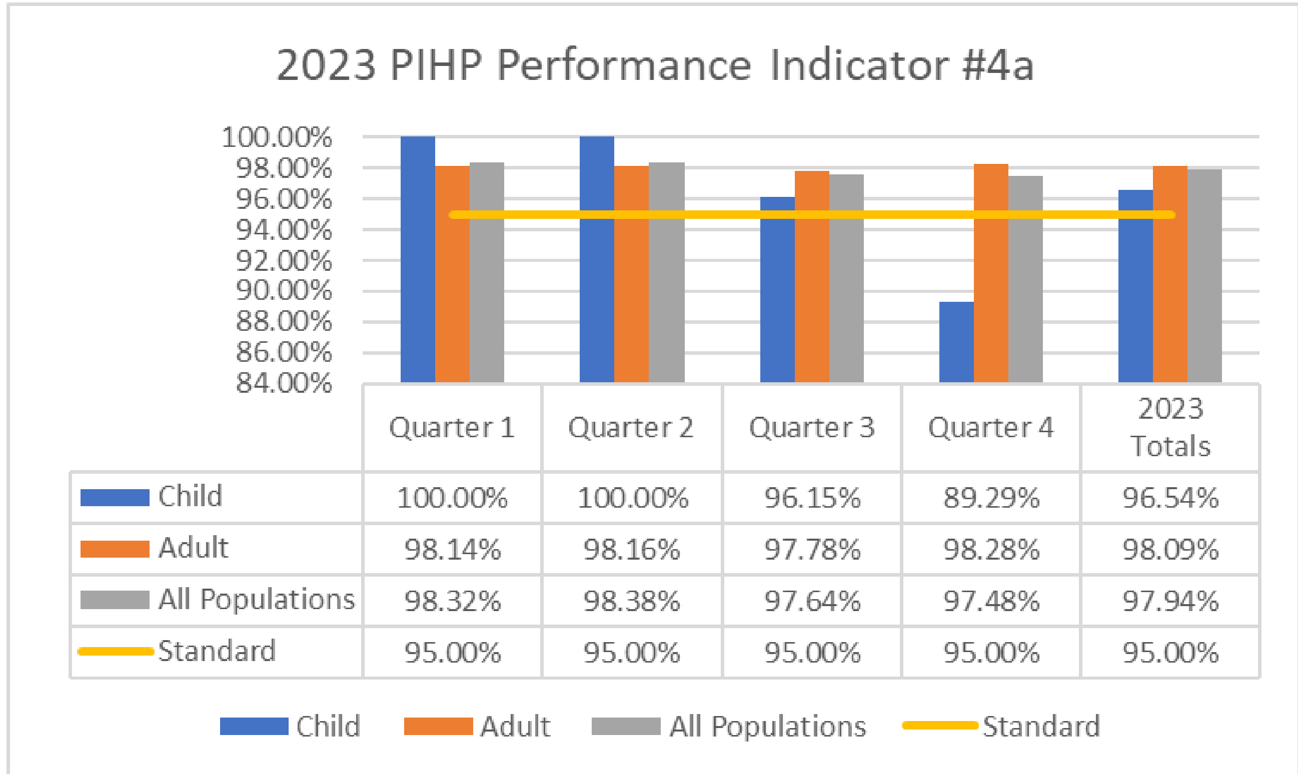
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2023 Totals
MI/Child	28.81%	31.42%	26.57%	32.49%	29.87%
MI/Adult	54.33%	59.53%	56.22%	55.13%	56.38%
DD/Child	28.71%	32.08%	32.60%	46.03%	35.25%
DD/Adult	43.55%	52.27%	52.68%	53.78%	51.44%
All Populations	45.15%	49.66%	48.04%	50.40%	48.38%

Indicator #3- Access/1st Service Timeliness
The percentage of persons during FY2023 needed on-going service within 14 days of a completed non-emergent biopsychosocial assessment. This measure allows for no exceptions.
Goal: The goal is to attain and maintain performance standards as set by the MDHHS contract. MDHHS has not established a minimum threshold for this measure. FY2024 standard will be 83.8%.
Results: Q1 (87.24%), Q2 (89.63%), Q3 (90.33%) and Q4 (90.54%). Total population rate (89.46%). The FY2023 goal was met for MI children, MI adults, IDD children and the total population. The IDD adult population did not meet 83.8%. Total population rate (89.46%).



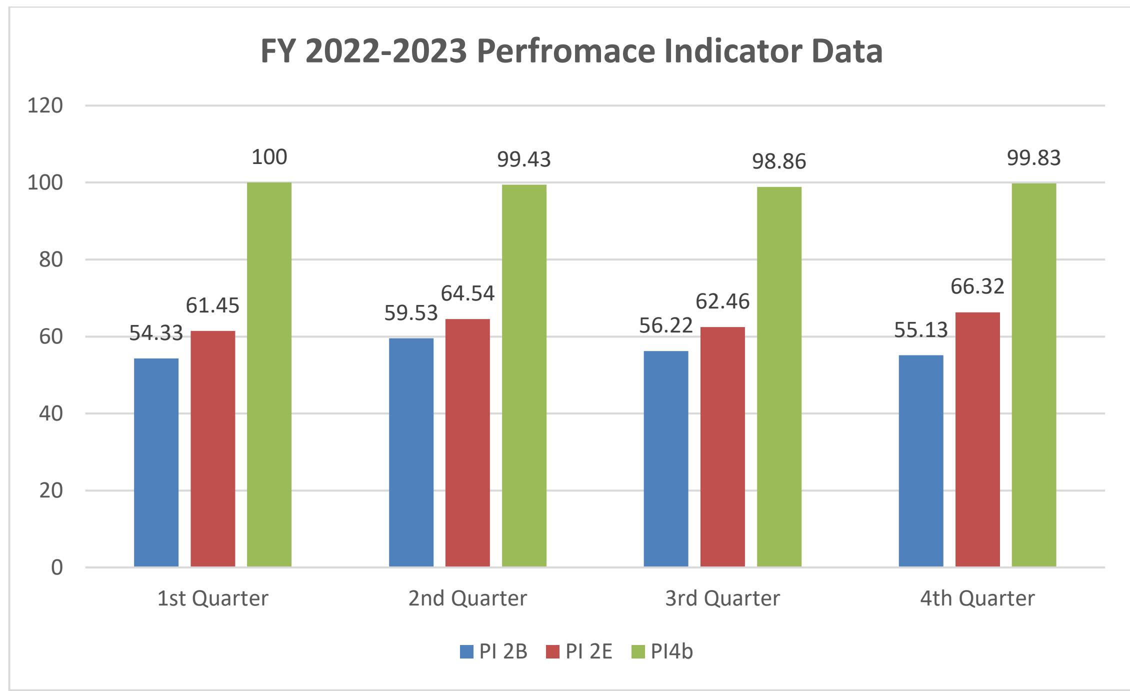
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2023 Totals
MI/Child	85.36%	90.12%	81.71%	85.27%	86.06%
MI/Adult	88.80%	89.30%	92.94%	91.69%	90.71%
DD/Child	84.78%	92.21%	89.38%	91.78%	89.63%
DD/Adult	77.05%	82.72%	86.60%	84.62%	83.38%
All Populations	87.24%	89.63%	90.33%	90.54%	89.46%

Indicator #4a- Hospital Discharge Follow-Up
The percentage of discharges from a psychiatric inpatient unit during FY2023 who are seen for follow-up care within seven days.
Goal: The goal is to attain and maintain performance standards as set by the MDHHS contract. Standard 95% or above.
Results: FY2023 standard was not met for the following quarters/populations Q4 Child (89.29%). Total population rate for FY2023 was 97.94%.



	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2023 Totals
Child	100.00%	100.00%	96.15%	89.29%	96.54%
Adult	98.14%	98.16%	97.78%	98.28%	98.09%
All Populations	98.32%	98.38%	97.64%	97.48%	97.94%
Standard	95.00%	95.00%	95.00%	95.00%	95.00%

Indicator #4b- SUD Detox Discharge Follow-up
The percentage of discharges from a Substance Abuse Detox Unit who are seen for follow- up care within 7 days.
Goal: The goal is to attain and maintain performance standards as set by MDHHS contract.
Standard 95% or above.
Results: FY2023 standard was met for all quarters Q1(100%), Q2 (99.43%), Q3 (98.86) and Q4 (99.83%)**.** Total rate for the year (100%).

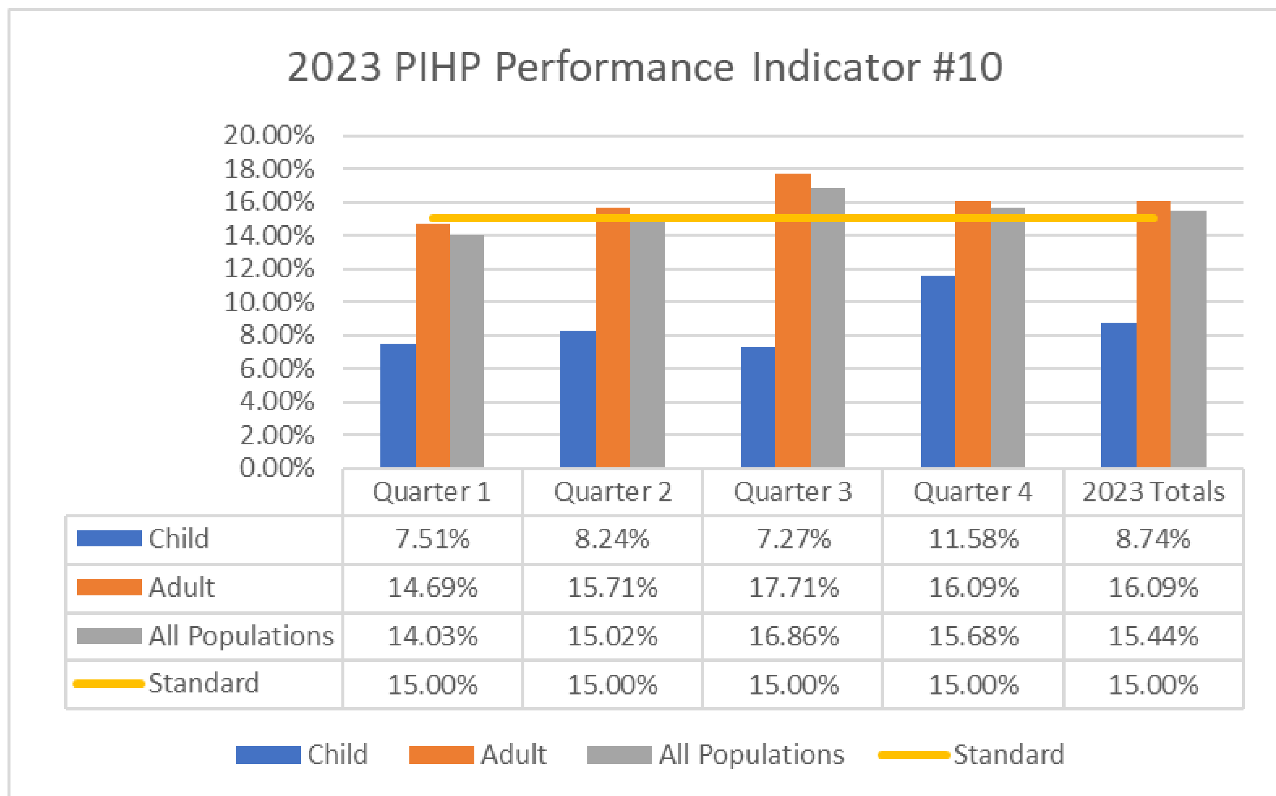


Causal Analysis
Providers faced funding constraints that limited their ability to invest in staff training for data management and interventions to improve performance. The presence of co-occurring mental health conditions, chronic medical conditions, and trauma histories among members with SUD complicated treatment efforts. Additionally, members were impacted by the lack of cell phones and computers, which limited access and their ability to request services.

To overcome and improve indicator 2b and use the MHWIN system effectively, SUD has implemented various interventions. Technical assistance sessions and collaboration with DWIHN have been provided to ensure that providers are aware of the Performance indicator goals, know how to achieve them, and have the best practices in place to achieve those goals. Moreover, SUD has been sending weekly reports to remind providers to pay attention to performance indicators and keep them informed and engaged in the process. Regular feedback and coaching are given to help providers understand their performance, identify areas for improvement, and develop action plans to address deficiencies.

To assess the impact of the interventions, SUD has conducted a series of before-and-after comparisons on the reports that were run and sent to providers. To achieve this, SUD compared performance indicators before and after implementing the interventions, using periods such as monthly and quarterly reports. By analyzing the changes in performance indicators over time, we gained insight into the interventions' effectiveness.

Indicator #10- Inpatient Recidivism
The percentage of readmissions of children and adults during FY2023 to an inpatient psychiatric unit within 30 calendar days of discharge from a psychiatric inpatient unit.
Goal: The goal is to attain and maintain performance standards as set by the MDHHS contract. Standard 15% or below.
Results: The child population met the 15% and below standard each quarter for FY2023. FY2023 standard was not met for the following quarters Q2 Adult (15.71%) and Total (15.02%), Q3 Adult (17.71% and Total (16.86%) and Q4 Adult (16.09%) and Total (15.68%). Total population rate for the year (15.44%).



	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2023 Totals
Child	7.51%	8.24%	7.27%	11.58%	8.74%
Adult	14.69%	15.71%	17.71%	16.09%	16.09%
All Populations	14.03%	15.02%	16.86%	15.68%	15.44%
Standard	15.00%	15.00%	15.00%	15.00%	15.00%

Evaluation of Effectiveness

The results below show that the initiatives and interventions have been generally effective in reducing recidivism rates. These were first implemented in FY2021 and have continued through 2023. Several interventions from DWIHN's Crisis and Access team have helped decrease the rates. This has led to a decrease with the adult recidivism rate from 17.94% during Quarter 1 in FY2021 to 15.89% for Quarter 4 for FY2023, with a total population rate of 15.19%. The threshold for PI#10 is 15% or less.

- Individual CRSP rates began being shared with CRSPs at the 45-Day CRSP meetings every 45 days.
- Recidivism reports were sent out to CRSPs at the end of each quarter. These reports requested CRSP review each recidivistic member and provide DWIHN responses.
- Performance Improvement Plans were requested from CRSPs who did not meet the 15% or less.
- Financial incentives were offered for high performing CRSPs during FY2023. The threshold for eligibility was 10% or less for AMI and 5% or less for SED.
- Lastly, DWIHN's Recidivism Workgroups, led by DWIHN Crisis/Access team and includes our Clinically Responsible Service Providers (CRSP).

Indicator 10: Percentage who had a Re-Admission to Psychiatric Unit within 30 Days	Population	2021				2023			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Children	8.94%	12.03%	6.76%	8.22%	5.06%	7.69%	6.76%	7.64%
	Adults	17.94%	17.34%	17.03%	15.01%	14.93%	16.31%	17.79%	15.89%
	Total	17.12%	16.97%	16.23%	14.51%	14.05%	15.63%	16.86%	15.19%

DWIHN met the standards for PI#1 (Children & Adults), PI#4a (Children &Adult) and PI#10 (Children) during FY2023. For PI#1, DWIHN was able to provide 97.56% of members needing a pre-admission screening for psychiatric inpatient care within 3 hours of a request for service. DWIHN's Crisis and Access team works closely with the Crisis providers that complete the pre-admission screenings with members. Hegira Health's COPE unit completes adult screenings and New Oakland, The Guidance Center, and The Children's Center provide child pre-admission screenings. DWIHN requests monthly out of compliance reports from COPE stating the reasons for events that were outside of the 2- and 3-hour timeframe. This process has helped DWIHN and COPE monitor their efforts and address any technical or procedural barriers that have arisen.

- PI#1 - The child rate was 98.54% for Q4 (95% standard), a decrease of 0.70 percentage points from Q1 (99.24%).
- PI#1- The adult rate for Q4 was 95.70% (95% standard), a decrease of 2.42 percentage points from Q1 (98.12%).
- PI#1- All populations rate for Q4 was 97.56% (95% standard), a decrease of 0.82 percentage points from Q1 (98.38%).

DWIHN's PI#2a overall population rate for 2023 was 48.38%. While it was below DWIHN's expectations, the rates for all PI#2 categories increased from Q1 to Q4. DWIHN continued to work to address PI#2 since MDHHS eliminated the exceptions in 2020. This change, combined with the pandemic, has made this standard a challenging one. The 45-day meetings with several DWIHN departments, including Quality, Managed Care Operations, Integrated Health Care and Access Center as well as19 CRSPs were specifically created to address the challenges with PI#2. Through these meetings, DWIHN has been able to collaborate with CRSPs to address barriers and interventions. MDHHS' announcement of the 2024 benchmarks for PI#2 and PI#3 provided DWIHN with numbers to set its goals. It also provided data for DWIHN to gauge its progress. Details about these meetings will be discussed below.

- PI#2 - The MI/child rate was 32.49% for Q4, an increase of 3.68 percentage points from Q1's 28.81% rate.
- PI#2 - The MI/adult rate was 55.13% for Q4, an increase of 0.80 percentage points from Q1's 54.33% rate.
- PI#2 - The IDD/child rate was 46.03% for Q4, an increase of 17.32 percentage points from Q1's 28.71% rate.
- PI#2 - The IDD/adult rate was 53.78% for Q4, an increase of 10.23 percentage points from Q1's 43.55% rate.
- PI#2 – The total population rate was 50.40% for Q4, an increase of 5.25 percentage points from Q1's 45.15% rate.

DWIHN continued to have some of the highest rates of all the PIHPs in the state of Michigan for PI#3 (follow-up service within 14 days of completed Integrated Biopsychosocial). DWIHN's overall rate for FY2023 was 89.46%. The 45-day meetings with 19 CRSPs included discussions about their individual quarterly rates. These meetings ensured all the departments and agencies were in unison and working collaboratively.

- PI#3 - The MI/child rate was 85.27% for Q4, a decrease of 0.08 percentage points from Q1's 85.36% rate.
- PI#3 - The MI/adult rate was 91.69% for Q4, an increase of 2.89 percentage points from Q1's 88.80% rate.
- PI#3 - The IDD/child rate was 91.78% for Q4, an increase of 7.00 percentage points from Q1's 84.78% rate.
- PI#3 - The IDD/adult rate was 84.62% for Q4, an increase of 7.57 percentage points from Q1's 77.05% rate.
- PI#3 – The total population rate was 90.54% for Q4, an increase of 3.30 percentage points from Q1's 87.24% rate.

For PI#4a (children), the percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days, DWIHN met MDHHS' standard of 95% of greater the first three quarters of 2023. DWIHN did not meet the 95% standard during Quarter 4 (89.29%). PI#4a (adults) met the MDHHS' standard of 95% or greater each quarter in 2023. Following MDHSS' formula of allowing exceptions, DWIHN was able to see 98.09% of members for follow-up within 7 days of discharge from a psychiatric inpatient hospitalization.

- PI#4 – The MI/child rate was 89.29% for Q4, a decrease of 10.71 percentage points from Q1's 100.00% rate.
- PI#4 – The adult rate was 98.28% for Q4, an increase of 0.14 percentage points from Q1's 98.14% rate.

PI#10 (children) met MDHHS' standard of 15% or less for each quarter in 2023. As discussed in the previous section, 2023 rates are improvements from 2021. The PI#10 rates were added as a discussion topic at the 45-day meetings. Detailed CRSP recidivism reports are requested at the end of each quarter. These reports ensure the CRSPs complete a thorough review of each recidivistic member. Financial incentives were offered for high performing CRSPs during FY2023. The threshold for eligibility was 10% or less for AMI and 5% or less for SED. Lastly, Performance Improvement Plans are also completed when CRSPs are above the 15% rate for a quarter.

- PI#10 – The adult rate was 11.58% for Q4, an increase of 3.07 percentage points from Q1's 7.51% rate.
- PI#10 – The adult rate was 16.09% for Q4, an increase of 1.40 percentage points from Q1's 14.69% rate.
- PI#10 – The total population rate was 15.68% for Q4, an increase of 1.65 percentage points from Q1's 14.03% rate.

Identified Barriers and Interventions

DWIHN met MDHHS' goals for PI#1 (psychiatric screening within 3 hours with disposition). It met PI#3 (follow-up service within 14 days of a completed Integrated Biopsychosocial) for all populations except IDD adults. There were no barriers or opportunities for improvement found at this time. DWIHN will continuously examine the data and identify/address any barriers that may arise.

The PI#3 IDD adult rate for 2023 was 83.38%. This 0.42 percentage points below the 83.80% goal. A low first quarter 2023 rate of 77.05% appeared to be a major factor in the final number. DWIHN's network was able to improve its rates for the rest of 2023 and the next three quarters' rates were all above 82.50%. These increases were positive signs of meeting the 83.80% goal in the future.

In 2022, DWIHN developed dashboards to measure and track the outcomes for evidence-based practices, which are tied to DWIHN value-based service models. These dashboards track incentives related to outcomes for several standards. As it relates to this project, the module measured performance indicators (PI#1, PI#2a, PI#3, PI#4a, and PI#10). CRSPs were able to view their data during all of 2023 in DWIHN's electronic health record system (MHWIN). Providers were also able to begin looking at their compliance rates at the end of 2022 in the "CRSP Risk Matrix" (Power BI Module). Since then, CRSPs began to use this module more frequently and help troubleshoot any discrepancies with the new module. DWIHN and CRSP agencies continue to collaborate to improve any issues with the system.

DWIHN's overall PI#2 compliance rate for all members was 48.38%. During all of 2023, DWIHN has dedicated extensive time and resources into improving its rates for PI#2 (completion of an Integrated Biopsychosocial within 14 days of request). While the total rates remain below the future MDHHS' benchmarks, DWIHN did see improvements in the rates for all its populations and total from Q1 2023 to Q4 2023 (5.25 percentage point increase). This increase provides support that some of the barriers that were identified during the second half of FY2022 were accurate. The complexity of the 2022 barriers continued to be challenges in 2023.

Barriers, interventions, and best practices were discussed with 19 CRSPs every 45 days for 2023. These meetings included DWIHN departments (Quality, Managed Care Operations, Integrated Health Care, and Access Center) as well as CRSP leaders. Performance Indicator rates and a variety of other topics, such as CRSP monthly capacity forms, were discussed at each of these meetings. The most common topic for the year was staff shortages and lack of appointments.

The staff shortages have affected DWIHN's child populations the most. The State of Michigan's MI child rate dropped from 54.88% in Q1 2022 to 46.20% in Q3 2023 (8.68 percentage point decrease over a 21-month span). The IDD child rate decreased from 62.40% in Q1 2022 to 46.68% in Q3 2023 (15.72 percentage point decrease over a 21-month span). Like many other industries experiencing staff shortages, CRSPs continue to report that this remains its biggest hurdle to improving this standard. In addition to staff leaving the field, the Michigan school system positions have increased their salaries due to receiving additional funding from the state of Michigan as well as offering a summer break. DWIHN has also lost staff to private practice therapy companies, who can offer high pay, flexible scheduling, minimal paperwork, and work from home options. Additionally, these companies can also now hire staff with limited licensure, a change from years' past. This shortage caused some CRSPs to temporarily pause accepting new members. In turn, other agencies are overwhelmed with more new requests. This strain on the network has caused some members to get a first intake appointment scheduled for 30-60 days from their initial screening, thus not having any chance at being seen within 14 days of request. This has also been reflected in the number of appointments that are scheduled outside of the 14-day time frame. It has also been seen in the number of members seen outside of the 14 days. DWIHN explored increasing base salary pay for children's staff to assist with the low child rates but were unable to make increase due to union status complications.

Financial incentives for high performing CRSPs continued for PI#2a, PI#3, PI#4a and PI#10. DWIHN's SED and AMI populations were eligible for this financial incentive in 2022. The IDD population was added in 2023 to improve IDD rates for PI#2 and PI#3 and assist IDD providers. A change was also made to adjust the rate calculation to remove cases where it was not the CRSP's fault that a member was not seen within 14 days. This helped CRSPs become eligible for the 10 payments mentioned below. DWIHN's Finance, Quality, Access Center and Crisis and Access team met on 9/14/23, 10/12/23, 10/19/23, 10/26/23. The team discussed the lowering of the eligibility criteria more to make the incentives more realistic. The hope is that this will provide more funding throughout the network in 2024. For the first three quarters of 2023, the following financial incentives were paid out to the network (4th Quarter payments will be paid in March 2024). These incentives were aimed at improving the staff shortages and improving the quality of care.

- PI#2 MI adults- 0 payments and $0
- PI#2 MI children- 3 payments totaling $7,604.
- PI#2 IDD- 10 payments totaling $270,913.

- PI#3 MI adults- 10 payments totaling $197,403.
- P#3 MI children- 5 payments totaling $85,379.
- PI#3 IDD- 17 payments totaling $327,902.

DWIHN's Children's Initiatives department has taken steps to address and improve coordination of care among DWIHN, the hospital and the CRSP. DWIHN's Children's Director reported five providers are moving forward in the Request for Proposal to become CRSPs in 2024. The optimism is that this will assist in addressing some of the staffing challenges throughout the network. Lastly, the Children's Initiative team has added this topic to their 2024 January Children's Provider meeting agenda.

A new intervention to try and address transportation issues began in 2023. DWIHN contracted with two providers to offer transportation to members throughout the network for non-emergency transportation services. Requests must be made within 48 hours advance notice and appointments include Physician appointments, Outpatient Behavioral Health appointments, and post hospital discharge appointments. This took effect during the 4th quarter of 2023. An official memo was sent in October 2023.

Efforts to decrease hospital admissions and readmissions have continued to be a challenge. DWIHN seeks to reduce psychiatric inpatient admissions and provide safe, timely, appropriate, and high-quality treatment alternatives while still ensuring members receive the appropriate required care. DWIHN continues its efforts to expand the comprehensive continuum of crisis services, support, and improve care delivery. Rates continue to decrease slightly from quarter to quarter. The 15.44% rate for 2023 showed continued progress from the 2021 rate of 16.20%. DWIHN's Crisis Care Center is expected to open in 2024. There is hope that this will improve DWIHN's coordination of care and relieve some of the challenges from the past experienced throughout the network.

Opportunities for Improvement

DWIHN will continue to monitor and focus its efforts on some of the following identified interventions:

- Address staff shortages throughout its network to ensure members can receive services within the appropriate timeframes.
- Continue to work with DWIHN's Crisis Team to identify potential delays in care for PI#1. Its new Crisis Care Center could improve this indicator as well as the coordination of care throughout the network.
- Work on expansion of "Med Drop" Program to improve outpatient compliance with goals to decrease need for higher level of care inpatient hospitalizations.
- Continue engagement and collaboration with members' outpatient (CRSP) providers to ensure continuity of care and when members present to the ED in crisis but may not require hospitalization.
- Properly navigate and divert members to the appropriate type of service and level of care.
- Provide referrals to Complex Case Management (CCM) for members with high behavioral needs.
- Continue coordination and collaboration with crisis screeners on measures to decrease inpatient admission.
- Improve education and coordination with hospitals regarding DWIHN's initiatives and goals.
- Hospital, DWIHN and CRSP improve accuracy of member's contact information. Incorrect or outdated contact information continued to be a frequent topic throughout FY2023.
- Educate network on new transportation companies and increase usage of program.
- Meet and discuss financial incentives and provide a higher payout.
- Review CRSPs and hopefully, increase the number of children's CRSPs/network capacity.

Timeliness of Utilization Management

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

Quantitative Analysis and Trending of Measures

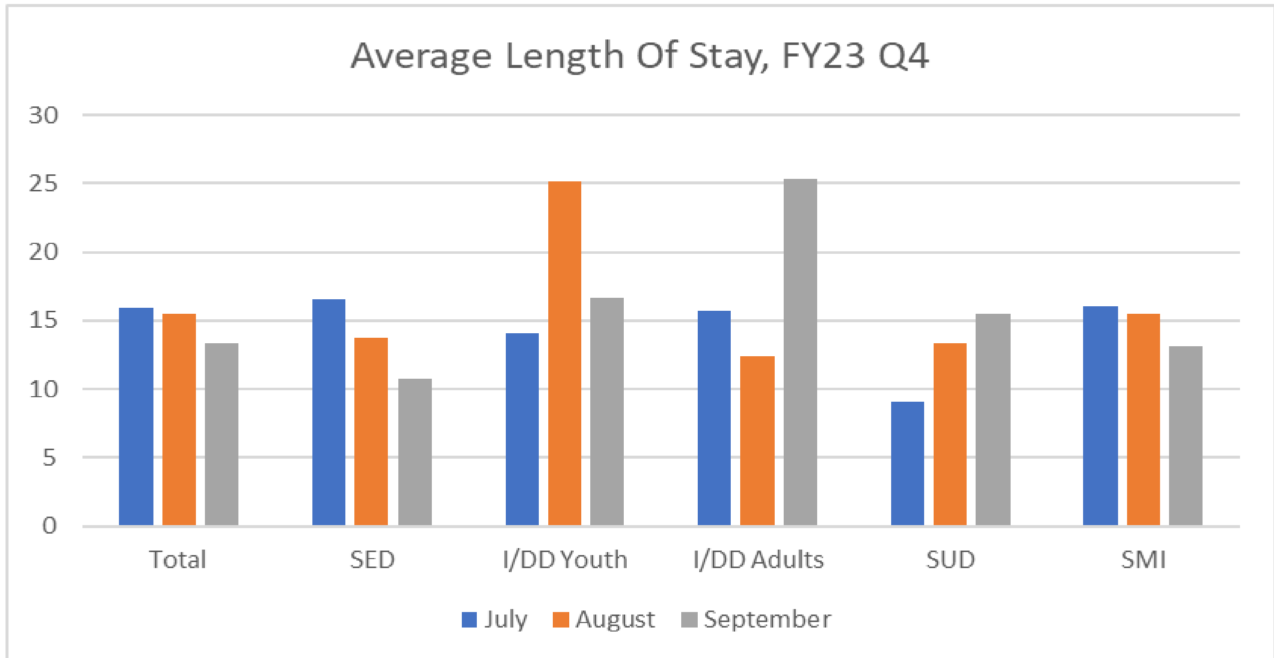
The chart below indicates the trend of unique members served each month during FY2023. Accomplishment of a 98% enrollment rate for our HSW Program, the highest rate of enrollment since January 2020. This means that members who need Habilitation Supports in addition to their regular State Plan Services, are now educated on the Waiver program and able to access those supports.

Fiscal Year to Date												
	Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	Aug	Sept
Total Slots	1084	1084	1084	1084	1084	1084	1084	1084	1084	1084	1084	1084
Used	1009	1009	1008	1007	1007	1005	1015	1019	1026	1029	1037	1054
Available	76	76	76	77	77	79	69	65	58	55	47	30
New Enrollments	9	5	6	2	7	6	13	11	13	17	16	22
Disenrollments	4	8	4	8	8	3	4	6	7	6	5	2
Utilization	93%	93.1%	93%	92.9%	92.9%	92.7%	93.6%	94%	94.6%	94.9%	95.8%	97.2%

- Collaboration with the Residential Department regarding developing discharge plans for members with complex needs.
- Collaboration with the Crisis Services Department regarding developing a discharge plan process flow for members who have had an Inpatient Psychiatric Hospitalization.
- Participated in interdepartmental focus groups to address the notification of CRSP providers when members present to the ERs and/or admissions and discharges, ensuring members are scheduled for timely discharge appointments, managing ACT referrals, increased use and implementation of Assisted Outpatient Treatment orders and utilization of SUD services.
- Cross-training on outpatient service authorization requests including the Autism Benefits

Hospitalization

While inpatient psychiatric services may be necessary to support members who find themselves in crisis, we also recognize the importance of supporting our members in the community, in the least restrictive environments possible. To decrease length of stay and the number of hospital admissions, and to improve the supports available within the community, the UM department conducts regular case conferences with the physician consultant to review cases with lengths of stay greater than 14 days. Additionally, UM continues its interdepartmental collaboration with Crisis Services, Residential and Integrated Care to develop comprehensive plans to support our members in reaching their goals once they are discharged from the hospital setting.



Alternative Levels of Care

There are several alternative levels of care that can be utilized to support our members within the community, without necessitating inpatient psychiatric hospitalization. Crisis Residential Units provide a short-term alternative to inpatient psychiatric services for individuals experiencing an acute psychiatric crisis. Services are designed for a subset of individuals who meet psychiatric inpatient admission criteria or are at risk of admission, but who can be appropriately served in settings less intensive than a hospital. This level of care has continued to be an integral part of our treatment and service provision to our members.

Partial Hospital is another cost-effective alternative to inpatient hospitalization, as clinically appropriate. It offers a structured treatment setting, inclusive of individual and group therapy, psychoeducation, skill-building practice, and periodic evaluations but allows for the individual to return home at the end of the program day. The UM Department also provides clinical review and authorization for outpatient mental health services, Outpatient I/DD Services, Outpatient Autism Services, and Substance Use Disorder Services.

Opportunities for Improvement

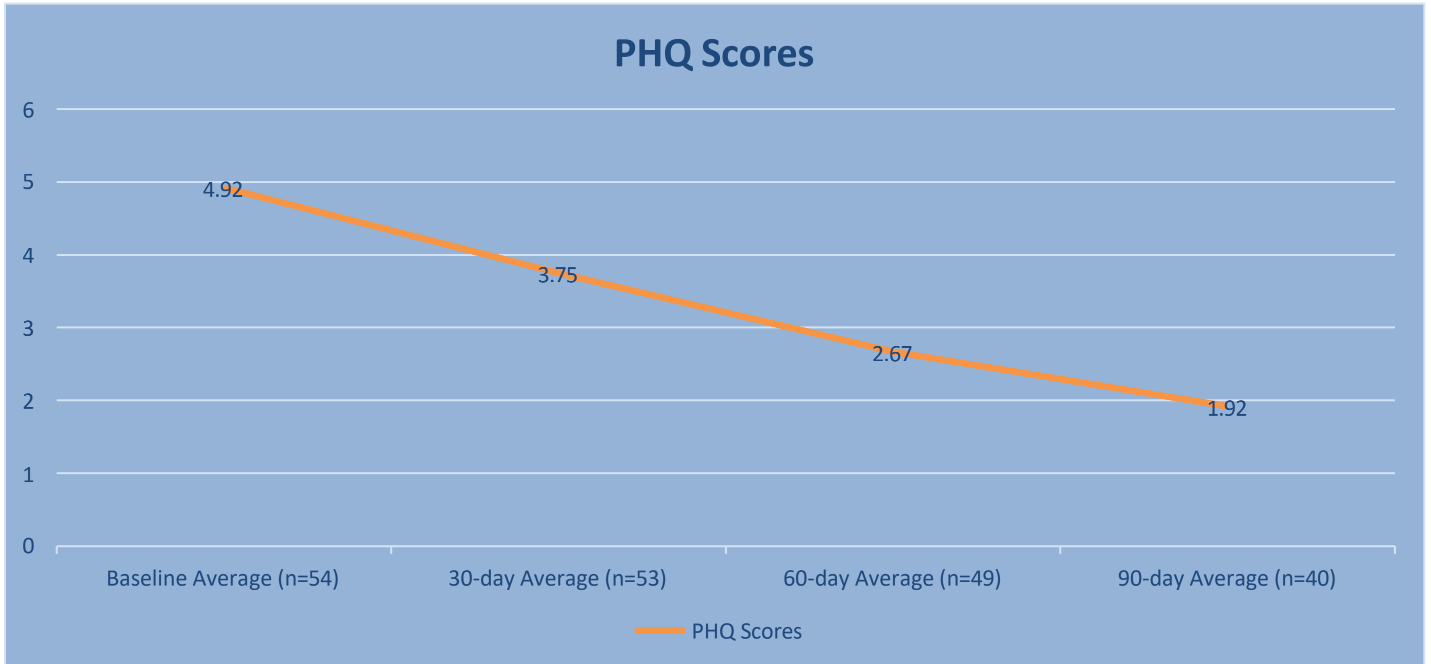
- Implementation of ongoing Authorization, Code, and Modifier training for Provider Network
- Continued implementation of updates to current processes and procedures that reflect 42 CFR requirements including oral notification of members, use of extension letters for decision timeframes, updated language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

Complex Case Management (CCM)

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

Qualitative Analysis and Trending of Measures

In FY2023, 74 members were enrolled in CCM services, a decrease of 11 from FY22. 55 members were enrolled in CCM for at least 60 days and 55 members were enrolled in CCM for at least 90 days during FY2023, a decrease of 11 from FY22. During FY2023, information was gathered to identify member rates of symptoms of depression. Depression symptoms were measured using the Patient Health Questionnaire (PHQ-9) for adults (18 and older) and Patient Health Questionnaire – Adolescent (PHQ-A) for children (under 18). The PHQ assessments are embedded in the CCM assessments for adults and children and are completed when the assessment is completed at the start of CCM services and every 30 days thereafter until CCM services end. The higher the score on the PHQ-9/PHQ-A, the greater the symptoms of depression are present. A decrease in PHQ score indicates an improvement in symptoms of depression. PHQ scores were gathered from the CCM assessments that were completed at the start of CCM services and at 30, 60 and 90 days after starting CCM services. PHQ scores were evaluated for members at closure who were open for at least 90 days in the CCM Program during FY 23. Members PHQ baseline scores ranged from 0 to 12, with an average score of 4.92. Members participating in Complex Case Management services demonstrated overall improvement in their PHQ scores, and the improvement increased the longer that the members participated in CCM services. Average PHQ scores improved 24% from baseline at 30 days, 28% at 60 days and 28% at 90 days of receiving CCM services.



Evaluation of Effectiveness

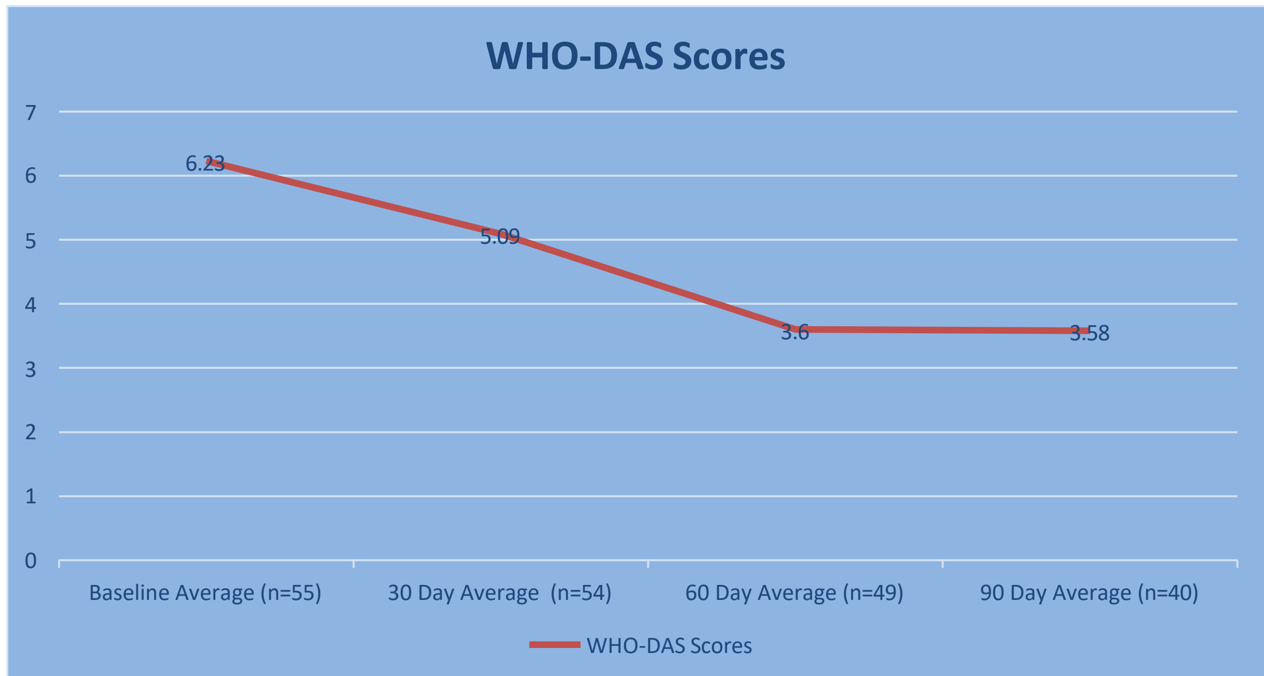
54 out of 63 members were included in the denominator for the baseline PHQ scores. 1 member was not included in the denominator due to being under the recommended age for PHQ assessments, per recommendations PHQ assessments are suitable for ages 11 and above. 8 members were not included in the denominator due to a case not being opened for 90 days. 16 member cases were active at and after the end of FY2023 (after 9/30/2023). 4 members were not included in the denominator due to having inconsistent assessments. 33/35 members (94%) met the goal of having a 10% improvement in PHQ scores from the start of CCM services to closure of CCM services.

Causal Analysis

Although we met and exceeded our goal of an overall 10% improvement in PHQ scores, we will continue to monitor this measure in 2024 with a goal increase to 20%. We will continue to assess if the improvement has been consistent over a sufficient time to either significantly increase the goal or retire this goal. Overall members who stayed in CCM even for just 30 days saw a significant improvement in their scores. There was a 38% improvement in 90-day PHQ scores from FY2023 in comparison to 90-day PHQ scores in FY2022. We are evaluating interventions that can continue to help us achieve our goal. Out of 35 members, 33 members showed an improvement and had an increase in PHQ scores from baseline to the time that CCM services ended. Two member scores remained the same and showed no change. The interventions that we believe helped us to meet and exceed our goal were connecting members to behavioral health providers, assisting with appointment scheduling, and assisting with arranging transportation as needed. To continue to promote an improvement in PHQ scores, CCM will review, and update Crisis Plans with members and existing care team after hospitalization and will also encourage a connection with Members and Peer Support Specialists as an added support in 2024.

WHO DAS Scores

During Fiscal Year 2023, information was gathered to assess member quality of life using the World Health Organization's Disability Assessment Schedule (WHO-DAS). The WHO-DAS assessment is embedded in the CCM assessment and is completed when the assessment is completed at the start of CCM services and every 30 days thereafter until CCM services end. The higher the score on the WHO-DAS, the greater the level of disability. The WHO-DAS assesses six domains: cognition, mobility, self-care, getting along with others, life activities and participation. Practitioners must be trained to administer this assessment. A decrease in WHO-DAS score indicates an improvement in the level of disability. WHO-DAS scores were gathered from the CCM assessments that were completed at the start of CCM services and at 30, 60 and 90 days after starting CCM services. WHO-DAS scores were evaluated at closure for members who were open for at least 90 days in the CCM Program. Members WHO-DAS baseline scores ranged from 1 to 32, with an average score of 6.23. Members participating in Complex Case Management services demonstrated overall improvement in their WHO-DAS scores, and the improvement increased the longer that the members participated in CCM services. Average WHO-DAS scores showed improvement from baseline to 30 days of receiving CCM services. Average WHO-DAS scores improved 18% from baseline at 30 days, 29% at 60 days and .5% at 90 days of participating in CCM services.

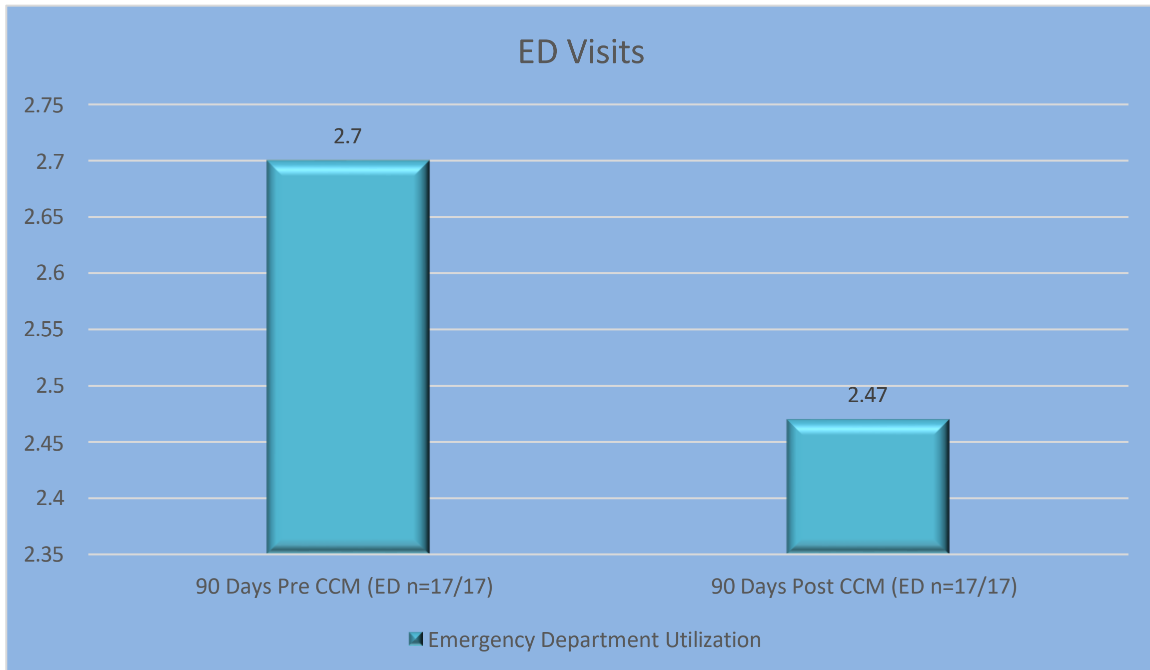


Evaluation of Effectiveness
55 out of 63 members were included in the denominator for the baseline WHO-DAS scores. 8 members were not included in the denominator due to cases not being opened for 90 days. 16 member cases were active at and after the end of FY2023 (after 9/30/2023). 4 members were not included in the denominator due to having inconsistent assessments. 32/35 members (91%) met the goal of having a 10% improvement in WHO-DAS scores from the start of CCM services to closure of CCM services.

The averages of members initial WHO-DAS scores were also evaluated with their 30 day WHO-DAS scores to see if there was any improvement within the first 30 days of starting CCM Services. 54 out of 63 members were included in the denominator for WHO-DAS scores. 8 members were not included in the denominator due to a case not being opened for 90 days. The average decreased from baseline to 30-days, showing an improvement in WHO-DAS scores within the first 30 days of starting CCM Services (Table 4).

Causal Analysis
Although we met and exceeded our goal of an overall 10% improvement in WHO-DAS scores, we will continue to monitor this measure in FY2024 with a goal increase to 20%. We will continue to assess if to see if the improvements are consistent over a long period of time and whether the goal will be increased, changed, or retired. We are seeing a correlation between the time in CCM and a decrease in WHO-DAS score and that members had to be in CCM at least 60 days to achieve our current goal. We are evaluating interventions that could help us to continue to achieve our goal in 2024. There was a 45% improvement in 90-day WHO-DAS scores from FY2023 in comparison to 90-day WHO-DAS scores in FY2022. Out of 35 members, 32 members showed an improvement in WHO-DAS scores from baseline to the time that CCM services were ended. One member’s score remained the same and showed no change. Two members showed a decrease in scores, one member had the barrier of medication compliance and inconsistencies in visits. The other member had inconsistencies in living residences and hospitalizations. Interventions that helped in reaching our goal were assisting members with obtaining services in their home and community as needed and encouraging participation in activities outside of the home. To promote an improvement in member WHO-DAS scores, CCM will continue to discuss added support in the home with members. If a member shows a consistent increase in WHO-DAS scores, CCM will assess and assist members with becoming established with added home support such as Physical Therapy, CLS Services, Occupational Therapy, and Adaptive Aids (Durable Medical Equipment). CCM will also assist with transitioning members to higher levels of care if a need is identified.

Emergency Department Utilization and Hospital Admissions
DWIHN analyzed member Admission, Discharge and Transfer (ADT) alerts and DWIHN claims data to measure utilization of Emergency Department and Hospital Admissions 90 days prior to participating in CCM services and 90 days after starting CCM services at closure in FY 2023. Members participating in CCM services showed an average 9% reduction in Emergency Department utilization from 90 days prior to 90 days after starting CCM services. Members had an average of 2.7 Emergency Department visits and 2.47 Emergency Department visits during the 90 days after starting CCM services.



Evaluation of Effectiveness

Out of 63 active cases, 16 members were not included in the denominator due to their CCM cases still being active and closing after October 2023 at the time of the review. 8 members were not included in the denominator due to their CCM cases not having been open for 60 days at the time of the review. 22 members were not included in the denominator due to not having any Emergency Department visits within 90 days prior to or 90 days after starting CCM services. 9/17 (53%) of members met the goal of experiencing a 10% decrease in the number of Emergency Department visits from 90 days prior to 90 days after starting CCM services. 2 members showed no changes in ED visits and 6 members showed an increase in ED visits.

Out of 63 active cases, 16 members were not included in the denominator due to their CCM cases still being active and closing after October 2023 at the time of the review. 8 members were not included in the denominator due to their CCM cases not having been open for 60 days at the time of the review. 38 members did not have any inpatient hospitalizations. Only 1-member experienced hospitalization within 90 days of starting CCM services. Inpatient admits could not be evaluated for FY23 as a goal due to only one CCM member being hospitalized.

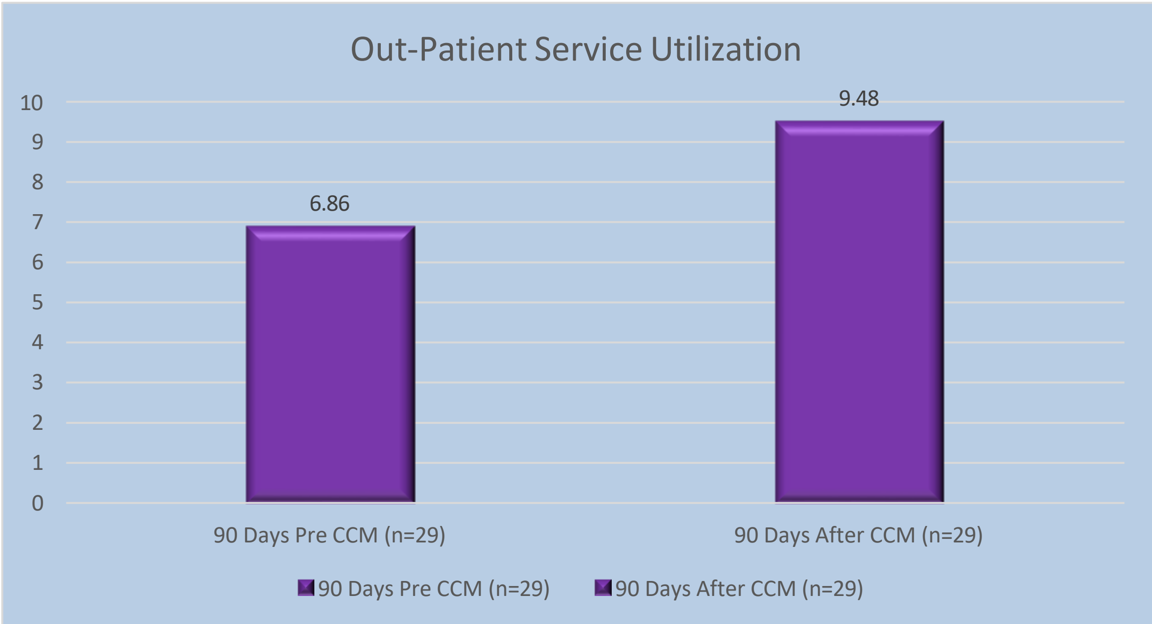
Causal Analysis

Although we did not make the 10% goal with Emergency Department Utilization, we are at 9%. 53% of our members experienced a decrease in Emergency Department visits during FY23. We will continue to monitor these measures in 2024 to see if we see improvements. Six members out of Seventeen experienced an increase in Emergency Department visits within 90 days prior to or 90 days after starting CCM services. Two members experienced no change in Emergency Department visits from 90 days prior to receiving CCM services to 90 days after starting CCM services. Only 1-member experienced hospitalization within 90 days of starting CCM services. We are evaluating interventions that could help us improve and achieve our goal. Interventions that we have employed are connecting members with behavioral health providers, assisting with appointment scheduling, and transition of care calls for members discharged from an inpatient admission. To promote a continued reduction of emergency room and inpatient admissions for members, CCM will review, and update Crisis Plans with members and existing care team after hospitalization.

CCM will continue to work with members to ensure members are receiving the appropriate community support and connect if higher levels of care are needed (ex ACT Programs, Home Health Care, or other Care Management). CCM will provide members, member's staff and/or family member with numbers to mobile crisis service units/crisis intervention services and provide education on how MCU's can provide support and possible deflection.

Utilization of Out-patient Services

DWIHN analyzed members claims data for out-patient behavioral health service utilization 90 days prior to participating in CCM services and 90 days after starting CCM services for members who were enrolled in CCM for at least 60 days or more at closure. The average number of out-patient behavioral health services during the 90 days prior to CCM services was 6.86 and the average number of out-patient behavioral health services after starting CCM services was 9.48, which amounts to a 38% increase in out-patient services utilization in the 90 days post CCM closure.



Evaluation of Effectiveness

29 members were included in the average for out-patient behavioral health services for 90 days prior to CCM services and 90 days after CCM services due to being enrolled in CCM for at least 60 days or more at closure. 8 members were not included in the average due to their CCM cases not having been open for 60 days at the time of the review. 15 members were not included in the average due to their CCM cases not being closed for 90 days at the time of the review. 11 members were not included in the average due to their CCM cases still being active and closing after October 2023 at the time of the review. 20/29 (69%) of members met the goal of a 10% increase in out-patient behavioral health services from 90 days prior to 90 days after starting CCM services and an overall 72% increase in out-patient health services from 90 days prior to 90 days after starting CCM services. 3 members had no changes in which the same number of out-patient behavioral health appointments were attended 90 days prior to 90 days after starting CCM services. 6 members experienced a decrease in the number of out-patient behavioral health services from 90 days prior to 90 days after starting CCM services.

DWIHN also measured the number of members who attended two out-patient behavioral health services within 60 days of starting CCM services who were in CCM for at least 60 days and closed by October 2023. Out of 44 members that were available to participate in 2 out-patient services after starting CCM services and were in CCM for at least 60 days, 41 members (93%) attended two or more out-patient behavioral health services within 60 days of starting CCM services. 8 members were not included in this measure due to not being enrolled in CCM services for 60 days at the time of the report. 11 members were not included in the denominator due to their CCM cases still being active and closing after October 2023 at the time of the review.

DWIHN also measured the number of members who attended two out-patient behavioral health services within 60 days of the closure of CCM services. Out of 36 members that were available to participate in 2 out-patient services after CCM case closure, 26 members (72%) attended two or more out-patient behavioral health services within 60 days of CCM case closure. 8 members were not included in this measure due to not being enrolled in CCM services for 60 days at the time of the report. 8 members were not included due to cases not being closed for at least 60 days at the time of review. 11 members were not included in the denominator due to their CCM cases still being active and closing after October 2023 at the time of the review.

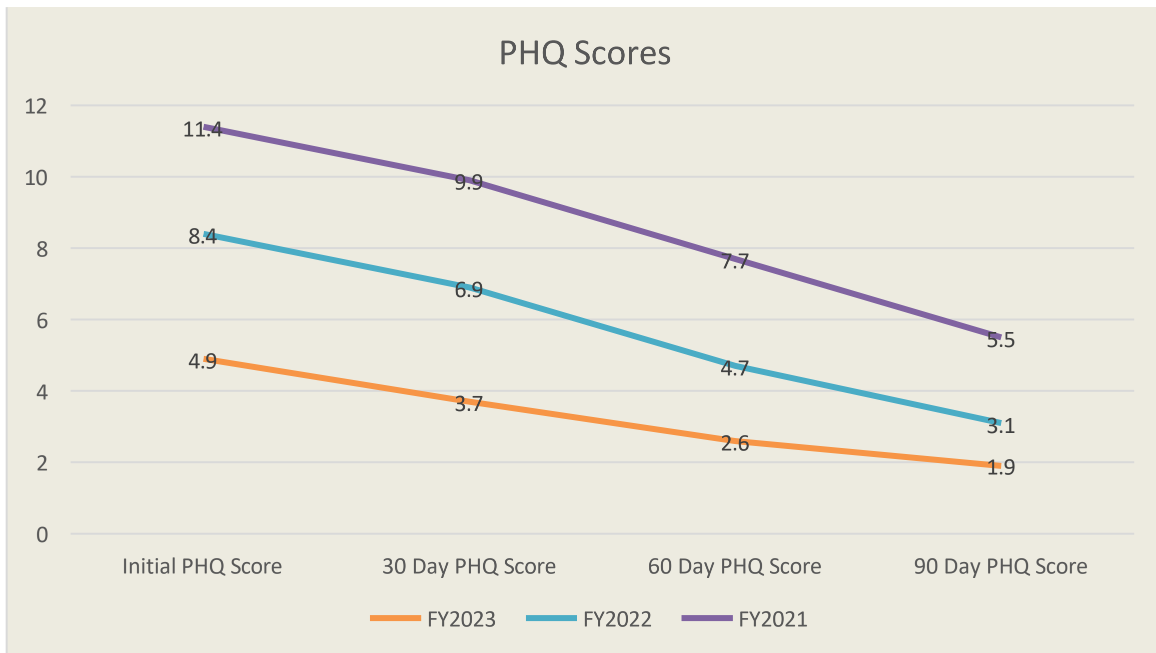
Causal Analysis

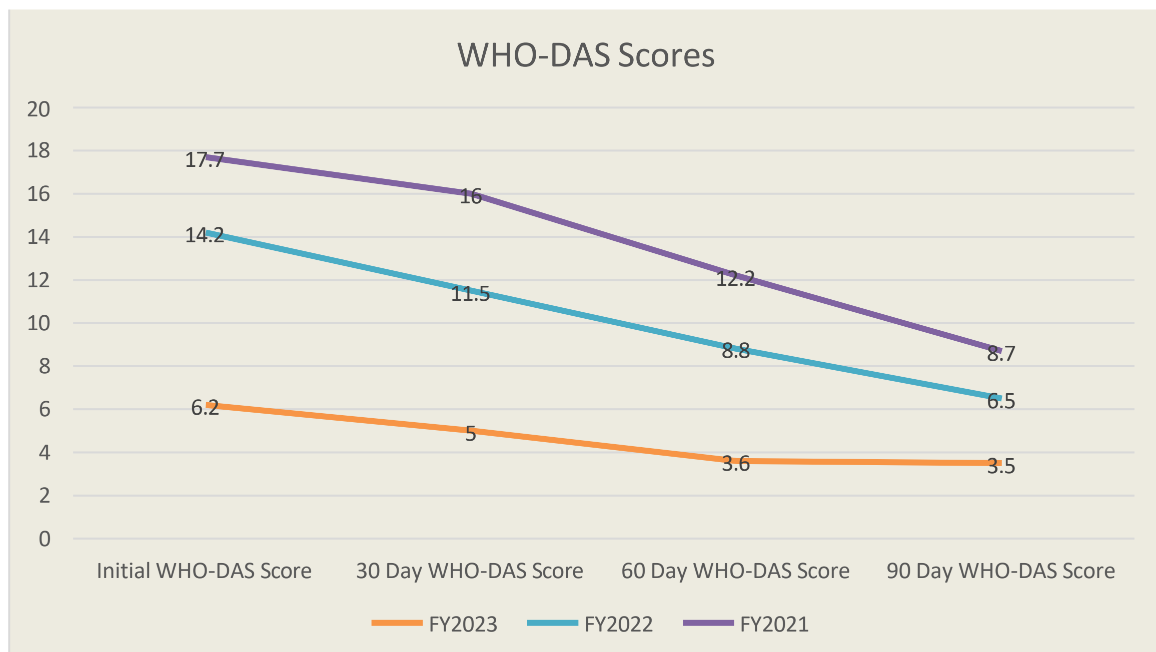
For FY23, we meet the goal of an overall 10% improvement in Outpatient Behavioral Health Visit attendance. Since this is a newer goal, we will continue to monitor this measure in 2024. Comparing FY 2022 data with FY 2023 data there was a 1.5% decrease in this measure. 6 out of 29 members experienced a decrease in Outpatient visits within 90 days prior to or 90 days after starting CCM services. 3 members experienced no change in Outpatient visits from 90 days prior to receiving CCM services to 90 days after starting CCM services.

DWIHN exceeded our goal of 10% increase in participation of two or more behavioral health services within 60 days of starting CCM services. As this was a new measure that was created in FY2021, we will continue to monitor this measure in FY 2024. 3 out of 44 members did not make the goal of attending two or more Outpatient visits within the first 60 days after starting CCM services. Some interventions that were utilized in FY2023 is to continue to address barriers to attendance but to do this at each discussion with member and to ensure that the provider is meeting the needs of the member and is a good match for the member and that it is emphasized with member how important attending Outpatient Appointments are in overall care. We will also continue connecting with Behavioral Health Service Providers, providing reminders to members and assistance with arranging transportation when needed. CCM also provides education to members on the importance of attending aftercare appointments 2-3 weeks post CCM closure. CCM also works with members and providers to schedule the next few appointments to improve aftercare attendance.

Qualitative Analysis and Trending of Measures

The results of the FY2023 analysis of CCM services can be compared to the results of analysis completed for FY2022 and FY2021. Comparisons can be made in the areas of PHQ scores, WHO-DAS scores, hospital admissions, behavioral health engagement, and Satisfaction Survey results. The PHQ and WHO-DAS scores were lower than PHQ and WHO-DAS scores at baseline, 30 days, and 60 days after starting CCM services in FY2023 compared to the previous fiscal years. PHQ and WHO-DAS score averages consistently declined the longer members participated in CCM services for all three fiscal years. Overall, members have consistently reported high levels of satisfaction with the CCM program. The rates of return of completed Satisfaction Survey increased in FY23 (88%), being the highest of the previous fiscal years. In FY22 the return rate was 55% and 38% in FY21.





Identified Barriers

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

- Provider incentives were offered across the Network to help with staffing.
- Increased Provider Reimbursement for services
- Added stability payments to Providers.
- Increasing Provider Network
- The Director of Integrated Care meets with Providers across the network to review Hospital Readmits, FUH 30, and Michigan Based Performance Indicators 7- & 14-day appointment measures
- DWIHN Social Worker works with the Detroit Police Department to provide Crisis education to staff and handle non-violent crisis calls.
- DWIHN is opening a new Crisis Center towards the end of 2023 to provide crisis intervention to members and reduce Emergency Department Utilization and Inpatient admits.
- Launching an Adult Mobile Crisis Unit to provide crisis intervention for reduction in emergency department visits and inpatient admits.

Opportunities for Improvement

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

- Improve medical and/or behavioral health concerns and increase overall functional status as well as improve overall quality of life as evidenced by an overall 10% improvement in PHQ scores and an overall 10% improvement in WHO-DAS scores at CCM closure for members enrolled for at least 90 days.
- To provide early intervention for members appropriate for Complex Case Management to prevent recurrent crisis or unnecessary hospitalizations as evidenced by an overall 10% reduction in Emergency Department (ED) utilization and an overall 10% reduction in hospital admissions from 90 days prior to receiving CCM services to 90 days after receiving CCM services for members at closure who were enrolled for at least 60 days.
- Increased participation in attending out-patient appointments as evidenced by an overall 10% increase in out-patient behavioral health services from 90 days prior to receiving CCM services to 90 days after receiving CCM services for members at closure who were enrolled for at least 60 days.
- Improve participation in the number of members who attended two out-patient behavioral health services within 60 days of starting CCM services who were open for at least 60 days and closed as of October 2023 as evidenced by an overall 10% increase in participation.
- 80% or greater member satisfaction scores for members at closure who have received CCM services.
- Educate members on the importance of familiarization with crisis plans and becoming more knowledgeable of managing conditions.
- Worked with members to address barriers of attending appointments.
- Care Coordinators completed transition of care calls to members to encourage FUH appointment attendance and ensure needs were met. Care Coordinators also contacted members assigned Clinically Responsible Service Provider (CRSP) for increased coordination to improve member attendance for aftercare appointments. This will still be an area of focus in
- Increase members participation in Follow up after Hospitalization appointments as well as attendance for regular outpatient appointments. Reducing emergency department visits will continue to be an area of focus.

Access Call Center

In February 2021, DWIHN brought the Access Call Center in-house to streamline the process of how Community Mental Health services are initially accessed in Wayne County. For almost three years, the Call Center has continued to provide the community with prompt, efficient services while treating individuals with dignity and respect. Staff works hard at maintaining required performance metrics, adhering to quality standards and regulatory compliance, and leveraging technology to enhance operational processes.
In FY 2023-2024, a new phone system will be implemented, improving the quality of services.

Qualitative Analysis and Trending of Measures

The data tables and descriptions below will give an overview of the Access Call Center performance for FY 22-23 and annual comparison of FY 21-22 to FY 22-23.

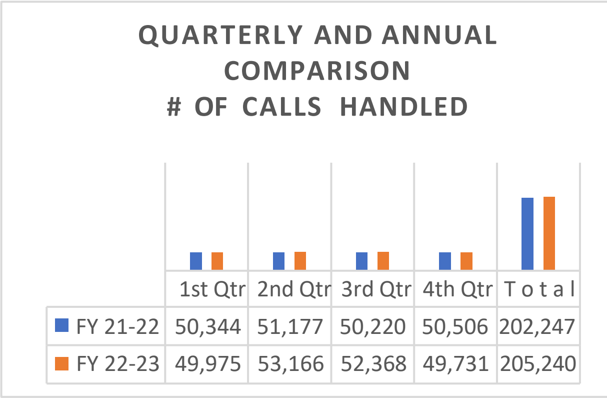
Fiscal Year	Queue	Incoming Calls	Calls Handled	% Calls Abandoned (Dropped, Disconnected, Hang Up)	Avg Speed to Answer	Avg Call Length	% of Calls Answered	Service Level
2022-2023	Call Reps	263,832	205,240	3.45%	:28 secs	4.57 mins	96.83%	82.73%
2021-2022	Call Reps	209,686	202,247	3.51%	:22 secs	4:52 mins	96.50%	84.9%

For FY 22-23, Mental Health (SMI, SED, I/DD, ABA) services, the Access Call Center scheduled a total of 14,091appointments with 1,691 scheduled outside of 14 days. For these populations there was an appointment availability of 88%. That means that 12% of those persons in our community calling for a MH intake appointment had to wait for an appointment or were scheduled outside of the 14 days for the original appointment or called back to change or reschedule their original appointment. For FY 21-22, Mental Health (SMI, SED, I/DD, ABA) services the Access Call Center scheduled a total of 14,721 appointments with 3,154 scheduled outside of 14 days. In a comparison of FY 21-22 to FY 22-2, there was an increase in appointment availability from 78% to 88%.

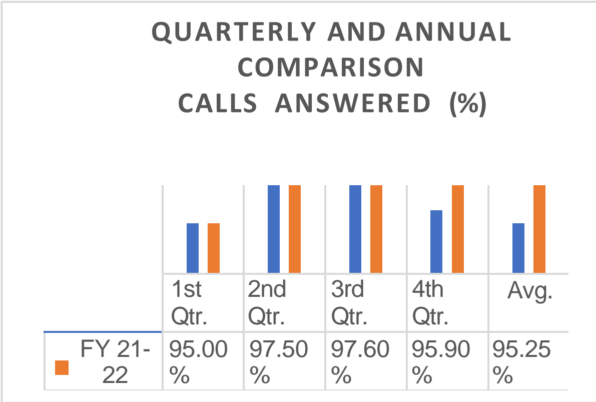
For FY 22-23, SUD Services, the Access Call Center scheduled a total of 17,046 appointments with 2,896 scheduled outside of 14 days. For this population there was an appointment availability of 83%. That means that 17% of those persons in our community calling for a SUD intake appointment had to wait for an appointment or were scheduled outside of the 14 days for the original appointment or called back to change or reschedule their original appointment. For FY 21-22, SUD services, 15,523 appointments were scheduled with 2,701 scheduled outside of 14 days. There was no change in the appointment availability from last year to this year, it remained 83% even though there was an increase in the number of appointments scheduled this year, by 1, 523 appointments.

For Hospital Discharge follow up appointments (9,195), 36% were scheduled outside of 7 days due to no provider availability at the time of request or rescheduling of the original appointment. The access call center experienced 64% appointment availability for Hospital Discharge appointments, occurring within 7 days of discharge. For FY 21-22, there were 8,711 hospital discharge appointments scheduled with 1,667 scheduled outside of 7 days. From last year to this year there was a decrease in appointment availability by 17%, with 81% availability in FY 21-22 to 64% availability in FY 22-23.

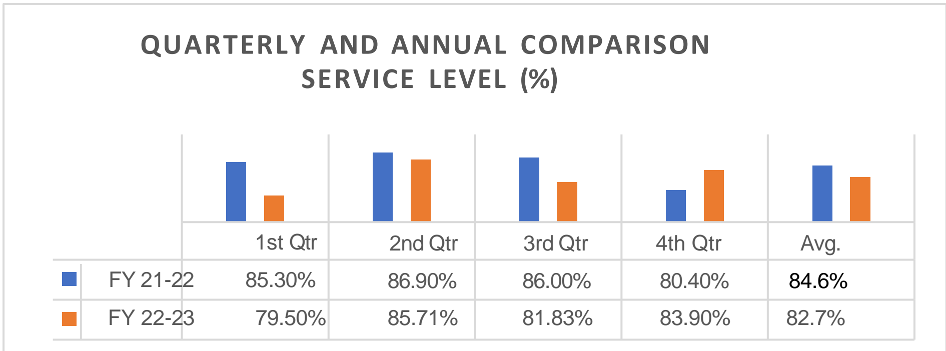
The following areas are monitored weekly to ensure that DWIHN Access Call Center meets MDHHS Standards. All standards were met for fiscal year 22-23: % Abandoned Goal is < 5% (3.45% - above standard), Avg. speed to answer Goal <30 sec. (:28 secs – above standard), % of calls answered Goal > 80% (96.83% - above standard), Service level Goal >80% (82.73% - above standard).



	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	Total
FY 21-22	50,344	51,177	50,220	50,506	202,247
FY 22-23	49,975	53,166	52,368	49,731	205,240



	1st Qtr.	2nd Qtr.	3rd Qtr.	4th Qtr.	Avg.
FY 21-22	95.00 %	97.50 %	97.60 %	95.90 %	95.25 %



	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	Avg.
FY 21-22	85.30%	86.90%	86.00%	80.40%	84.6%
FY 22-23	79.50%	85.71%	81.83%	83.90%	82.7%

Clinical Operations

DWHIN has continued to move our direct clinical care efforts forward by planning to establish Clinical Outpatient Services. This consists of multi-phased approach to providing integrated care in our Region. The first phase will be establishing Outpatient Services in co-located primary health care clinics throughout the County. DWIHN used heat mapping, member demographic data, and Medicaid Health Plan information to determine potential clinic partnerships. Based on this information, DWIHN provided outreach to twenty (20) primary health care clinics to gauge interest. To date, five clinics have expressed an initial interest in a co-location partnership. These clinics are in the following areas: Detroit, Dearborn, Highland Park, and Southgate. Clinic services will include psychiatry, therapy, case management, and peer/recovery support services. This will align with the CCBHC model of service and assist in meetings demonstrated gaps in care. The next phase in the project plan will include the establishment of a stand-alone DWIHN Outpatient Clinic.

Health Homes are a supplementary comprehensive care coordination model for Medicaid beneficiaries with select diagnoses. The Opioid Health Home launched October 2021 and the Behavioral Health Home launched in May 2022. These services provide behavioral and physical health care coordination to treat the person holistically, and help people navigate the healthcare system. DWIHN continues to work at expanding our Health Home enrollment. To date, DWIHN's Opioid Health Home has 604 (Nov- 593) beneficiaries, and DWIHN's Behavioral Health Home has 674 (Nov- 628) beneficiaries. Recent Medicaid redeterminations have slowed our expansion efforts due to members 'loss of Medicaid and re-initiation of spend downs.

Certified Community Behavioral Health Clinic (CCBHC)

The CCBHC site provides coordinated, integrated, comprehensive services for all individuals diagnosed with a mental illness or substance use disorder. It focuses on increased access to care, 24/7/365 crisis response, and formal coordination with health care. CCBHC's incorporate Quality Based Performance Measures in the form of an incentive model. CCBHC are supported both on the national level and State level. This model is the future of behavioral health and DWIHN is currently planning for this change. Currently, DWIHN region has one CCBHC Demonstration site, The Guidance Center, who serves 3,412 individuals under this model. The State of Michigan announced its' expansion of the CCBHC State Demonstration sites, starting October 1, 2023. DWIHN was informed that six (6) providers applied for certification and five (5) providers were approved for certification (ACCESS, CNS Healthcare, Elmhurst Home, Development Centers, Southwest Counseling Solutions). DWIHN is working with these providers on the transition and launch of these services by providing technical assistance. It is estimated that 173,994 individuals are eligible for CCBHC services in region 7. MDHHS's goal is to have 26,099 individuals enrolled in CCBHC services in FY2024.

Crisis Services

The Crisis Services Department works to ensure access to care for members via DWIHN's full array of services within the Crisis Continuum Service System. In FY23, the Requests for service increased by 2% for adults and 4% for children as compared to last fiscal year. The diversion rates increased for both adults and children in FY23. This has been a direct result of the Crisis Services Department increasing communication between the provider network, DWIHN Liaisons, and the Clinically Responsible Service Providers (CRSP) to place members in the least restrictive environment. In FY23, the Inpatient admissions have increased by 9% for adults and 41% for children as compared to last fiscal year.

Recidivism to inpatient hospitalization remains an opportunity for improvement. In FY23, recidivism increased through Q3 in this fiscal year and has decreased in Q4. The Crisis Services team will continue to work with the CRSPs to require members be seen within 72 hours of admission to an inpatient level of care. The team will work with the CRSPs to forward member information to inpatient treatment teams upon member admission. The Crisis Services Department will also continue to improve working relationships with Access, UM, Adult and Children's Initiatives and Residential to coordinate member information in support of discharge planning. The team will require the screening agencies to notify the CRSP 90% of the time. The CRSP will be required to initiate no less than 5 attempts to re-engage members over the course of 60 days once a member is identified as recidivistic.

Crisis Care Center

Detroit Wayne Integrated Health Network Crisis Care Center is scheduled to open in the spring of 2024, in the heart of Detroit. This care center will offer a full array of children and adult crisis intervention and stabilization services in addition to fifteen (15) adult crisis residential beds. DWIHN will also open a regional integrated behavioral healthcare campus in Detroit in 2025, providing physical and behavioral healthcare to the surrounding communities and counties. There are also plans to open a third crisis center in the downriver area. We will continue placing special emphasis on children, as we look to the future on how to better serve children and families through innovation, technology, and community engagement.

Downriver Care Center

Plans are underway to open a third DWIHN Care Center in the downriver area. The Facilities Department developed specific criteria and project budget information related to the needs of the building DWIHN is currently working with a consultant real estate broker using criteria to locate and review potential properties.

Crisis Mobile Unit

Detroit Wayne Integrated Health Network launched the first phase of mobile crisis unit on December 18th, 2023. The mobile crisis unit serves anyone 18 years or older who is in Wayne County that may be experiencing either a mental health or substance use crisis. Currently, as of 1/18/2024, the mobile crisis team operates Monday – Friday, 7am-3pm. There are currently four units that operate during this time. Each unit is staffed by two team members, a licensed clinician, and a peer support specialist/peer recovery coach. We have received 14 dispatches over the last 30 days. On January 16, 2024, Detroit Wayne Integrated Health Network applied for children's designation and is awaiting MDHHS's decision. If granted, phase 2, will be launched that will include children's services and weekend hours. The goal is to have four units, 24/7/365, for children and adults by Summer 2024.

Quality Pillar

Provider Network

DWIHN provides services in coordination and collaboration with over four hundred (400) providers and contractors. On an annual basis the performance monitoring staff conduct provider reviews to ensure the safety and wellness of all persons served. Quality Improvement (QI) staff monitor compliance with federal and state regulations including MI Health Link demonstration project, through a process that may include a combination of desk and/or on-site reviews, verification activities and claims verification. When necessary other oversight and compliance enforcement strategies are enacted to improve quality outcomes and minimize risk. CMHSP organizations and SUD Providers that are unable to demonstrate acceptable performance may be subject to additional oversight and intervention.

Quantitative Analysis and Trending of Measures

During FY2023, a total of 63 network providers were reviewed by the Quality Department. These reviews consisted of administrative, case records, and comprehensive staff reviews. The completed reviews were inclusive of the Clinically Responsible Service Providers (CRSP), and Substance Abuse Disorder (SUD) treatment and prevention providers. Additional reviews occurred with 16 Autism providers, 79 B3/(i)SPA providers, and 9 inpatient hospital settings. Plans of correction were required for providers with review scores less than 95%. Follow-up validation reviews were completed on those providers to ensure the implementation of the plan. Monitoring of trends and practices to improve quality outcomes was also exhibited through CRSP self-monitoring audits. Data from these provider self-reviews were analyzed on a quarterly basis by performance monitoring staff and consultation was provided as needed.

CRSP Providers were found to have strong documentation supporting the implementation of the person-centered planning process, including thorough assessments of members' supports and needs. This year saw an improvement in the development of "SMART" goals, plans being written in the language of the member / family, the inclusion of the specific amount, scope, frequency, & duration of supports and services, and the documentation of the member/legal representative's satisfaction. However, this area remains an area for improvement along with coordination of care. Lastly, the documentation necessary to demonstrate compliance with the Home and Community Based (HCBS) Final Rule was found to be an area for improvement.

CRSP Self-monitoring Audits

Monitoring of trends and practices to improve quality outcomes was also exhibited through CRSP self-monitoring audits. Data from these provider self-reviews were analyzed on a quarterly basis by performance monitoring staff and consultation was provided as needed. In preparation for the 2024 MDHHS Waiver review, providers supporting members enrolled in the three waiver programs, Children's Waiver (CWP), Seriously Emotionally Disturbed Waver (SEDW), and the Habilitation Supports Waiver (HSW), were issued waiver cases to review. Results from the provider self-reviews are as follows:

- FY23 Quarter 1 the average combined score for 17 CRSP providers reviewing a total of 35 case records each, revealed a 94% compliant rate.
- FY23 Quarter 2 the average combined score for 18 CRSP providers reviewing a total of 35 case records each, revealed a 92% compliant rate.
- FY23 Quarter 3 the average combined score for 20 CRSP providers reviewing a total of 25 case records each, revealed a 92% compliant rate.
- FY23 Quarter 4 the average combined score for 18 CRSP providers reviewing a total of 25 case records each, revealed a 93% compliant rate.

Monitoring of B3/(i)SPA Service Providers

Monitoring of providers of B3/(i)SPA services occurs through the Medicaid claims verification process. This occurs twice a year and is a collaboration with the billing provider. It involves a detailed look at the documentation of the service claimed, as well as the staff's eligibility to provide the service. During FY 2023 there were 40 providers of B3/(i)SPA services consulted and 44 Medicaid claims audited which averaged 86%.

Home and Community Based Services (HCBS) Monitoring

During FY2023, monitoring of the Home and Community Based Services (HCBS) compliance occurred through two processes: Remediation and Validation of 2020 Survey responses and onsite Environmental reviews of residential service providers. The remediation and validation of the 2020 HCBS survey responses was an assignment issued by MDHHS. The process involved a collaboration with 81 Provider settings providing HCBS / (i)SPA services to 293 members. Upon completion of this project, evidence of remediation and / or validation of 4,100 survey responses was obtained to support compliance with the HCBS Final Rule.

Environmental reviews of residential providers are completed with existing providers and new settings seeking contracts with DWIHN. During FY2023, a total of 76 settings were reviewed and provisionally approved HCBS compliant. Of the 76 settings, 35 were new residential settings that received pre-operational reviews and 41 were existing settings that received a full Environmental Health and Safety review. Providers with findings inconsistent with the HCBS final rule and or with Compliance scores less than 95% were issued plans of correction. Follow-up reviews were completed within two weeks to ensure remediation and full HCB compliance.

Substance Abuse Disorder (SUD) Monitoring

Treatment Providers

During FY2023, 22 Treatment Providers were reviewed for various Levels of Care. A site visit was conducted at each provider setting to ensure cleanliness of the facility, required signage was posted, and to view areas where services (Individual, group, recreational, etc.) were being provided. Reviews were conducted both remotely and onsite and consisted of the following: Administrative Policies and Procedures, Case Record Reviews, and Staff Qualification Reviews. Findings from the Administrative Policies and Procedures resulted in an average score of 98%. A total of 224 clinical case records were reviewed with an average score of 89% and 214 staff files were reviewed with an average score of 97%. Corrective action plans for areas of deficiencies were issued to 19 providers. Follow up validation reviews are scheduled for the first quarter of FY2024.

Prevention Providers

During FY2023, 29 SUD Prevention providers received an annual site review to assess the effectiveness of Prevention Provider Program outcomes for reducing and preventing the incidence of substance abuse as well as to monitor compliance with laws, regulations and the provisions of contracts or grant agreements. In addition to program evaluation, the qualifications of 28 prevention staff were completed. The average program score across the network was 96% and the average staff score was 95%. 7 providers were issued plans of correction to address deficiencies. Follow up reviews were completed throughout the year to validate remediation.

Autism Services

In FY202, DWIHN QI staff conducted on-site and remote reviews of case records with 16 Autism / ABA providers to ensure compliance with regulatory requirements. The results from the review of 84 clinical records found an average score of 82%. In addition to clinical record reviews, 51 staff files of ABA services were completed with an average score of 91%. DWIHN has continued requiring provider quarterly self-reviews to assist with improvement efforts.

Verification of Services

Additional monitoring of network providers also included verification activities and Medicaid Claims Verification reviews. This process involved 229 providers, 1,707 individual claims randomly selected, and 1,707 staff delivering the service associated with the claim. Plans of correction were requested from 101 providers for 53% of the claims with verification scores below 95%.

Critical/Sentinel, Unexpected Deaths, and Risk Reporting

During FY 2022/2023, Critical/Sentinel Event training was provided for DWIHN's Clinically Responsible Provider (CRSP) Staff and Specialized Residential Providers. A total of 198 staff throughout the provider network participated in the training. All training was conducted via the webinar platform. In addition to this training, the QPIT (Quality Performance Improvement Team) provided on-going technical assistance supporting CRSPs in meeting Critical/Sentinel Event MDHHS reporting requirements.

The **Critical/Sentinel Event Guidance Manual** was revised based on NCQA, HSAG, ICO, and MDHHS changes for reporting in collaboration with **enhancements** made by the IT Department to streamline and improve the **MH-WIN Critical/Sentinel Event module**. Additions to the module included the ability to directly input Root Cause Analysis (RCA) reviews, and to track preventable/non-preventable events for Risk Management reviews. The **Sentinel Event Committee/Peer Review Committee** (SEC/PRC) was once again expanded adding more DWIHN department representatives closing the communication gap for risks to DWIHN members. SEC/PRC Committee can focus on issues impacting a particular department with the ability to allow for more expedient resolutions to the individual event and any systemic problem. During this fiscal year's HSAG audit the QPI section was very successful achieving compliance to all standards. Regular reporting to the ICO systems has been timely as well as the monthly meeting reviews which have met all requirements. This FY recommendations from QPIT reviews and committee meetings included:

- Piloting the CareAcademy training modules as part of the corrective action plan process. This will include the opportunity to directly assign staff involved in preventable events to specific training which certifies the updated instruction and testing of the staff. 500 slots have been included in this pilot which will also include the top seven (7) providers with repetitive sentinel events. QPIT will track the impact of the training in reducing severity and/or eliminating the issue through the staff enhanced training.
- QPIT will continue to work with the IT Department to upgrade the Critical/Sentinel Event module to swiftly notify DWIHN departments of significant risks reported by the CRSPs for all populations. Several modifications have already been implemented which demonstrate increased effectiveness with the integration of recommended improvements: and
- FY 2023/24 QPIT has re-established the role of the CRSP to secure Death Certificates for members given the smaller number of requests that would be made by the individual CRSP and their ability to secure copies within the 30-day MDHHS reporting timeframe.

Quantitative Analysis and Trending of Measures
In FY 2022/2023, the Quality Performance Improvement Team processed 1828 Critical/Sentinel Events again showing a decrease in reporting by 10% from the prior fiscal year. According to the team's analysis of reports submitted to other departments (Office of Recipient Rights in particular) there is a significant failure to report these events as required by Policy/Procedure and contract.

Reported data remained significantly the same across almost every category; however, the noticeable trend of low reporting rates particularly in areas of high risk (deaths) remains an area of focus. A high rate of deaths that occurred due to overdose (or suspected overdose), and those that occurred, and members had not been seen for more than 60 days. These two areas are trending rather high and sometimes attributable to inconsistent follow-up and re-engagement processes. Another causal factor identified is attributed to staff not being appropriately educated/trained on how to implement the plan of care. Both identified factors will be addressed in the piloting of the new program offered by the CareAcademy during the second quarter of FY 2023/2024.

Qualitative Five-Year Comparative Analysis of Data by Category

CATEGORY	FY 2022/23	FY 2021/2022	FY 2020/2021	FY 2019/2020	FY 2017/2018
ARREST	61	64	72	83	144
Behavior Treatment	73	88	61	NEW CATEGOGY FY 2020/2021	
Deaths	449	492	551	731	443
Environmental Emergencies	85	57	79	38	205
Injuries Requiring ER	177	177	227	259	673
Injuries Requiring Hospitalization	39	35	47	70	83
Medication Errors	20	14	16	27	172
Physical Illness Requiring ER	211	216	975	634	2188
Physical Illness Requiring Hospitalization	154	239	445	400	1107
Serious Challenging Behavior	455	437	609	815	1697
Administrative	104	96	77	173	361
TOTAL	1828	1915	3159	3230	7073

The significant decrease in events reported does not represent a significant decrease in events; however, it represents that within our provider network there is a significant decrease in the reporting of events. This is evidenced by QPIT teams expanded analysis of other MH-WIN systems identifying unreported hospitalizations, deaths, injuries, etc. The QPIT is working with other departments to address this "failure to report" issues within our provider network. The team continues to work toward collaboration both internally and externally to mitigate this systemic issue. DWIHN's IT Department staff are assisting in the development of a data pull program that will identify those contracted providers who are not reporting, and the team will then target training for those organizations/contractors.

Behavioral Treatment Review

The QAPIP quarterly reviews analyses of data from the Behavior Treatment Review Committee (BTRC) where intrusive or restrictive techniques have been approved for use with members and where physical management has been used in an emergency. The data 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 systemwide key indicators such as psychiatric hospitalization, behavior stabilization, and reductions or increases in the use of behavior treatment plans.

Quantitative Analysis and Trending of Measures

In FY23, DWIHN BTPRC reviewed 1,551 members on Behavior Treatment Plans, an increase of 56 (3.6%) from the previous year. The data below depicts all the use of intrusive and restrictive techniques, 911 calls/critical events and the use of medication per Individual receiving the intervention. The data below illustrates the BTAC Summary of Data Analysis FY23.

- New: 227
- Continued: 1,034
- Discontinued: 15
- Reported Psychotropic Medications: 4474
- Reported Anti-Psychotic Medications: 1710
- Restrictive Interventions: 1283
- Intrusive Interventions: 358
- 911 Calls: 222
- Sentinel Events: 81

Evaluation of Effectiveness

During FY 2022-2023, DWIHN BTAC staff provided technical assistance to the clinical teams of Community Living Services, Inc., Children's Center, The Guidance Center, Neighborhood Services Organization, Hegira Downriver, Gesher Human Service, Hope Network, Goodwill Industries, Henry Ford Health System, (Wyandotte) and Wayne Center on the Technical Requirements of Behavior Treatment Plan Review Committee (BTPRC) Processes.

- DWIHN is in full compliance with PIHP Administrative Review Procedures of Behavior Treatment (B.1) for the fifth consecutive year based on MDHHS Habilitative Supports Waiver 1915(c) Review findings. Similarly, based on the Health Services Advisory Group (HSAG) Review findings, DWIHN fully complies with the required elements for the BTPRCs.
- The Michigan Department of Health and Human Services (MDHHS) has recently updated the Technical Requirements for Behavior Treatment Plans. Compliance with the Technical Requirements is a contractual obligation of DWIHN to the MDHHS. DWIHN policy "Use of Behavior Treatment Plans in Community Mental Health Settings" and the ten attachments have been updated with effect from October 1, 2023. The BTAC staff offered a virtual technical assistance session via Zoom to update the network BTPRCs on September 18, 2023. The total number of participants was 150.
- DWIHN does not have the Functional Behavior Assessment (FBA) code for psychologists to use when they complete FBAs. The staff prepared the bulletin guidelines on the appropriate use of 97151 (Replacement of FA-H0031) for nonbeneficiaries of 1915(c) Waivers. The FBA bulletin has been published on DWIHN website and sent to the network providers.

- Furthermore, as a step towards continuous quality improvement, the network providers present their complex cases with serious challenging behaviors to the BTAC. During FY2022-2023, the network providers presented Thirteen (13) complex cases with severe behavior challenges to the BTAC.
- The BTPRC requirements remain in the Outpatient and Residential contract for FY 2022-2023.
- DWIHN submits quarterly data analysis reports to MDHHS on systemwide BTPRC trends.
- DWIHN BTAC staff has been reappointed to serve on the MDHHS Behavior Treatment Advisory Group for a fourth consecutive year.
- The BTAC staff provides systemwide consultation to the eighteen BTPRC providers, Performance Monitoring unit, and DWIHN departments and works with the SEC/PRC team and MH CRSPs on the Root Cause Analysis involving Behavior Treatment.

Trends and Patterns:
The required data of Behavior Treatment beneficiaries, including 911 Calls, Deaths, Emergency Treatment, and Use of Physical Management, is still under-reported. DWIHN continues to work with network providers to address this issue. Under-reporting of 911 calls and critical and sentinel events is an opportunity to improve the system. DWIHN continues to work with network providers to address this issue.

Identified Barriers:
The required data of Behavior Treatment beneficiaries, including 911 Calls, Deaths, Emergency Treatment, and Use of Physical Management, is still under-reported. DWIHN continues to work with network providers to address this issue.

- The network BTPRCs have an electronic health record system that is not patched with the DWIHN PCE system (MHWIN), and that is one of the barriers to improving the under-reporting of 911 calls and other reportable categories of the events.
- Reporting under the wrong category is one of the barriers. The Behavior Treatment category is live in the Sentinel Events Reporting module in MHWIN to improve the systemic under-reporting of Behavior Treatment beneficiaries' required data. However, many of the reportable events are reported in the wrong category.
- In-service on behavior treatment plans by the staff not qualified. The shortage of clinical staff with MDHHS-required credentials for BTPRC review continues to be challenging.

Opportunities for Improvement:
DWIHN has identified the following interventions and improvement efforts:

- Develop a mechanism to track instances where physical management or 911 calls to law enforcement have been used in an emergency behavioral crisis and ensure the length of time the emergency intervention was used per individual is included.
- The Behavior Treatment Category is live in the MH-WIN Critical and Sentinel Reporting Module to improve the systemic under-reporting of the four reportable categories for the members on BTPs. However, the required data of Behavior Treatment beneficiaries, including 911 Calls, Deaths, Emergency Treatment, and Use of Physical Management, is still under-reported.
- CRSP and BTPRCs must collaborate to ensure that IPOS and Behavior Treatment Plans are specific, measurable, and revised per the policy/procedural guidelines.
- Crisis Prevention Intervention (CPI) training is recommended to be included in the Detroit-Wayne Connect required list of training for network providers staff to help reduce recidivism and emergency hospitalizations.
- Each CRSP ensures the support coordinator or Case Manager provides the Individual's IPOS and ancillary plans before delivery of services at the service site.
- Hiring clinical staff with MDHHS-required credentials for BTPRC review at DWIHN to improve the quality of BTPRC processes.

Children's Initiatives

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

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

Quantitative Analysis and Trending of Measures

Over eleven thousand four hundred (11,400) children, youth, and families received community mental health services during fiscal year 2023. This included approximately five thousand nine hundred (5,900) children with Serious Emotional Disturbance (SED) and five thousand five hundred (5,500 children with Intellectual/Developmental Disability (I/DD) disability designations.

Service Expansion

During FY2023, DWIHN expanded children behavioral health services by adding additional Providers and services:

- SED Waiver: 4 new Providers (Starfish, Lincoln Behavioral Services, Hegira Health, CNS)
- Home Based Services: 1 new Provider (Team Wellness)
- Art Therapy, Music Therapy, Recreational Therapy: 1 new Provider (Advanced Therapeutic Solutions)
- Infant and Early Childhood Mental Health Consultation Expansion Grant: 2 new Providers (The Guidance Center, Hegira Health)
- New Juvenile Restorative Program with Team Wellness: A Day treatment program that assists with preventing juvenile justice recidivism and having community-based services specifically to address the high risk needs of youth.

Autism Services

DWIHN offers Autism Behavioral Analysis (ABA) services for children and youth ages 0 to 21st birthday. ABA is an intensive, behaviorally based treatment that uses various techniques to bring about meaningful and positive changes in communication, social interaction, and repetitive/restrictive behaviors that are typical of ASD.

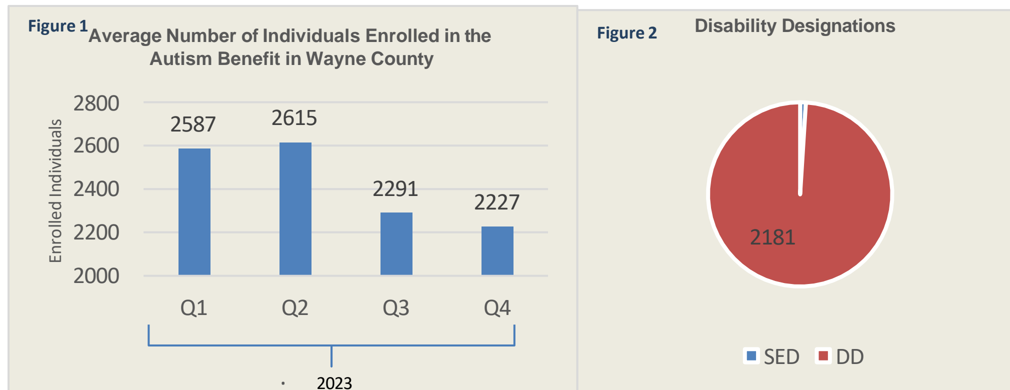
Quantitative Analysis and Trending of Measures

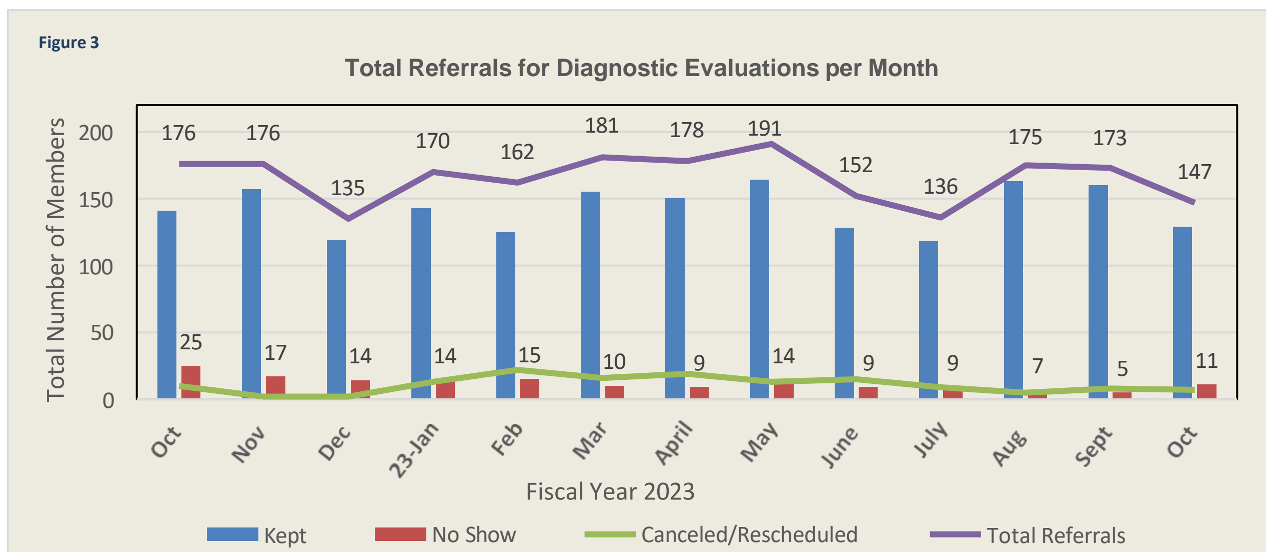
For FY 23, a total of 1,012 new children / youth was enrolled into the Autism Benefit:

Figure 1: Highlights the average number of children/youths who were actively enrolled in the Autism Benefit per quarter.

Figure 2: Highlights members actively enrolled in the Autism Benefit 0.99% (22 members) - Serious. Emotional Disturbances (SED) and 99% (2,181 members) - Intellectual Developmental Disabilities (IDD).

Figure 3: Highlights the total number of referrals to determine eligibility for the Autism Benefit for fiscal year of 2023. On average, 178 referrals were scheduled each month with an average of 23 identified as non-spectrum (not eligible), and an average of 120 members diagnosed with autism spectrum disorder (ASD).





Integrated Health Care
During FY23, DWIHN and Vital Data finalized the HEDIS Scorecard that enables DWIHN to provide all CRSP, Medicaid Health Plans and Integrated Care Organizations data as to how the network is scoring as a whole and individually based on alignment. The Scorecard has data going back to 2019 so trends and areas of improvement can be examined, and plans put into place. The platform displays diagnosis, Rx, physician on claim, and care gaps needed. All individuals who have access to the database can only see the members they serve.

DWIHN and Vita Data continue to make improvements. The Scorecard has been rolled out to all CRSP providers and 4 Medicaid Health Plans on November 22. IHC has met with CRSP and Medicaid Health Plans to train on the shared platform. IHC RN monitors HEDIS measures and sends out quarterly letters to CRSP CEOs on the current scores and where improvements are needed. The Adult Initiatives department has staff that are trained on the HEDIS Scorecard. IHC performs quarterly lunch and learns on HEDIS measures allowing all these tasks to increase the scores which means more people are receiving integrated care to aid in better treatment for their behavioral and physical health.

Measure goals are based on Quality Compass which is what the Health Plans base their goals on. Goals that we have improved on since 2022 are: ADD, AMM, APM, FUH, Adults FUM, SAA, SMD and SSD.

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

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

NCQA's HEDIS assesses the percentage of inpatient discharges for a diagnosis of mental illness or intentional self-harm among patients aged 6 years and older that resulted in follow-up care with a mental health provider, (Adult Core Set, appendix C), within 7 and 30 days. Research suggests that follow-up care for people with mental illness is linked to fewer repeat ED visits, improved physical and mental function and increased compliance with follow-up instructions.

Quantitative Analysis and Trending of Measures
The State of Michigan goal for this measure for 30-day follow-up is 70% for children 6-17 and 58% for adults 18- and older. DWIHN has chosen to use the State of Michigan metric measures as a comparison goal. DWIHN 2020 rate for 30-day follow-up for ages 6-17 is 62.96%. DWIHN 2021 rate for 30-day follow-up for ages 6-17 is 66.32%. This is a 3.36 percentage point increase. DWIHN 2022 rate for 30 days for ages 6-17 is 67.68%. In comparison to 2021 which was 66.32% this is a 1.06 percentage point increase and 2.32 percentage points below the State of Michigan comparison goal.

DWIHN 2020 rate for 30-day follow-up for ages 18-64 is 48.74%. DWIHN 2021 rate for 30-day follow-up for ages 18-64 is 46.67%. This is a 2.07 percentage point decrease. DWIHN 2022 rate for 30day follow-up for ages 18-64 is 50.81%. In comparison to 2021 this is a 4.14 percentage point increase and 7.19 percentage points below the State of Michigan comparison goal. DWIHN 2020 rate for 30 day follow up for ages 65 and older is 27.37%. DWIHN 2021 rate for 30 day follow up for ages 65 and older is 22.58%. This is a 4.79 decrease. DWIHN 2022 rate for 30 days for ages 65 and older is 36.78%. In comparison to 2021 which was 22.58% this is a 14.20 percentage point increase and 21.22 percentage points below the State of Michigan comparison goal.

The State of Michigan goal for measure for 7 days is 70% for 6 years and older and 58% for ages 18-64. DWIHN has chosen to use the State of Michigan metric measures as a comparison goal. DWIHN 2020 rate for 7-day follow-up for ages 6-17 is 41.33%. DWIHN 2021 rate for 7-day follow-up for ages 6-17 is 44.14%. This is a 2.81 percentage point increase. DWIHN 2022 rate for 7-day follow-up for ages 6-17 is 45.70%. In comparison to 2021 this is a 1.56 percentage point increase and 24.30 percentage points below the State of Michigan comparison goal. DWIHN 2020 rate for 7 days for ages 18-older is 29.14%. DWIHN 2021 rate for 7 days for ages 18-older is 28.33%. This is a 0.81 percentage point decrease. DWIHN 2022 rate for 7 days for ages 18-64 is 30.74%. In comparison to 2021 this is a 2.41 percentage point increase and 27.26 percentage points below the State of Michigan comparison goal. DWIHN 2020 rate for 7 days for ages 65 and older is 17.89%. DWIHN 2021 rate for 7 days aged 65 and older is 14.09%. This is a 5.80 percentage point decrease. DWIHN 2022 rate for 7 days for ages 65 and older is 28.74%. In comparison to 2021 this is a 14.65 percentage point increase and 29.26 percentage points below the State of Michigan comparison goal.

FUH 30 Day

Time period	Measurement	Numerator	Denominator	Rate	Goal	Comparison to Goal State of Michigan
1/1/2020-12/31/2020	6-17 years 18-64 years 65-older	323 1803 26	513 3699 95	62.96% 48.74% 27.37%	70% 58% 58%	70% 58% 58%
1/1/2021-12/31/2021	6-17years 18-64 years 65-older	317 2606 35	478 5584 155	66.32% 46.67% 22.58%	70% 58% 58%	70% 58% 58%
1/1/2022-12/31/2022	6-17years 18-64 years 65-older	421 3370 64	622 6689 174	67.68% 50.38% 36.78%	70% 58% 58%	70% 58% 58%

FUH 7 Day

Time period	Measurement	Numerator	Denominator	Rate	Goal	Comparison to Goal State of Michigan
1/1/2020-12/31/2020	6-17 years 18-64 years 64-older	212 1078 17	513 3699 95	41.33% 28.14% 17.89%	70% 58% 58%	70% 58% 58%
1/1/2021-12/31/2021	6-17years 18-64 years 64-older	211 1582 155	478 5584 22	44.14% 28.33% 14.09%	70% 58% 58%	70% 58% 58%
1/1/2022-12/31/2022	6/17years 18-64years 64-older	280 2033 50	622 6689 174	45.02% 30.39% 28.74%	70% 58% 58%	70% 58% 58%

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

Identified Barriers

The following were barriers that were identified by the IPLT and through clinical literature:

- Members having difficulty getting an appointment within the timeframes required. (Referral access)
- Members choosing not to schedule and/or keeping appointment (Member Knowledge)
- Members forgetting to schedule appointments and/or forgetting a scheduled appointment. (Member knowledge)
- Member not understanding process to notify provider if unable to keep appointment. (Member knowledge)
- Member lacks information regarding whom to follow-up with and where they are located and how to contact which can result in non-adherence to attending appointment. (Member knowledge)
- Transportation issues with either member not being able to schedule their own transportation with Medicaid vendor or Medicaid transportation vendor not showing up to pick up member for their appointment. (Referral access and member knowledge).
- Members have barriers of not having things like childcare issues that interfere with keeping appointments. (Access)
- Members follow up with their primary care provider instead of a behavioral health provider due to not understanding the importance of following up with a behavioral health provider after an inpatient behavioral health admission. (Member knowledge)
- Members not aware that compliance with aftercare can improve their treatment outcomes. (Member knowledge).
- Lack of coordination and continuity of care between inpatient and outpatient follow up services. (Provider/practitioner knowledge)
- Members are not fully involved in discharge planning, as a result they are not engaged in follow-up. (Member knowledge)
- Practitioners and Providers lack understanding of the importance of seeing a member in follow-up within 7 days of discharge. (Provider/practitioner knowledge.
- Low health literacy. (Member knowledge and provider/practitioner knowledge)

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

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

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

- Enrollee/members have a 7- and 30-day follow-up visit scheduled before being discharged with a mental health practitioner.
- Process developed to have hospital contact Access Center to schedule an appointment. Access will now have access to open appointments for follow up appointments via MHWIN calendar. Hospital case managers encouraged to involve member/caregiver in discharge planning date and time preferences for appointments.
- Created follow up post hospital visit checklist for providers/practitioners to help providers prepare for visit as well as targeting key items to cover during visit.
- Telephone calls are made to clients as a reminder of an upcoming appointment. Providers are expected to make 3 calls to the client to assess barriers to the client's care.
- Face to face visit to the client by care coordinators at the treating facility to assess client's barriers to follow up care (ex. transportation). Educational material given to client while hospitalized that address, transportation, importance of medication compliance, follow up after hospitalization and importance of primary care physician visits.
- DWIHN will continue to mail letters from our Chief Medical Officer, stating the importance of follow-up care along with the educational material that states the same.
- Text messaging as a reminder will continue for those clients that give permission to have the information texted to their phone.
- Education for providers and clients regarding the importance of follow up after hospitalization. Interventions will continue to include providing educational material that addresses FUH, medication compliance, and provider tools.
- Posting of educational material on DWIHN website and updated as needed.
- Publish educational articles in client's newsletter Patient Point of View

Goal: Improving Adherence to Antipsychotic Medications for Individuals with

HEDIS Measurement-Adherence to antipsychotic medications for individuals with schizophrenia: percentage of members 18 and older of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.

Quantitative Analysis and Trending of Measures

DWIHN reviewed the results of the baseline data in 2021 for the antidepressant compliance HEDIS measure including review by the Improvement Practice Leadership Team (IPLT) committee it was decided that DWIHN would benchmark themselves against the Michigan Medicaid Health plans. Michigan contracts with Health Services Advisory Group, Inc. (HSAG) to analyze Michigan Medicaid Health Plans' performance relative to quality Compass National Medicaid percentiles. Michigan HSAG 2022 reports the antipsychotic management average health plan results for 2021 rate as 66.28% which is above the HEDIS 50th percentile.

DWIHN purchased Quality Compass in October 2022. DWIHN changed their benchmark comparison at this point to compare themselves to the regional results as opposed to the National percentiles that HSAG uses. It gives DWIHN an idea of where their providers should be headed in terms of quality improvement and benchmarking plan performance compared to their regional peers. Before this purchase DWIHN compared its rate to the Michigan HSAG report. DWIHN current rates for antipsychotic management as of December 2022 was 47.05% which is below the State of Michigan quality compass benchmark for 2022 average of 66.28% According to quality compass, this places DWIHN below the 5th percentile for this measure. DWIHN continues to work to be in the 95th percentile.

DWIHN results for 2021 antipsychotic medication rate, using vital data, (Vital Data Technology is our NCQA certified vendor who runs and reports our HEDIS results) was 46.42%. DWIHN rate of results for2022, using vital data was 47.05%. This is a 0.63 percentage point increase over our baseline results.

DWIHN saw an increase in measure 1 during 2021, although it is a small percentage, we still saw an overall increase. DWIHN believes that the following interventions were key interventions that helped with the improvement:

Time Period	Measurement	Numerator	Denominator	Rate	Goal	Comparison to goal
1/1/2021-12/31/2021	18-older	2462	5304	46.42%	85.09%	85.09%
1/1/2022-12/31/2022	18-older	2796	5942	47.05%	85.09%	85.09%

Identified Barriers

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

The following barriers were identified by the IPLT and clinical literature search:

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

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

- Improve the relationships with physicians by providing members with key pre-appointment questions.
- Improve treatment approach by physicians by memo's sent to physicians quarterly regarding review of member's medication.
- Improve patient compliance with medication adherence by educating client of the importance.
- Improve patient adherence to medication refill by educating client of the importance.
- Improve patient follow up by telephone calls, text and mailed letters to clients addressing the importance of follow up care. Case managers are also instructed to provide a follow-up appointment for the client.

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

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

Goal: Improving Diabetes Monitoring for People with Schizophrenia and Bipolar

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

Quantitative Analysis and Trending of Measures

Time period	Measurement	Numerator	Denominator	Rate	Goal	Comparison to Goal
1/1/2020-12/31/2020	18-64years	4891	7597	64.38%	78.01%	78.01%
1/1/2021-12/31/2021	18-64years	5228	8061	64.86%	78.01%	78.01%
1/1/2022-12/31/2022	18-64years	6549	9264	74.43%	86.36%	86.36%

Evaluation of Effectiveness

After reviewing our 2020 baseline data, DWIHN chose to compare its 2021 remeasurement data to the ten contracted Michigan Medicaid Health Plans. The Michigan Department of Health and Human Services (MDHHS) contracts with Health Services Advisory Group, (HSAG) to analyze Michigan Medicaid health plan HEDIS results objectively and evaluate each health plan's performance relative to national Medicaid percentiles using Quality Compass National percentile results.

The Michigan Medicaid HEDIS Results Statewide Aggregate for 2021 reports the diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications, average health plan results as 78.01% which is between the 75th and 89th HEDIS percentile. DWIHN results for 2020 diabetic screening were 64.38%. DWIHN results for 2021 were 64.86%. DWIHN's 2021 rate of 64.86% places DWIHN below the HEDIS 25th percentile and 13.63 percentage points below benchmark of 78.01% but did show a 0.48 percentage point increase compared to 2020. It is believed that COVID could have impacted our rate in 2021 and prevented greater improvement due to restrictions on face-to-face appointments and member reluctance to want to go to a lab for fear of contacting COVID. Some members did not have consistent access to technology in which to participate in virtual appointments and electronic prescriptions for lab draws as opposed to an in-hand prescription, may have contributed to member not following through.

DWIHN purchased Quality Compass in October 2022 to run customer reports that will report HEDIS percentile to determine where DWIHN results fall, 25th, 50th, 75th or 95th percentile. Quality Compass provides online access to health plan HEDIS results and benchmark at the regional and national levels to help organizations evaluate individual and competitor performance, identify areas of improvement, and set quality goals. DWIHN rate of results for 2022 was73.43%. This was an 8.57 percentage point increase over the 2021 rate of result 64.86% and a 9.05 percentage point increase over the 2020 baseline rate 64.38. We remain below the 25th percentile but our results are trending up.

DWIHN's long term goal is to be in the HEDIS 95th percentile. In 2022 we changed our benchmark utilizing Quality Compass Regional results which allow us to compare ourselves with other health plans within our geographic region. This allowed us to compare ourselves with the 95th percentile for this measure. Our benchmark for 2022 was set at 86.36%, which is 12.93 percentage points above our 2022 rate of results 73.43% but again still trending in a positive direction. In comparing 2021 total to the 2022 total, there was an 8.57percentage point increase and a 9.05 percentage point increase compared to baseline.

Targeted Interventions that had a major impact on improvement:

- Multiple educational sessions on the Diabetes Screening HEDIS measure and the Clinical Practice Guidelines were completed with all adult practitioners as well as with the Quality Directors of all our contracted provider groups.
- The ability of the providers to run their own reports and identify their members who still need to have a HbA1c or FBS drawn and to work with the member to get this completed.
- The Quality and Performance Monitoring department conducted Clinically Responsible Service Provider (CRSP) site reviews to ensure compliance standards were addressed and maintained by performing chart audits. Results were shared with network providers and if scoring was not met or partially met on the question of whether a HbA1c or FBS was done if appropriate, re-education was provided.
- Monthly Care Coordination Data Sharing meetings with each of the 8 Medicaid Health Plans (MHP). Joint Care Plans between DWIHN and the Medicaid Health Plans were developed, and outreach completed to members and providers to address gaps in care, for almost 200 members. IHC staff participated in integration pilot projects with two MHPs: Blue Cross Complete of Michigan (BCC) and Total Health Care/Priority Health Care (THC). DWIHN and THC began sharing electronic data to assist in risk stratification, develop shared care plans, and document care coordination activities including working on HEDIS measures such as Diabetes Screening of schizophrenic and bipolar members on antipsychotics. DWIHN and BCC staff held meetings to review a sample of shared members who experienced a psychiatric admission within the past month. In September 2021, DWIHN and Vital Data Technologies completed a demonstration of the shared platform with BCC who are interested in collaborating to further the care coordination and risk stratification of shared members.

Outcomes of Other Interventions

MyStrength is a digital resource that complements other forms of care, such as medication and working with a behavioral health professional and is our member self-management tool vendor. MyStrength addresses behavioral health, physical health, healthy eating, and exercise. In 2020 there were 4,798 members enrolled in MyStrength. In 2021 there were 5,051 members enrolled in MyStrength. There has been a strong initiative to encourage providers to integrate MyStrength use as a complement to treatment resulting in an 11.3% month over month growth, (DWIHN MyStrength Scorecard).

DWIHN has an email list of 105 enrollees/members that are sent the DWIHN newsletter electronically. In addition, the newsletter is sent to anyone who may call and ask for an electronic copy. We send about 350 copies of the newsletter to various organizations on our postal mail list. DWIHN gives out an additional 150 copies to Board members and at outreach events. The newsletter is also posted on DWIHN's website. DWIHN had an average number of visits to its website in calendar 2020, (352,640), calendar year 2021, (397,934) and 2022 (398,243). The Persons Point of View newsletters continued to be published quarterly. In addition, monthly video announcements on trending topics were featured on YouTube and reached 86% of our population.

During FY/21 and 22 DWIHN was invited to over 100 community engagement events this past year which included presentations to community groups, outreach events for children, and recovery and prevention programs. DWIHN also launched Mindwise in 2023, a free, anonymous mental health assessment tool located on the homepage of the dwihn.org website this past year. The app can also be downloaded. It includes DWIHN events, training, and resources for both providers and members.

During FY 20/21 and 22/23 the Member Engagement division continued to find new ways to connect with members. Staff continued outreach efforts using its Quarterly member meetings (EVOLVE), the Persons Point of View newsletter, educational materials, and the What's Coming Up video updates as a means of communicating with members. The divisions' initiative of promoting virtual platforms and distributing computers and training to residential facilities and clubhouses proved to be beneficial in keeping members engaged. In collaboration with the Constituent's Voice Advisory group, the division organized members, peers, and ambassadors to participate in the "Walk a Mile in My Shoes" rally and organized the annual Reaching for the Stars award ceremony. The DWIHN Ambassador program participated in more than 170 outreach events, activities, and trainings.

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

AMM Data Results/HEDIS Measurement-Medication Compliance for Members 18 years or Older with a Diagnosis of Major Depression on Antidepressant Medication for at least 84 Days (12 weeks).

Acute Phase Treatment

Time Period	Measurement	Numerator*	Denominator*	Rate	Goal	Comparison to goal
1/1/2020-12/31/2020	18-older	664	3066	21.66%	42.98%	42.98%
1/1/2021-12/31/2021	18-older	989	2396	41.28%	42.98%	42.98%
1/1/2022-12/31/2022	18-older	1064	2993	35.55%	77.32%	77.32%

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

Effective Continuation Phase Treatment

Time Period	Measurement	Numerator*	Denominator*	Rate	Goal	Comparison to goal
1/1/2020-12/31/2020	18 years-older	664	3066	21.66%	59.28%	59.28%
1/1/2021-12/31/2021	18 years-older	320	2396	13.36%	59.28%	59.28%
1/1/2022-12/31/2022	18 years-older	374	2993	12.50%	63.41%	63.41%

Evaluation of Effectiveness

DWIHN results for 2020 effective acute phase treatment rate, using vital data, (Vital Data Technology is DWIHN NCQA certified vendor who runs and reports our HEDIS results) was 26.94%. DWIHN results for 2021 effective acute phase treatment rate, using vital data was 41.28%. This is a 14.37 percentage point increase over our 2020 results, 18 percentage points below our 2021 comparison benchmark 59.28% but trending in the right direction. DWIHN results for 2022 effective acute phase using Vital Data were 35.55%. This was a 5.73 percentage points decrease compared to the 2021 results but was an 8.61 percentage point increase over the 2020 baseline data.

DWIHN results for 2020 continuation phase treatment rate, using vital data was 21.66%. DWIHN results for 2021 continuation phase treatment rate, using vital data was 13.36%. This is an 8.3 percentage point decrease over our 2020 results, 29 percentage points below our 2021 benchmark 42.98%. DWIHN results for 2022 continuation phase treatment rate using vital data was 12.50%. This was a 0.86 percentage point decrease compared to the 2021 results and a 9-percentage point decrease compared to the 2020 baseline data.

DWIHN purchased Quality Compass in October 2022. DWIHN changed their benchmark comparison at this point to compare themselves to their regional peer results as opposed to the National percentiles that HSAG uses. It gives DWIHN an idea of where their providers should be headed in terms of quality improvement and benchmarking plan performance compared to their regional peers. Before this purchase DWIHN compared its rate to the Michigan HSAG report. DWIHN current rate of results for effective acute phase as of December 2022 was 35.55% which is below the State of Michigan quality compass benchmark for 2022 average of 77.32%. This is a 41.77 percentage point difference. According to quality compass, this places DWIHN below the 25th percentile for this measure. DWIHN continues to work to be in the 95th percentile. DWIHN current rate of results as of December 2022 for continuation phase was 12.50%, which is below the State of Michigan quality compass benchmark for 2022 average of 63.41%. This is a 50.71 percentage point difference. According to quality compass, this places DWIHN below the 5th percentile for this measure. DWIHN continues to work to be in the 95th percentile.

Targeted interventions initiated that had significant outcomes:

- Monthly care coordination meetings with the Medicaid Health Plans address concerns of medication adherence of shared members.
- DWIHN participation in monthly Collaboration Work Group meetings with 9 Michigan Medicaid Health Plans, 10 Prepaid Inpatient Health Plans, representatives from the Institute for Health Policy, Optum (one of MDHHS health services and technology partners who supports CC360) and MDHHS to work on ideas for collaboration with HEDIS measures with the help of CC360 which is the Michigan statewide Web Portal and care management tool to integrate physical and behavioral health data. It allows identification of shared members who meet the inclusion criteria, dates of last services for applicable screenings for identified members and performance measure results for shared members.
- DWIHN implemented guidelines that instruct providers on the importance of educating members of the importance of medication adherence.
- Clinical guidelines on depression management including medication management reviewed at least every two years and rolled out after each review plus posted on DWIHN website.
- Memo sent quarterly to providers Chief Medical Officers providing them with their quarterly rate and asking their plan of action to improve the rates.
- DWIHN quarterly lunch and learn to educate providers of their HEDIS scores on the antidepressant continuation measure.
- Med Drop supports members who need additional support to prevent a transition to a higher level of care. There has been a total of 49 Admissions with no readmissions. 60% (32) of the members have a Co-Occurring Disorder. 36% (19) have Bi-Polar Disorder. 15% (8) have Major Depressive Disorder. 64% (34) have either Schizophrenia (15) or schizoaffective disorder (19), 11% (6) members have antisocial personality disorder and 6% (3) have an Intellectual Developmental Disability. 36% (19)
- There has been a 72% reduction in the number of Med Drop clients admitted to a psychiatric hospital, who had a psychiatric hospital admission within the 12 months prior to entering the program. There is a 69% reduction in psychiatric hospital admissions for Med Drop clients who had a psychiatric hospital admission within the 12 months and 71% reduction in psychiatric hospital days for people who utilized hospital days within 12 months prior to entering the program. There is a 100% reduction in the number of people admitted to jail who had an admission within the 12 months prior to entering the program. With the addition of the Med Drop program, the provider network has reduced its hospital costs for this fiscal year.
- Educational sessions provided to over 200 providers that addressed the importance of antidepressant medication adherence.
- Adequate documentation of a consumer's signs and symptoms, past treatment response history, medication adherence history and social/environmental support.
- Texting reminders to members that agree to texts of their upcoming appointments. Prior to the initiation of the texting program, data showed that 40% of members kept their appointments. In FY 2021 66% kept their appointments.

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

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

Quantitative Analysis and Trending of Measures

Comparing the FY2021 baseline data (40%) for Case Finding for Opiate Treatment for the re-measurement 2 period of FY2023, showed an increase of 7 percentage points from FY21. The comparison goal for FY2023 is (48%), although DWIHN did not exceed our goal for FY23 of the percentage of persons referred to Peer Recovery Coach to an SBIRT/SUD Screening by Mobile Units, FQHC, Urgent Care, and Primary Care. The goal was 48% or 8% over the Baseline Measurement. The actual measurement was 47%.

Time Period	Measurement	Numerator	Denominator	Rate	Goal	Statistical Test and Significance
10/1/2020 – 9/30/2021	Baseline	1314	3268	40%	NA	NA
10/1/2021-9/30/2022	Remeasurement 1	1578	1839	49%	44%	Exceed goal
10/1/2022-9/30/2023	Remeasurement 2	1831	3857	47%	48%	Not Met

Evaluation of Effectiveness

Below are some of the steps taken to increase and enhance our efforts to identify individuals with SUD issues throughout Wayne County:

- Regular training for providers to increase their knowledge and skills in conducting SBIRT screening and brief interventions.
- Standardized protocol for conducting SBIRT screening and brief interventions that all providers in the network can follow.
- Tracking and monitoring system for outcomes of SBIRT screenings and interventions.
- Partnerships with community-based organizations and other stakeholders to help identify and refer patients to SUD treatment services.
- Outreach materials to promote the availability and benefits of SBIRT screening and brief interventions to patients and healthcare providers.
- Ongoing support and resources to providers to help them implement SBIRT screening and interventions effectively and efficiently.
- Regular evaluation of the effectiveness of the SBIRT program and adjusting as needed to improve its impact and outcomes.
- Referral of Post Partum Women's Specialty program members to treatment through SBIRT screening by three providers- Elmhurst House, Star Center, and Central City Integrated Health.

Mobile units in Wayne County communities have been working hard to build relationships with individuals who are not yet ready for treatment but continue to use substances. They have increased the number of hotspots they have identified and provide harm reduction material like fentanyl strips and needle exchange to reduce the risk of overdose, HIV spread, and infections. The hope is to engage these individuals when they become ready for treatment.

Since April of 2023, Peer Recovery Coaches (PRCs) have been meeting weekly with doctors at Henry Ford to develop strategies on how to increase the number of people screened and referred to SUD treatment, especially with the rise in overdose cases. In June, Henry Ford's staff presented to the SUD Oversight Policy board to emphasize the importance of PRCs in helping them identify and refer patients to SUD treatment. Currently, there are 65 recovery coaches providing these crucial services.

Barriers were identified through discussions at community town hall events. The barriers include:

- Some health care settings limit Peer Recovery Coaches in their emergency rooms (ER), Federally Qualified Health Centers (FQHCs), Urgent Care and Primary Care (PC) settings which limits the ability of the Peer Recovery Coach to engage persons diagnosed with a substance use disorder with an emphasis on Opioid Use Disorder (OUD).
- Area hospitals do not see the benefit of the Peer Recovery Coach concept. Hospitals limited access to them as they did not identify Peer Recovery Coach’s as professional staff. They also reported concerns that some Peer Recovery Coach’s had criminal background history and were openly admitting to being in recovery.
- Stigma surrounding addiction is a barrier.
- The lack of knowledge, importance, and effectiveness of SBIRT screenings in FQHC’s jail, hospitals, and the public to detect and address individuals with an opioid or substance abuse disorder.
- Due to the transient nature of the SUD population and the inability to follow-up due to no phone or permanent housing.
- Celebrate Recovery is normally a well-attended event that is held indoor and outdoor venues in Wayne County. DWIHN is unable to tell how many potential clients were referred to treatment from Celebrate Recovery’s monthly zoom event due to COVID-19.

Opportunities for Improvement

- Increasing community awareness of treatment services and the ease of accessing treatment services
- Developed outreach materials to promote the availability and benefits of SBIRT screening and brief interventions to patients and healthcare providers.
- Created a system for tracking and monitoring the outcomes of SBIRT screenings and interventions, including the number of patients screened, the number of positive screens, the number of interventions provided, and the number of patients referred to treatment.

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

DWIHN offers Autism Behavioral Analysis (ABA) services for children and youth ages 0 to 21st birthday. ABA is an intensive, behaviorally based treatment that uses various techniques to bring about meaningful and positive changes in communication, social interaction, and repetitive/restrictive behaviors that are typical of ASD.

Quantitative Analysis and Trending of Measures

As illustrated in the chart below, the baseline measurement was obtained by finding the percentage of ABA Providers who received ABA referrals compared to when ABA services started during FY 21, Q1. The baseline goal was set at 100% compliance and the rate was 33%. Throughout all the remeasurement periods the goal remained at 100%; in which, did not achieve the goal expectation. This performance improvement plan presented various challenges that led to the rate decreasing below the baseline goal of 33% during FY 23, Q1 (36%), FY 23, Q2 (35%), FY 23, Q3 (61%), and FY 23, Q4 (57%). FY 23, Q3 was the best performing rating period at 61%.

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

Time period	Measurement	Numerator	Denominator	Rate	Goal	Statistical Significance
FY 21 – Q1 10/1/20 – 12/31/20	Baseline	63	202	31%	100%	NA
FY 21 – Q2 1/1/21 – 3/31/21	Remeasurement 2	63	211	30%	100%	Below Goal
FY 21 – Q3 4/1/21 – 6/30/21	Remeasurement 3	84	226	37%	100%	Below Goal
FY 21 – Q4 7/1/21 – 9/30/21	Remeasurement 4	89	272	33%	100%	Below Goal
FY 2021 Total	**33%**					
FY 22 – Q1 10/1/21 – 12/31/21	Remeasurement 1	89	307	36%	100%	Below Goal
FY 22 – Q2 1/1/22 – 3/31/22	Remeasurement 2	91	292	31%	100%	Below Goal
FY 22 – Q3 4/1/22 – 6/30/22	Remeasurement 3	70	274	26%	100%	Below Goal
FY 22 – Q4 7/1/22 – 9/30/22	Remeasurement 4	89	254	35%	100%	Below Goal
FY 2022 Total	**30%**					
FY23 – Q1 10/1/22 – 12/31/22	Remeasurement 1	89	247	36%	100%	Below Goal
FY 23 – Q2 1/1/23 – 3/31/23	Remeasurement 2	78	223	35%	100%	Below Goal
FY 23 – Q3 4/1/23 – 6/30/23	Remeasurement 3	76	125	61%	100%	Below Goal
FY 23 – Q4 7/1/23 – 9/30/23	Remeasurement 4	63	111	57%	100%	Below Goal
FY 2023 Total	**47%**					

Evaluation of Effectiveness

Various interventions were implemented during FY 23 to address improving timely access to ABA services. A Request for Qualification (RFQ) was posted to capture a list of qualified ABA Providers for Wayne County. The RFQ resulted in identifying (6) six new ABA Providers to add to the provider network. In addition, the Autism Department conducted 10hrs of direct training to DWIHN Access Call Center to promote a consistent and accurate screening process for autism services. Also, the Autism Department trained Clinically Responsive Service Providers (CRSPs) on the ABA referral process and submitting appropriate forms in MHWIN electronic health record. Michigan Department of Health and Human Services (MDHHS) provided an official memorandum informing the Autism Benefit will no longer require entry into the Waiver Support Application (WSA) system effective March 21, 2023. Furthermore, the U5 modifier will be added to billing code 97151 to track the Behavioral Assessment. In March 2023 the Autism Department provided a Mental Health public event to Wayne State University for students interested in entering the mental health field.

In addition, Detroit Wayne Integrated Health Network (DWIHN) issued $3.76/hr. direct care wage increase payment on March 6, 2023, which directly impacts the Autism benefit CPT codes of 97153, 97154, 0373T. Per MDHHS Letter 23-04, MDHHS no longer requires hazard pay to be separately identified in the pay stubs. Also, the Autism Services website on www.dwihn.org was updated with 4 new videos: 1) Significance of Early Intervention 2) Is My Child at Risk for Autism 3) Autism Evaluation & Applied Behavioral Analysis Services 4) ASD Diagnosis: Next Steps. The service utilization guidelines were updated to best practice of 20% supervision for behavior technicians for every 10 hours. Lastly, during August 2023 DWIHN will provide a one-time 3% increase in rates or approximately $20 million distribution across all fees for service codes. The rate will be applied across all claims submitted in March, April, and May of 2023.

Identified Barriers

- Significant delay in Individual Diagnostic Evaluators completing the evaluation reports to determine autism eligibility.
- Delay with CRSPs completing the annual Individual Plan of Service (IPOS) and submitting ABA authorizations. As a result, behavior technicians are unable to provide ABA direct services until IPOS is completed.
- Lack of capacity to provide autism services within the provider network and staffing shortages.
- Low pay rate for behavioral technicians compared to commercial insurance rates.
- The supervision for behavior technician staff ratio was not comparable to other counties.

Opportunities for Improvement

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

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

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

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

Quantitative Analysis and Trending of Measures
As illustrated in the charts below, the baseline measurement was obtained by finding the percentage of youth who received the PHQ-A screening at the initial intake between October 1, 2019, and September 30, 2020. The baseline goal was set as 100% compliance for all youth ages 11-17 and designated as SED and/or SUD. Within Fiscal Year 2020 (baseline measurement), 4,452 intakes for youth with an SED/SUD designation were completed and 4,170 PHQ-A screenings were completed upon intake. The baseline rate equaled 93%._The first remeasurement covered Fiscal Year 2021 (October 1, 2020-September 30, 2021), during which 4,218 intakes were completed and 4,061 received the PHQ-A screening. The rate then increased to 96% of completed intakes with a PHQ-A screening. The second remeasurement covered Fiscal Year 2022 (October 1, 2021- September 30, 2022) during which 3,291 intakes were completed and 3,267 members received the PHQ-A screening. The rate increased to 99.2% of completed intakes with a PHQ-A screening. Remeasurement 3 covered Fiscal Year 2023 (October 1, 2022 – September 30, 2023) during which 3,218 intakes were completed and 3,226 members received the PHQ-A screening at a rate of 99.7%. This was a slight increase from FY 22. Overall, continued to show progress with this measurement and plan to continue this performance plan until achieve the goal of 100%.

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

Measurement Period	Measurement	Numerator	Denominator	Rate	Comparison Goal	Statistical Significance
10/1/2019 - 9/30/20 (FY 2020)	Baseline	4170	4452	93%	N/A	NA
10/1/2020 - 9/30/2021 (FY 2021)	Remeasurement 1	4061	4218	96%	95%	Above Goal
10/1/2021 - 9/30/2022 (FY 2022)	Remeasurement 2	3267	3291	99.2%	100%	Under Goal
10/1/2022 – 9/30/2023 (FY 2023)	Remeasurement 3	3218	3226	99.7%	100%	Under Goal

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

During the rating period of October 1, 2020, and September 30, 2021, 1,639 youth had a PHQ-A greater than 10 upon intake and, of those youth, 763 received a follow-up PHQ-A within 16 weeks until their score dropped below 10. The rate increased to 46.5% and the rate of compliant follow-up compared to the previous rating period increased by 7.9%. During the rating period of October 1, 2021, and September 30, 2022, 1,370 youth had a PHQ-A greater than 10 upon intake, and, of those youth, 594 received a follow-up PHQ-A consistently every 16 weeks until their score dropped below 10. The rate decreased from 46.5% in Fiscal Year 2021, dropping to 43.4% compliance (a decrease of 3.1%). During the rating period of October 1, 2022, through September 30, 2023, 715 youth scored at least 10 on the initial PHQ A screening and 1298 youth received the PHQ A within 16 weeks until the score decreased below 10: averaging 55.1%. This is a 11.7% increase since the previous remeasurement period. Overall, the performance improvement plan is trending in a positive direction and the goal is to continue until reaches the goal of 95%.

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

Measurement Period	Measurement	Numerator	Denominator	Rate	Comparison Goal	Statistical Significance
10/1/2019 -9/30/20 (FY2020)	Baseline	654	1693	38.6	N/A	NA
10/1/2020-9/30/21 (FY2021)	Remeasurement 1	763	1693	46.5%	95%	Below Goal
10/1/2021- 9/30/22 (FY2022)	Remeasurement 2	594	1370	43.4%	95%	Below Goal
10/1/22-9/30/23 (FY2022)	Remeasurement 3	715	1298	55.1%	95%	Below Goal

Quantitative Analysis and Trending of Measures

DWIHN has made considerable progress with the initiative to have practitioners consistently complete a PHQ-A with youth ages 11-17 upon initial intake, with the rate of completion rising from 93% (baseline), to 96% during the first remeasurement (October 1, 2020-September 30, 2021), to 99.2% at the end of the second remeasurement (October 1, 2021-September 30, 2022). Due to the first remeasurement exceeding the Comparison Goal of 95%, it was determined that the Comparison Goal be changed to 100% for Quantifiable Measure #1. All interventions listed below are strong interventions that aided in this success. In the period between October 1, 2019, and September 20, 2020, DWIHN addressed one of the biggest barriers which was that practitioners were not forced to complete the PHQ-A as part of the biopsychosocial assessment by adding a hard stop that requires practitioners to complete the PHQ-A before being able to sign the assessment document. Also, during the first remeasurement period, the Special Projects Specialist created and launched a public service video highlighting the importance of the PHQ-A, which was available for all provider staff to view on DWIHN's You Tube website.

Evaluation of Effectiveness

In February 2022 this intervention was modified to track the number of clinical staff who viewed the video more efficiently. DWIHN required that all providers have staff responsible for intake assessment's view and report their viewing of the public service video by completing a brief survey. As of September 30, 2023, 594 clinical staff have viewed the video. Another intervention was implemented in October 2020 which involved sending each children's provider an update via a letter regarding the use of the PHQ-A within their respective agency- both providing the number completed upon intake as well as the compliance with timely follow-up screening. Providers were given an update letter initially in October 2020 with data from the previous fiscal year, then follow-up letters including data quarterly. This intervention was modified in May 2021 where providers were given the data as before as well as a list of youth (Excel spreadsheet) who did not receive follow-up PHQ-A screenings in a timely manner. Providers were then able to trouble shoot the data, finding if the case was truly out of compliance or if something else occurred, such as a case being closed but the MH-WIN system not properly updated. These reports will also help identify and remove cases that were closed during the data collection period, as cases closed by the providers are not closed in MH-WIN until up to 90 days later.

Barrier Analysis

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

Opportunities for Improvement

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

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

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

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

Quantitative Analysis and Trending of Measures

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

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

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

The baseline goal was set at 95% compliance for all adults seeking SMI and/or SUD services. Within the first two quarters for FY2023 (FY2021 Q1 and Q2) 9,433 adults completed intakes for SMI and SUD during the first and second quarter. Of that number, 5,145 scored 10 or greater, and placed them in the category for 90-day rescreening. The data indicated only 7,525 reassessments were conducted. The results are displayed in the tables below.

The Percentage of Members ages 18 years and older presenting for intake/assessment for serious emotional disturbance (SED), serious mental illness (SMI), or substance use disorder (SUD) who had an initial PHQ-9 performed

Time period	Measurement	Numerator	Denominator	Rate	Goal	Difference
10/1/2022-12/31/2022	1st Quarter Remeasurement	5596	5621	99.6%	95%	**Over goal**
1/1/2023-3/31/2023	2nd Quarter Remeasurement	6980	7049	99.0%	95%	**Over goal**
4/1/2023-6/30/2023	3rd Quarter Remeasurement	6068	6133	98.9%	95%	**Over goal**
7/1/2023-9/30/2023	4th Quarter Remeasurement	6183	6226	99.3%	95%	**Over goal**
10/1/2022-9/30/2023	Total Average Rate	24827	25029	99.2%	95%	**Over goal**

Percentage of members ages 18 and older with a PHQ-9 score of 10 or greater at Intake that Had a Follow-up PHQ-9 Screening completed in 90-Days.

Time period FY2023	Measurement	Numerator	Denominator	Rate	Goal	Difference
10/1/2022-12/31/2022	1st Quarter Remeasurement	2938	4602	63.8%	95%	**Under goal**
1/1/2023-3/31/2023	2nd Quarter Remeasurement	3279	4999	65.6%	95%	**Under goal**
4/1/2023-6/30/2023	3rd Quarter Remeasurement	3171	5018	63.2%	95%	**Under goal**
7/1/2023-9/30/2023	4th Quarter Remeasurement	3134	4953	63.3%	95%	**Under goal**
FY 2023	Total Average Rate	12522	19572	64.0%	95%	**Under goal**

Evaluation of Effectiveness

DWIHN clinical guidelines implemented the utilization of the PHQ-9 for screening, as well as monitoring treatment outcomes. DWIHN expects its provider network to treat depression to remission, and tools such as the PHQ-9 help the clinician and member monitor the target symptoms and overall progress. DWIHN expects that the percentage of adult members aged 18 and older that screened positive for depression (PHQ-9 score greater than or equal 10) will receive a second screening with a PHQ-9 within a three-month measurement period. DWIHN anticipates the goal of 95% at intake and follow up of members by October 1, 2021 (the beginning of fiscal year 2021/2022). In addition, DWIHN expects that there will be a decrease in PHQ-9 scores for members who screen positive for depression at intake to the subsequent screening. Knowing that depression symptoms often recede gradually, the goal is to see reductions in depressive symptoms for 50% of members by the 3rd screening beyond initial intake. In addition, there is an expectation that members will be introduced and encouraged to utilize self-management tools to assist in reducing and managing depressive symptoms. The current tool utilized by DWIHN to support member self-management is called MyStrength. MyStrength is a highly interactive, individually tailored web-based application which empowers MyStrength users to address depression, as well as anxiety, stress, substance use, chronic pain, and sleep challenges, while supporting the physical and spiritual aspects of whole-person health.

Identified Barriers

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

Workforce Pillar

DWIHN's Innovation and Community Engagement (ICE) strives to lead the organization in innovation by providing effective and efficient workforce development needs to the provider network. ICE provides continuous support to the community through educational outreach and engagement while placing an emphasis on recovery and resilience. Provider training is available at Detroit Wayne Connect, a continuing education platform for stakeholders of the behavioral health workforce. Log on at dwctraining.com. SUD Trainings are also available on Improving MI Practices posted at www.dwihn.org.

During FY 2023, ICE offered various mental health first aid and suicide prevention awareness training system-wide, and law enforcement organizations. Approximately, 2500 individuals learned about the signs and symptoms of mental illness, and behavioral clues to address the risk of suicide. The Veteran Navigator assisted 284 Veterans during this fiscal year.

Workforce Development and Retention

In FY2023, ICE focused on sustaining the centralized training program in collaboration with local and national educational institutions. The efforts resulted in continuing to provide comprehensive training to student learners in various settings to engage in integrated healthcare across the lifespan. During FY2023, we had 16 students complete the specialized training program with the University of Michigan School of Social Work. More than 57 behavioral health students completed a field practicum within our provider network to develop competent behavioral health professionals who are qualified mental health and child mental health professionals.

Retention efforts have included advocacy with the National Health Service Corporation to develop approved sites within our community to be eligible for consideration for student loan repayment.
Challenges with retention have been identified from focus groups held with former trainees, and limited supportive supervision, compensation not equitable, and frustration with systemic demands such as documentation and expectations emerged as common core themes for individuals seeking employment in other settings. All participants highlighted a continued commitment to the population served and provided recommendations for retention to focus on compensation and processes that center the engagement of participants. Future efforts to develop funding opportunities for student learners including options for employment-based field sites have been discussed with local universities.

Special Initiatives

Reach Us Detroit has successfully provided virtual therapy services and referrals, resulting in a notable impact on the individuals served. The data reflects a completion rate of 60%, showcasing the effectiveness of our virtual therapy sessions. Moreover, participants who accessed our services reported tangible improvements in their mental health and well-being, with individuals reporting reduced symptoms.
Participants who faced challenges in accessing care due to unfamiliarity with therapy, concerns about long-term diagnoses, or frustration with traditional access processes have found our virtual platform to be convenient and accessible.

The positive feedback from our participants underlines the value of our virtual services. Many have praised the flexibility of virtual therapy, which allows them to engage at various times of the day and have shared their success stories and personal journeys toward improved mental health.
Looking ahead, we remain committed to expanding and enhancing our virtual services to better serve our community. This includes plans to continue to utilize individual providers that can be dedicated to delivering virtual services as we have seen an improvement in consistency, retention, and satisfaction from callers.

The dedication to addressing the challenges of accessibility, stigma, and convenience through virtual therapy has not only enabled us to adapt to changing circumstances but also to provide effective, efficient, and impactful services for our community. We are proud of our achievements and look forward to continuing our mission of supporting the mental well-being of adolescents and adults in Wayne County through virtual services.

Also, DWIHN is working collaboratively with Wayne State University School of Social Work and select CRSPs to increase a pipeline of individuals obtaining both bachelor's and master's degrees in social work. This effort is aimed at Peer Recovery Support staff who would like to go to college and further their education by obtaining a degree or certification in social work or addiction studies. This program allows students to complete internships at their current mental health/substance use provider, so they do not have to do an internship outside of their current pace of employment after hours. They also offer guaranteed tuition and childcare services. The impact this has on increasing people's interest in higher learning and subsequently, workforce development, will be assessed annually.

DWIHN participates in a substance use provider workforce collaboration that includes several substance use disorders (SUD) providers and representatives from MCBAP. The workgroup is exploring avenues to increase the workforce, specifically in the SUD field. Starting to work with colleges (both 2 and 4-year) on presenting information to their students about the rewards of working in the substance use field. Discussions also center around social work licensing testing requirements, incentives, and parity.

The Jail Navigator Program

The Wayne County Jail Mental Health Unit screened 1860 new admissions and treated 973 members. Naphcare is the provider of jail mental health services. Upon release from jail, there were 509 members who were linked back with a provider. There was a 31% follow-up with members discharged from the jail. It is anticipated that this number will increase the following year as more members become enrolled in MHWIN prior to discharge. Naphcare Discharge Planners coordinate releases into post-release community mental health treatment. DWIHN coordinates discharges with Naphcare with a process whereby Discharge Planners provide the Access Center with assessments for the purpose of scheduling intake appointments with providers upon release from jail. This reduces members re-entering the community without a mental health and/or substance use provider.

Trauma Project Initiative Lessons

Throughout FY 23, partnering organizations identified common challenges related to the implementation practices, and workforce retention. Treatment services have been modified to include telehealth beginning April 2020 – current. It is recommended that partner organizations create a trauma-informed culture, safe work environment that includes physical and workplace policies that prevent harassment, stalking, and violence. Promote respectful interactions amongst staff members at all levels. In addition, implement regular and consistent clinical supervision for all clinical staff members and provide ongoing training related to trauma-informed care and evidence-based interventions. Develop consistent hiring practices to ensure the best candidate for the role, be clear and concise about role expectations, and offer training that will build staff competencies. Lastly, utilize general approaches and techniques of building a rapport, providing a safe and comfortable environment to increase consumer participation.

Opportunities for Improvement

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

Zero Suicide Grant

In FY2023, DWIHN responded to SAMHSAs notice of funding announcement for Zero Suicide. We received notice of award on September 8, 2023, for five years beginning 9/30/2023. DWIHN's Zero Suicide Initiative aims to eliminate suicides in Wayne County through system-wide culture change, workforce training, comprehensive screening, evidence-based treatment, and care management. The bold goal of zero suicides among persons receiving care is an aspirational challenge that health systems should accept. Attempting to reduce suicides for patients in care to zero may seem scary or even impossible, but what other number should we strive for? Several health care systems who have implemented this comprehensive suicide care approach have already seen significant reductions in suicide among their patient populations --with rates of suicide being reduced by as much as 70% -80% for those in their care.

The Zero Suicide initiative is a priority of the National Action Alliance for Suicide Prevention. It emphasizes the need to transform health care for those at risk for suicide through a focus on safety and error reduction as well as using best practices in suicide care by health systems and providers.

Core Elements:

LEAD	Lead system-wide culture change committed to reducing suicide.
TRAIN	Train a competent, confident, and caring workforce.
IDENTIFY	Identify individuals at-risk of suicide via comprehensive screening and assessment.
ENGAGE	Engage all individuals at-risk of suicide using a suicide care management plan.
TREAT	Treat suicidal thoughts and behaviors using evidence-based treatments.
TRANSITION	Transition individuals through care with warm hand-offs and supportive contacts.
IMPROVE	Improve policies and procedures through continuous quality improvement.

Credentialing and Re-Credentialing

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

Quantitative Analysis and Trending of Measures

There are over 4,000 practitioners in the network and over 2,301 have been credentialed. CVO refers to the use of a Credentials Verification Organization to perform medical credentialing on behalf of a healthcare practice or organization. Our CVO Medversant verifies a provider's credentials by obtaining primary source verification of a practitioners or provider's qualifications on our behalf. In FY2022/2023, there were 726 practitioners credentialed and 41 Behavioral Health and Substance Use Disorder providers credentialed. All files were clean, had appropriate checks done, and had no issues or concerns.

Evaluation of Effectiveness

DWIHN has oversight of the Credentialing Verification Organization to ensure that they comply with the contractual requirements. DWIHN meets weekly with the CVO. During each meeting an Action Item list is reviewed with goals to improve the primary source verification process. Each Action Item has a due date and the person responsible for achieving the goals. The individual might be a staff of the CVO or DWIHN. The items most of the time are systemic. There are instances where the items are specific to a provider or practitioner. This tool is utilized also to determine compliance with identified NCQA standards. The CVO also has a Call Center that practitioners and providers call to resolve credentialing issues and a report is submitted monthly. DWIHN receives policies and procedures annually for review as well as Systems Controls reports which disclose if any modifications have been made to credential/re-credential files. That report for 2023 indicated that there were no modifications made to DWIHN practitioner or provider files.

The credentialing staff currently reviews all unclean files to determine if they are false negatives as well as validates 10% of the clean files to ensure that they comply with MDHHS and NCQA standards. In addition, 100% of the verified profiles, summaries of the primary source verification, are reviewed for timeliness. Files that will not meet the timelines are returned to the CVO for reprocessing. Since that process was implemented April 2023 the files that have been approved by the Chief Medical Officer meet the timelines.

Opportunities for Improvement

Staff from the Credentialing Unit and the Strategic Planning Operations Unit assessed areas of the credentialing activities that needed to be addressed to improve the credentialing processes. The following will ensure that DWIHN remains compliant with 42CFR422.204, Michigan Department of Health and Human Services, and NCQA standards:

- Continue to improve internal processes and procedures to ensure there is timely follow-up and compliance for all credentialed providers/organizations.
- Expanding the credentialing process to include internal staff providing direct services.
- Letters regarding adverse decisions will be revised to ensure that they include the practitioners/providers rights to review, correct and submit information that is erroneous, missing or provides needed clarity.
- The process to manage adverse issues between credentialing cycles is going to be developed and attached to the Credentialing/Re-credentialing policy by April 1, 2024.
- Practitioner Rights will be included in communications that go out to the providers. It has been added as a tagline to Credentialing staffs' emails.

- Prior to the credentialing/re-credentialing of providers the Disclosure and Ownership forms will be reviewed for contracted providers by Provider Network Managers and Office of Inspector General and Systems for Award Management will be checked to ensure that owners are not excluded from the Medicare or Medicaid funding sources.
- Processes will be established for non-contracted providers in collaboration with the Senior Provider Network Manager to ensure that Disclosure and Ownership forms are completed.

Workforce Shortages

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

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

These factors have led to a shortage in clinical workers across the State of Michigan and many of DWIHN's provider network have experienced significant challenges in retaining and recruiting Qualified staff.

Finance Pillar

The mission of the Office of Fiscal Management (Finance) is to establish and maintain the financial controls necessary to safeguard the assets of the Authority in accordance with generally accepted accounting principles and applicable laws; to manage and accurately report Authority financial transactions through our Enterprise Resource Planning (ERP) system; to develop reporting tools and support internal and external stakeholders so they can have the information they need to make data driven decisions and achieve their goals.

Within the DWIHN Finance department are several functions including:

- Accounting – Accumulates and reports on the financial position of DWIHN.
- Accounts Payable – Processes all DWIHN's payments outside of payroll.
- Auditing and Grants – Provides oversight of the financial reporting process, audit process, DWIHN's system of internal controls and compliance with laws and regulations.
- Budget – Provides a framework for managing DWIHN's assets, cash flows, income, and expenses.
- Financial Systems – Maintains a financial management system with strong internal controls and for monitoring compliance with those controls to ensure the integrity of DWIHN's financial information and the safety of its assets.
- Fiscal Informatics and Analytics – Assists in establishing and enhancing data driven and data informed operational and management strategies, methods, processes, and systems. Manages and coordinates analytics and informatics projects related to cost and utilization, revenues, eligibility and other financial and risk related data.
- Payroll – Ensures that DWIHN pays its employees accurately and timely.
- Purchasing and Procurement – Manages and coordinates the acquisition of goods and services, including requisition processing, commodity code tracking, and bid specifications. Assists with contract management and the issuance of purchase orders.

Advocacy Pillar

Advocacy and Engagement

The DWIHN Constituent's Voice Advisory Group received the 2023 CMHA Partners in Excellence Award. This award recognizes those who have, in the process of utilizing community mental health services, enhanced the perception of those services and their recipients within the community. This award was presented during the CMHA 2003 Fall Conference.

Community Outreach

The department attended over 100 community outreach and engagement events during FY2022-2023. DWIHN has developed a community mobile application titled myDWIHN. The myDWIHN app allows you to find out information about mental health, substance use disorder, disability, and children's resources. It also allows you to find any one of our 400 service providers. The myDWIHN app is available to be downloaded by anyone.

Social Media Outreach

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

In FY23, our Google profile was viewed by 9,044 users utilizing different platforms and devices. Of those users 4,891 (83%) searched and discovered our profile via Google Search from their desktop or laptop, 790 (13%) searched and discovered our profile via Google Search from their mobile device, 160 (3%) searched and found our profile via Google Maps on their mobile device, and 58 (1%) searched and found our profile via Google Maps on their desktop or laptop. The Google Business Profile received 3,145 interactions such as when people call, message, ask for directions, and more from the Business Profile on Google.
Also, DWIHN's Google Business Profile appeared in 3,492 search results. Users have used a variety of words to find DWIHN when searching or discovering us on Google; DWIHN (1,602), Detroit Wayne Integrated Health Network (849), dwctraining (160), DWIHN (136), and DWIHN training (136).

DWIHN is also actively elevating mental health awareness on social media by sharing informative content, engaging narratives and fostering a supportive online community. Through strategic and compassionate messaging, DWIHN is creating a digital space that encourages dialogue, educates the public, and helps reduce the stigma associated with mental health challenges.

Community Outreach/DWIHN/Youth United/Youth Move Detroit

During FY23, DWIHN was a participant in several important events, such as "Stronger Together: A Community Chat About Preventing Domestic Violence" and a conversation addressing the disruption of the narrative surrounding youth suicide and mental health.

In November and December, DWIHN actively engaged in various outreach initiatives. Notably, DWIHN organized a Game Night at the Michigan Science Center, dedicated to exploring the impact of gaming on mental health. Additionally, DWIHN hosted "Let's Talk Mental Health" with Randi Rosario, fostering open discussions on mental health issues.

Self-Management Performance Improvement

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

Ask the Doc

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

DWIHN Website

In 2023, website sessions increased by an impressive 109% when compared to the previous year, totaling 27,701 sessions. The number of users entering via social media saw a growth of 321%. Facebook was the top social media platform driving the most users to the website. Paid ads brought in the highest percentage of users at 38%. The top pages (excluding the home page) were "substance use disorders" with 10,177 views, this is significant as The SUD page recorded over 10K sessions just for the month of April 2023.
"For Providers" with 4,937 views, and "Programs and Services" with 879 views. User engagement varied across pages, with "Contact Us" having the highest average session duration of 2 minutes and 41 seconds.

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

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

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

Sharing Information

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

- Quality Improvement Steering Committee (QISC)
  - QISC Agenda
  - QISC Minutes
- Quality Assurance Performance Improvement Plan (QAPIP)
  - QAPIP Description Plan FY2019-2021
  - QAPIP Description Plan FY2021-2023
  - QAPIP Description Plan FY2023-2025
- QAPIP Annual Evaluation
  - QAPIP Annual Evaluation FY 2017
  - QAPIP Annual Evaluation FY2018
  - QAPIP Annual Evaluation FY 2019
  - QAPIP Annual Evaluation FY2020
  - QAPIP Annual Evaluation FY2021
  - QAPIP Annual Evaluation FY2022
  - QAPIP Annual Evaluation FY2023
- Home and Community Based Services (HCBS)
  - For HCBS Questions please E-Mail to **Quality@dwihn.org** and **HCBSInfor.PIHP@dwihn.org**.

DWIHN Accreditation

DWIHN is currently seeking a renewed three-year certification. The final upload date is February 27, 2024, and the virtual review will commence on March 18 and 19, 2024. The review activities will be conducted in several critical areas including Member Experience, Self-Management Tools, Clinical Practice Guidelines, Clinical Measurement Activities, Coordination of Behavioral Healthcare, and Collaboration between Behavioral Health and Medical Care.

External Quality Reviews

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

Performance Improvement Project (PIP)

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

African American's make up the largest portion of our population served at 55%. In addition to supporting the initiative by the state to address issues of racial and ethnic disparities, DWIHN reports state performance measures to MDHHS in relation to 7 and 30-day follow-up after a behavioral health admission which has a goal of 95% set by the state and readmission rates whose goal set by the state is of 15% or less. DWIHN readmission rate in 2020 was 19.67%, in 2021 16.82%, 2022 16.23% and 2023 15.95, the state performance measures are part of how DWIHN is evaluated by the state. Improving the follow-up after 7 days after an inpatient behavioral health admission in African Americans this will help to positively affect these state performance measures and our annual evaluation by the state.

Quantitative Analysis and Trending of Measures

In FY2023, DWIHN received Full Compliance 100% with all the reportable areas for the HSAG PIP (Reducing the Racial Disparity of African Americans Seen for Follow-Up Care Within 7-Days of Discharge from a Psychiatric Inpatient Unit). The goal of the PIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time. The next scheduled reporting remeasurement period for DWIHN's PIP to HSAG will include data from 01/01/2023–12/31/2023. The interventions have been identified and the data will be shared with the provider network.

Evaluation of Effectiveness

In FY2023, the preliminary data for January – December 2023, revealed a racial disparity increase of 3.09 percentage points for 7.6% compared to 4.51% (baseline data) from January – December 2021. Efforts to reduce the Racial Disparity gap will continue in FY2024.

Identified Barriers

- Members forgetting to schedule appointments and/or forgetting a scheduled appointment.
- Transportation issues with either member not being able to schedule their own transportation with Medicaid vendor or Medicaid transportation vendor not showing up to pick up member for their appointment.
- Stigma among the African American Population in relation to having mental health issues.
- Many African Americans still lack trust in medical professionals and often do not seek mental health help because of their fear that they will not receive proper help for their issues.

Opportunities for Improvement

- Identification of ways that members can be reminded of appointments. Schedule follow-up appointment prior to discharge.
- Increase resources and solutions to assist members to get to their appointments.
- Creation of educational materials, advertising resources and increase communication with members.
- Encourage and educate healthcare providers to convey respect and compassion to members including acknowledging members feelings and perspectives during appointments.
- Improve education and awareness about mental health and stigma through public education campaigns and community educational presentations.

Performance Measures Validation (PMV)

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

Quantitative Analysis and Trending of Measures

In FY23, HSAG reviewed DWIHN's performance indicators reporting data for validation. The reporting cycle and measurement period was from October 1, 2022, through December 31, 2023. DWIHN received a full compliance score of 100% with no Plan of Correction (POC), for a third consecutive year.

Evaluation of Effectiveness

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

Identified Barriers
None identified.

Opportunities for Improvement

- Initiate a Value Based Performance Indicator 2a, 3 and 4 Incentive if Service Provider receives a metric of 80% or more for Performance Indicator 2a.
- Continue with existing provider and internal workgroups to regularly review progress on improving performance measure rates and data collection processes.
- Continue to monitor performance trends and target low performing areas, including an assessment of performance at the individual provider level, as well as within core member demographics, to identify systemic patterns of performance.
- Continue to use existing workgroups to identify root causes for low performance and disseminate best practices.
- Ensure that subsequent re-evaluations of members do not affect the original PAR disposition date and time.
- Access to provider notes on their attempts to reach members when they no show for intake appointments.

Compliance Review

The Compliance Review purpose is to ensure that standards are met as identified in 42 CFR and DWIHN's contract requirements. The review focuses on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable state-specific contract requirements. The compliance reviews consist of 13 program areas referred to as standards. HSAG conducts a review of the first six standards in Year One and review of the remaining seven standards in Year Two of the review cycle.

Quantitative Analysis and Trending of Measures

In FY2023, DWIHN received a full Compliance score of 94.2% (33 out of 35 completed). The data in the table presents an overview of the results of the FY2023 compliance review for DWIHN, which detailed the score of Complete or Not Complete to each of the individual elements that required a corrective action plan.

Standard	Total CAP Elements	# of CAP Elements Complete	# of CAP Elements Not Complete
Standard I – Member Rights and Member Information	3	3	0
Standard III – Availability of Services	1	1	0
Standard IV – Assurances of Adequate Capacity and Services	4	4	0
Standard V – Coordination and Continuity of Care	3	3	0
Standard VI – Coverage and Authorization of Services	4	4	0
Standard VII -Provider Selection	4	4	0
Standard VIII - Confidentially	1	1	0
Standard IX – Grievance and Appeal Systems	6	6	0
Standard X - Subcontractual Relationship and Delegation	1	1	0
Standard XI -Practice Guidelines	1	1	0
Standard XII – Health Information System	2	0	2
Standard XIII – Quality Assessment and Performance Improvement Program	5	5	0
Total	35	33	2

Evaluation of Effectiveness

Based on the findings of the FY2021 and FY2022 compliance review activities, DWIHN received a total Compliance score of 94.2% across all standards reviewed except for API requirements.

Identified Barriers

DWIHN must ensure that the Provider Directory API complies with all requirements of 42 CFR and the CMS Interoperability and Patient Access Final Rule.

Utilization Management

The Annual Utilization Management (UM) Program Executive Summary is under a separate cover for FY 2023. It is the responsibility of DWIHN to ensure that the UM Program meets applicable federal and state laws and contractual requirements and is a part of the QAPIP. DWIHN is required to have a written Utilization Management Program Description which includes procedures to evaluate medical necessity criteria, and the processes used to review and approve the provision of mental health and substance abuse services. DWIHN is also required to have an Annual Utilization Management Program Evaluation report to:

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

Adequacy of Quality Improvement Resources

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

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

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

Overall Effectiveness

An evaluation of DWIHN's QI Work Plan for FY2023 has been conducted. This evaluation included review of trended results for QI measures over time, comparison against performance objectives, quantitative and qualitative analyses for completed and ongoing QI activities. Overall, improvements were achieved in planned QI initiatives, both clinical and service. In addition, programs that address member safety were implemented. The Quality Improvement Steering Committee (QISC) and the Program Compliance Committee (PCC) Board reviewed and approved the 2023 QAPIP Evaluation and FY2023 Work Plan (Attachment A). The FY2023 QI Work Plan was implemented in accordance with the plan. The indicators measured cover a broad spectrum, including quality of clinical care, quality of service and safe clinical practices. The QI initiatives are relevant to the needs of the residents of Wayne County and in alignment with DWIHN's mission and vision. DWIHN's organizational structure and resources are adequate and supportive of the QI process.

The quality resource needs are determined based on the percentage of key activities completed and associated goals attained. After evaluating the performance of the Quality Program, DWIHN has determined there are adequate staffing resources to meet the current program goals and include highly educated and trained staff. DWIHN evaluated data, staff, resources, and software to ensure our health information system that collects, analyzes, and integrates the data necessary to implement the QI program is adequate. DWIHN IT has successfully designed, tested, and deployed the Provider Risk Matrix dashboard that is built upon scientific measurable goals for CRSP providers and implemented a new Business Intelligence platform built on Microsoft's world leader PowerBI platform which allows DWIHN to easily connect its data sources and share with staff and providers so they can focus on what's important to deliver quality care. IT also deployed a nationwide NCQA accredited Care Coordination platform that supports the calculation of HEDIS measures and enables us to partner with Health Plans to manage Behavioral and Physical Health services.

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

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

Analysis
DWIHN believes there is adequate practitioner involvement and consultation to meet the objectives of the Quality Program. No changes are anticipated for FY 2024.

Committee Structure
After evaluating the QI program committee structure, DWIHN committee involvement is adequate, and all committee members regularly attend and actively participate in QISC committee meetings. DWIHN's commitment to quality is strong and shared across all levels of the organization. DWIHN believes the structure supports effective governance and aligns key strategic initiatives to ensure adequate guidance to help DWIHN reach goals and objectives. No changes are anticipated for FY2024.

Practitioner Participation
DWIHN continues to have substantial practitioner participation in our QISC committees, Quality Operations Workgroup and adhoc provider advisory workgroups as needed. This represents input from the provider network and practitioner leadership. The practitioners actively participate in the planning, design, implementation, and program evaluation, through data collection and analysis. Their activities ensure program alignment with evidence-based care and overall population management between the health plan, care delivery systems and community partners. In addition to serving on the QISC committee, DWIHN enlists practitioner input regarding key initiatives. After evaluating the practitioner participation, DWIHN believes there is adequate practitioner involvement and consultation to meet the objectives of the Quality Program. No changes are anticipated for FY2024.

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

DWIHN's commitment to continuous improvement is integral to achieving excellent health outcomes and an excellent overall member experience. In 2024, DWIHN will continue to address identified opportunities for improvement to ensure optimal member experience.

Work Plan Goals and Objectives FY2024
In FY 2024, the QAPIP work plan will be reviewing these areas to achieve continuous quality improvement in the quality and safety of clinical care, quality of service and member experience.

- Maintain NCQA accreditation..
- Establish an effective Crisis Response System and Call Center.
- Continuously improve the quality, appropriateness, availability, accessibility, coordination, and continuity of health care services to members across the continuum of care.
- Continue implementation transition of Home and Community Based Services Waiver.
- Improve member and provider satisfaction.
- Ensure a high-quality network through credentialing, peer review and contracting processes.
- Establish and revised/improved regional standardized contract and provider performance monitoring protocols for autism service providers, fiscal intermediary service, specialized residential provider, and inpatient psychiatric units.
- Continue to collaborate with providers to share ideas and implement strategies to improve

care coordination and quality of service.

- Improve and manage member outcomes, satisfaction, and safety.
- Maintain excellent compliance with state and federal regulatory requirements, and accreditation standards.
- Ensure DWIHN's organizational initiatives related to cultural competency and diversity for members and providers meet the needs of DWIHN members.
- Address regional role in statewide training and provider performance monitoring reciprocity activities.
- Continue efforts to participate in children/family outreach by attending community events, schools, and working with children service providers to increase mental health awareness, information, and access to services.
- Demonstrate and communicate DWIHN's commitment to improving progress toward influencing network-wide safe clinical practices.
- Support DWIHN strategic planning efforts related to becoming a Certified Community Behavioral Health Home (CCBHC), Behavioral Health Homes (BHH) and increase Opioid Health Home (OHH) provider services.
- Continue to increase the training of providers, health care workers, jail staff, drug court staff, community organizations and members of our region on how to use Naloxone to reverse opioid overdose.

Work Plan Summary and Work Plan FY 2023-2024

DWIHN Quality Improvement goals are integrated and communicated throughout the organization with a structure Work Plan, with identified goals objectives that are owned at the departmental level. DWIHN's organizational monitoring activities, reports and documented processes are reviewed throughout the year by the Quality Improvement Steering Committee (QISC) and Program Compliance Committee (PCC) no less than quarterly to identify opportunities for improvements. These activities, in addition to ongoing Performance Improvement Projects (PIPs), form the basis of the organization's Work Plan and support all services offered by DWIHN. The Behavioral Healthcare landscape, key strengths, and opportunities for improvement guided DWIHN's overall quality-related efforts in FY2023

QAPIP Work Plan
FY 2022 - 2023 (October 1, 2022 through September 30, 2023)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
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 2022 ECHO® Survey (Children and Adult) results will be collated, reviewed, analyzed and reported by April of 2023.	The target goal is to increase each outcome reported during FY2021 for both Adults and Children. **Adults:** Improve member access to behavioral health services for the 3 reporting measures scoring < 50% which include:1) Perceived Improvement 29%; 2)Getting Treatment Quickly 46% 3). Office Wait 44%. **Children: I**mprove member access to behavioral health services for the 2 reporting measures scoring < 50% which include: 1). Perceived Improvement 28% 2). Getting Treatment Quickly 46%.	Previously identified issues are to increase outcomes and makes recommendations for planning interventions and improvements to optimize five major categories, including, but not exclusive of; Treatment of Care issues, Access to Care, Timeliness and appropriateness of Care.	**Target goal met**. DWIHN has noted slight improvements in both the Adult and Children's population in review of the combined trends, with slight variations in the outcomes between the two surveys over serveral years. Goal will continue in FY 2024.	Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 4 of FY-2024.

QAPIP Work Plan
FY 2022 - 2023 (October 1, 2022 through September 30, 2023)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
I.2	Provider and Practitioner Satisfaction Survey	Director of Strategic Operations, Director of Managed Care Operations (MCO)	In FY 2023 Q4 results of the Provider Satisfaction surveys will be collated, reviewed, analyzed for comparison between FY2022 and FY2023. The 2022 Practitioner Satisfaction Survey results will be collated, reviewed, analyzed and reported by September of 2023.	The target goal is to increase providers response outcomes by 10% or higher.	Previously identified issue. Provider Satisfaction survey questions were modified in FY2022, no data is available for comparison until FY2023. This is a continuation goal from FY2022.	The baseline data has been collected from FY2023; the re-measurement 1 data will be collected during FY2024. Goal will continue in FY 2024.	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 FY2024.
I.3	Grievance/Appeals	Director of Customer Service	FY 2022-2023 (October 1, 2022 through September 30, 2023) results will be collated, reviewed, analyzed and reported by Q2 of January 2024.	The target goal is to improve outcomes by resolving grievances and appeals within the required time frame.	Previously identified issue resolving grievances within required time frame. This is a continuation goal from FY2022.	**Target goal met**. 95.6% grievances were resolved within the Customer Service unit during FY2023. Goal will continue 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.

QAPIP Work Plan
FY 2022 - 2023 (October 1, 2022 through September 30, 2023)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
I.4	Timeliness of Utilization Management Decisions	Director of Utilization Management	FY 2022-2023 (October 1, 2022 through September 30, 2023) 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 FY2022.	**Target goal met** at 93.5% for FY2023.	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.
I.5	Practice Guidelines	Chief Medical Officer	FY 2022-2023 (October 1, 2022 through September 30, 2023). 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.	Previously identified issues. Lack provider feedback and participation to review practice guidelines as required. This is a continuation goal from FY2022.	**Target goal met**. DWIHN has adopted practice guidelines that are in consultation with the provider network.	Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.

QAPIP Work Plan
FY 2022 - 2023 (October 1, 2022 through September 30, 2023)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
I.6	Cultural and Linguistic Needs	Director of Customer Service, Director of Managed Care Operations, Director of Quality Improvement Diversity, Equity & Inclusion Administrator	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to improve outcomes through cultural competency, language, and physical accessibility by identifying existing racial and ethnic disparities within our provider network for all populations.	Previously Identified Issue: Develop best practices that promote cultural linguistic competency and enrich workforce development on cultural linguistic competency specific needs. This is a continuation goal from FY2022.	**Target goal met.** DWIHN established a DEI Coalition made up of 24 Providers and Community Stakeholders. The Coalition was established to create an inclusive community that stands up for equity at all levels throughout the 75,000 people.	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.
Access Pillar							
Goal II (Quality of Service and Quality of Clinical Care)	**Improve members Access to Services, Quality of Clinical Care, and Health and Safety**						
	Michigan Mission Based Performance Indicators (MMBPI)						

QAPIP Work Plan
FY 2022 - 2023 (October 1, 2022 through September 30, 2023)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
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 2022-2023 (October 1, 2022 through September 30, 2023). 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 FY2022.	**Target goal met**. Standard met for all quarters. Total population rate Adult (97.47%); Child (98.15%) Goal will continue in FY2024.	Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
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 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to achieve comparable scores within the region to the state wide average. FY22 results: Q1(52.85%), Q2 (59.23%), Q3 (37.84%) and Q4 (44.26%). Total population rate (48.30%).	Previously identified issues. This measure allows for no exceptions. MDHHS has not established a minimum threshold for this measure. This is a continuation goal from FY2022.	**Target goal met**. Achieve comparable scores during FY23 Q1(45.15%) (Q2 (49.66%), Q3 (48.04%), Q4 (50.40%) The state average for FY23 (51.92%) Benchmark for FY24 (57%).	Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.

QAPIP Work Plan
FY 2022 - 2023 (October 1, 2022 through September 30, 2023)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
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 2022-2023 (October 1, 2023 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to achieve comparable scores within the region to the state wide average. FY22 results: Q1(82.36%), Q2 (87.27%), Q3 (84.66%) and Q4 (88.32%). Total population rate (85.71%).	No previously identified issues during FY2022. This measure allows for no exceptions. MDHHS has not established a minimum threshold for this measure. This is a continuation goal from FY2022.	**Target goal met**. Achieve comparable scores during FY23 Q1(87.24%) (Q2 (89.63%), Q3 (90.33%), Q4 (90.54%) The state average for FY23 (72.21%) Benchmark for FY2024 (83%).	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.
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 2022-2023 (October 1, 2022 through September 30, 2023). 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 FY2022.	**Target goal partially met**. Standard not met for Q4 Child (89.29%). Goal will be continued 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.

QAPIP Work Plan
FY 2022 - 2023 (October 1, 2022 through September 30, 2023)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
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 2022-2023 (October 1, 2022 through September 30, 2023). 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 FY2022.	**Target goal met.** Standard met for all quarters. Total rate population (99.53%). Goal will be continued 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.
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 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to meet or exceed performance standard. Standard is 15% or less. FY22 results Q2 (16.31%), Q3 (17.79%), Q4 (15.89%). Total population rate (15.43%).	Previously identified issues. Targeted goal not met with Recidivism for the adult population for three out of four quarters. This is a continuation goal from FY2022.	**Target goal partially met.** Standard met for the children population. Standard not met for the adult population for three out of four quarters Q2 (15.71%), Q3 (17.71%), Q4 (16.09%). Total population rate (15.39%). Goal will continue 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.

QAPIP Work Plan
FY 2022 - 2023 (October 1, 2022 through September 30, 2023)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
II.7	Complex Case Management	Director of Integrated Health Care	FY 2022-2023 (October 1, 2022 through September 30, 2023) results will be collated, reviewed, analyzed and reported by Q2 of February 2024.	The target goals are to improve medical and behavioral health concerns and increase overall functional status by 10% in PHQ scores, provide early intervention for members appropriate for Complex Case Management to prevent recurrent crisis or hospitalizations, increase participation in the number of members who attended two out-patient behavioral health services within 60 days of starting CCM services who were open for at least 60 days and improve member satisfaction scores by 20%.	No previously identified issues during FY2022.	**Target goal met**: Members participating in Complex Case Management services demonstrated overall improvement in their PHQ scores, and the improvement increased the longer that the members participated in CCM services. Average PHQ scores improved 24% from baseline at 30 days, 28% at 60 days and 28% at 90 days of receiving CCM services.	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.

QAPIP Work Plan
FY 2022 - 2023 (October 1, 2022 through September 30, 2023)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
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 number of re-hospitalization within 30 days of discharge to 15% or less for Adults. FY22 results Q2 (16.31%), Q3 (17.79%), Q4 (15.89%). Total population rate (15.43%).	Previously identified issues. Targeted goal not met with Recidivism for the adult population for three out of four quarters. This is a continuation goal from FY2022.	**Target goal partially met**. In FY23, recidivism increased through Q3 in this fiscal year and has decreased in Q4. The Crisis Services team will continue to work with the CRSPs to require members be seen within 72 hours of admission to an inpatient level of care. Continue efforts to decrease adult recidivism rate.	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.
Workforce Pillar							

QAPIP Work Plan
FY 2022 - 2023 (October 1, 2022 through September 30, 2023)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
Goal III. (Quality of Service)	Develop and maintain a Competent Workforce through the Credentialing and Re-Credentialing Process						

QAPIP Work Plan
FY 2022 - 2023 (October 1, 2022 through September 30, 2023)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
III.1	Maintain Competent Workforce	Innovation and Community Engagement (ICE), Provider Network Administrator Credentialing, Director of Quality Improvement, Director of Clinical Practices Improvement, Director of Managed Care Operations	FY 2022-2023 (October 1, 2022 through September 30, 2023). 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 FY2022.	**Target goal met.** During FY 2023, ICE offered various mental health first aid and suicide prevention awareness training system-wide, and law enforcement organizations. Approximately, 2500 individuals learned about the signs and symptoms of mental illness, and behavioral clues to address the risk of suicide. Goal will continue in FY 2024.	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.
Finance Pillar							
Goal IV (Quality of Service)	**Maximize Efficiencies and Control Costs**						

QAPIP Work Plan
FY 2022 - 2023 (October 1, 2022 through September 30, 2023)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
IV.1	Verification of Services	Director of Quality Improvement, Corporate Compliance Officer	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed Bi-quarterly (1st & 2nd Quarter (October 1, 2022 - March 31, 2023); (3rd & 4th Quarter April 1, 2023 - September 30, 2023).	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 FY2022.	**Target goal met.** Reviewed 100% of randomly selected Paid Encounters/Claims in FY2023. This will be a continuation goal for 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.
Quality Pillar							
Goal V (Safety of Clinical Care)	**Improve Quality Performance, Member Safety and Member Rights system-wide**						

QAPIP Work Plan
FY 2022 - 2023 (October 1, 2022 through September 30, 2023)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V.1	Provider Network Performance Monitoring - Clinically Responsible Service Provider (CRSP)	Director of Quality Improvement	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to increase the number of provider reviews from FY2022 by 15% or higher to ensure Continuous Quality Improvement.	No previously identified issues during FY2022.	**Target goal met.** DWIHN saw an increase in provider monitoring by 30%. Goal will continue 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.2	Residential Treatment Providers	Director of Quality Improvement	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to increase number of Residential Treatment Provider reviews from FY2022 by 15% or higher to ensure Continuous Quality Improvement.	No previously identified issues during FY2022.	**Target goal met.** DWIHN saw an increase in residential treatment provider monitoring by 20%. Goal will continue 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.

QAPIP Work Plan
FY 2022 - 2023 (October 1, 2022 through September 30, 2023)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V. 3	Long Term Supports Services (LTSS)	Director of Quality Improvement; Director of Customer Service	FY 2022-2023(October 1, 2022 through September 30, 2023). 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.	Previously identified issues for FY2022 include no data collection or analysis for members receiving LTSS services.	**Target goal met**. Nearly 80% of participants expressed satisfaction with in LTSS services in FY2022 survey. This goal will continue 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 2022-2023(October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to increase Provider's participation in Self Monitoring reviews from the pervious year by 20% or higher to ensure inter rater reliability.	No previously identified issues during FY2022.	**Target goal met**. DWIHN saw an slight increase in Provider self-monitoring reviews compared to FY22. Goal will continue 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.5	Autism Services	Director of Quality Improvement, Director of Children's Initiatives	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to increase the number of Providers reviewed from FY2022 by 15% or higher to ensure Continuous Quality Improvement.	No previously identified issues during FY2022.	**Target goal met**. All ABA providers were reviewed during FY2023. Goal will continue 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 FY-2024.

QAPIP Work Plan
FY 2022 - 2023 (October 1, 2022 through September 30, 2023)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V.6	Critical/Sentinel/Unexpected Death and Risk Reporting	Director of Quality Improvement	FY 2022-2023 (October 1, 2022 through September 30, 2023). 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 FY2022.	**Target goal met**. MDHHS requirements met to timeliness of data and reporting standards, along with concerning trends identified. Monitoring for unexpected deaths and risk events according to the system. Goal will be continued 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.7	Behavior Treatment Review	Director of Quality Improvement, Chief Medical Officer	FY 2022-2023 (October 1, 2022 through September 30, 2023). 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 FY2022.	**Target goal met.** Goal will continue 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.
(Quality of Clinical Care)	**Quality Improvement Projects (QIP's)**						

QAPIP Work Plan
FY 2022 - 2023 (October 1, 2022 through September 30, 2023)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
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 2021-2022 (October 1, 2022, through September 30, 2022). Data reporting is collated, reviewed, and analyzed quarterly. 90-day lag on 2023 data analysis.	The target goal for 7-day Follow-up: Ages 6-17 (70%) for ages 18-64 (58%); 65 Older (58%) or higher in improving the availability of a follow up appointment with a Mental Health Professional within 7 days after Hospitalization for Mental Illness. The target goal for 30-day Follow-up: Ages 6-17 (70%); 18-64 (58.0%); 65 Older (58.0%)	Previously identified issue. Targeted goal not met. This is a continuation goal from FY2022 Workplan.	**Target goal not met.** Results for 7 Day: Ages 6-17 Years 45.02% for 7-day ages18-64 (30.39%) 65 and older (28.74%) Results for 30 Day: Ages 6-17 (67.68%); 18-64 (50.38%); 65 Older (36.78%) This will be a continuation 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.8b	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Director of Integrated Health Care Director of Quality Improvement	FY 2021-2022 (October 1, 2022, through September 30, 2022). Data reporting is collated, reviewed, and analyzed quarterly. 90-day lag on 2023 data analysis.	The target goal is 45% or higher. This measure analyzes the percentage of members 19 to 64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.	Previously identified Issue. Targeted goal not met for FY2022. This is a continuation goal from FY2023.	**Target goal not met**. Results was 47.05% which is below the State of Michigan quality compass benchmark for 2022 average of 66.28%. This will be a continuation 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 2022 - 2023 (October 1, 2022 through September 30, 2023)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V.8c	Antidepressant Medication Management for People with a New Episode of Major Depression	Director of Integrated Health Care, Director of Quality Improvement	FY 2021-2022 (October 1, 2021, through September 30, 2021). Data reporting is collated, reviewed, and analyzed quarterly. 90-day lag on 2023 data analysis.	The target comparison is goal is 77.32% (Acute). The target comparison goal is 63.41% (Chronic)	Previously identified Issue. Targeted goal not met for FY2022. This is a continuation goal from FY2022 Workplan.	**Target goal not met.** Results for the Acute Phase 35.55%. Results for the Chronic Continuation Phase 12.50%. This will be a continuation goal for FY2024 Workplan.	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 2021-2022 (October 1, 2022, through September 30, 2022). Data reporting is collated, reviewed, and analyzed quarterly. 90-day lag on 2023 data analysis.	The target goal is 86.35% or higher. This measure analyzes the percentage of patients 18-64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening during the measurement year.	Previously identified issue. Targeted goal not met for FY 2022 (64.86%). This is a continuation goal from FY2022 Workplan.	**Target goal not met.** DWIHN results for 2022 was 74.43% this is a 9.57 percentage point increase compared to FY2021. The goal of 86.36% was not achieved. This will be a continuation 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	Case Finding for Opiate Treatment	Director of Substance Use Disorder	FY 2022-2023 (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 is a continuation goal from FY2022 Workplan.	**Target goal not met.** Rate 60%, Goal at 79%. This will be a continuation 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 2022 - 2023 (October 1, 2022 through September 30, 2023)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V.8g	PHQ-9 Implementation	Director of Clinical Practice Improvement	FY 2022-2023 (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%)	**Target goal met** at 99.1%. This will be a continuation 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.8h	PHQ-A Implementation	Director of Children's Imitative	FY 2022-2023 (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 FY22 (99.2%).	**Target goal met** at 99.7%. This will be a continuation 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 2022 - 2023 (October 1, 2022 through September 30, 2023)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V.8i	Decreasing Wait for Autism Services	Director of Children's initiative	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is 100%	Previously identified issue. Targeted goal not met (67.5%). This is a continuation goal from FY2022 Workplan.	**Target goal not met. Results** (47%) This performance improvement plan presented various challenges that led to the rate decreasing below the baseline goal of 33% during FY 23, Q1 (36%), FY 23, Q2 (35%), FY 23, Q3 (61%), and FY 23, Q4 (57%). FY 23, Q3 was the best performing rating period at 61%. This will be a continuation goal for FY2024.	Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2022 on the reporting measure. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.
	Advocacy Pillar						
Goal VI.	**Increase Community Inclusion and Integration**						

QAPIP Work Plan
FY 2022 - 2023 (October 1, 2022 through September 30, 2023)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
VI.1	Home and Community Based Services (HCBS)	Director of Quality Improvement	FY 2022-2023 (October 1, 2022 through September 30, 2023). 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 FY22. DWIHN must ensure all new providers of HCBS services are assessed and meet the final rule requirements. This is a continuation goal from FY2022.	**Target goal not met**. This will be a continuation goal for 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.
Goal VII (Quality of Service)	**External Quality Reviews**						

QAPIP Work Plan
FY 2022 - 2023 (October 1, 2022 through September 30, 2023)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
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, Provider Network Administrator Credentialing, Director of Integrated Health Care, Director of Human Resources	FY 2022-2023 (October 1, 2022 through September 30, 2023). 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 FY2022.	MDHHS Full Site Review for the Habilitation Supports Waiver, the Children's Waiver, the Children's Serious Emotional Disturbance Waiver Review is scheduled for March 11, 2024 to April 26, 2024.	Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 3 of FY-2024.

QAPIP Work Plan
FY 2022 - 2023 (October 1, 2022 through September 30, 2023)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
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, Provider Network Administrator Credentialing, Director of	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.	DWIHN is currently seeking a renewed three-year certification. The upload date is February 27, 2024, and the virtual review will commence on March 18 and 19, 2024.	Submit quarterly reports to PCC on the recertification process. DWIHN will be revaluated for re-certification in January 2024.

QAPIP Work Plan
FY 2022 - 2023 (October 1, 2022 through September 30, 2023)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
VII.3	Health Services Advisory Group (HSAG)-Validation of Performance Projects (PIP)	Director of Quality Improvement	FY 2022-2023 (October 1, 2022 through September 30, 2023). 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 during FY22.	**Target goal met**. In FY23, DWIHN received 100% compliance for barriers, interventions and for the data analysis for submission requirements.	Submit quarterly reports to PCC on performance outcomes. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 3 of FY-2024.

QAPIP Work Plan
FY 2022 - 2023 (October 1, 2022 through September 30, 2023)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
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, Provider Network Administrator Credentialing, Director of Integrated Health Care, Director of Human Resources	FY 2022-2023 (October 1, 2022 through September 30, 2023). 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 2023.	Previously identified issue. Targeted goal not met in FY22; achieved an overall score 83.0%.	**Target goal met.** FY2023, DWIHN received a full Compliance score of 94.2% (33 out of 35 completed CAP's.) No MDHHS TA sessions required.	Submit quarterly reports to PCC on performance outcomes. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 4 of FY-2024.

QAPIP Work Plan
FY 2022 - 2023 (October 1, 2022 through September 30, 2023)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
VII.3b.	Health Services Advisory Group (HSAG) - Performance Measure Validation (PMV)	Director of Quality Improvement, IT Administrator, Claims Administrator	FY 2022-2023 (October 1, 2022 through September 30, 2023). 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 with no plan of correction during FY22.	**Target goal med**ian received a full compliance score of 100% with no Plan of Correction (POC).	Submit quarterly reports to PCC on performance outcomes. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 3 of FY-2024.

QAPIP Work Plan
FY 2022 - 2023 (October 1, 2022 through September 30, 2023)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
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, Provider Network Administrator Credentialing, Director of Integrated Health Care, Director of Human Resources	FY 2022-2023 (October 1, 2022 through September 30, 2023). 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 during FY2022.	**Target goal met.** MDHHS needs assessment documents submitted as required.	Submit quarterly reports to PCC on performance outcomes. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.

QAPIP Work Plan
FY 2022 - 2023 (October 1, 2022 through September 30, 2023)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
VII. 5	QAPIP Description: The QAPIP Description is written according to MDHHS and NCQA guidelines. The QAPIP Description scope, goals, objectives and structure are written to assure regulatory compliance.	Director of Quality Improvement	Complete written QAPIP Description for FY2023-2025 by February 2024. Reviewed Annually	No previous issues identified in FY2023	No previously issues requiring follow-up	Target Goal: All MDHHS and NCQA requirements are met 95% or greater	Present QAPIP Description to QISC, PCC and Full Board (Q2-FY2024).
VII. 6	QAPIP Evaluation The Evaluation is developed annually.	Director of Quality Improvement	Annual (FY2023)	The Target Goal is to Collate analyze and report annually by February 2024. Annual results to be shared with stakeholders and members.	Previous issues identified during FY2022: Not all QI goals were met during FY2023.	**Target Goal** Partially Met: Goals that were not met or partially met will be continued in FY(2024)	Present QAPIP Evaluation to QISC, PCC and Full Board annual (Q2-FY2024)
VII. 7	QAPIP Work Plan The QI workplan is developed after review of previous year's work plan. The work plan is evaluated and updated on an ongoing basis to reflect the status of all QI goals.	Director of Quality Improvement	The QAPIP work plan will be developed by FY2024.	Target Goal is that the work plan will include all MDHHS and NCQA requirements. Annual results to be shared with stakeholders and members.	Previous issues identified during FY2023. Goal completion rate for FY2023 was 80%. Threshold is 95% or higher.	**Target Goal** Partially Met: FY2023 (5%) Not Met: (15%) Completion Rate.	Present QAPIP Work Plan to QISC, PCC and Full Board annual (Q2- FY2024).