



DETROIT WAYNE INTEGRATED HEALTH NETWORK  
QUALITY ASSURANCE PERFORMANCE  
IMPROVEMENT PLAN  
(QAPIP) DESCRIPTION  
FY2021-2023  
REVIEWED  
3/1/2023

**Approved:**

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Approved by Program Compliance Committee (PCC)	2/9/2022
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## SECTION 1: Introduction

The Detroit Wayne Integrated Health Network (DWIHN), a National Committee Quality Assurance (NCQA) accredited Managed Behavioral Health Organization (MBHO) is the Pre-Paid Inpatient Health Plan (PIHP) and Community Mental Health Service Provider (CMHSP) for Detroit and Wayne County. DWIHN is the largest community mental health service provider in the State of Michigan. The Quality Assurance Performance Improvement Plan (QAPIP) Description provides the structure and governance to guide the formal processes for evaluating and improving the quality and appropriateness of health care services and the health status of the populations we serve. The QAPIP describes the quality activities undertaken by DWIHN to promote and achieve excellence in all areas through continuous quality improvement.

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

The term of the QAPIP begins October 1, 2021 and ends September 30, 2023. Upon expiration of the term, the QAPIP shall remain in effect until the DWIHN's Board of Directors approves a new QAPIP. The QAPIP incorporates by reference, any and all policies and procedures necessary to operate as a Prepaid Inpatient Health Plan and Community Mental Health Services Program. The DWIHN's Board of Directors hereby approves all current and subsequent policies and procedures through the approval of the QAPIP.

## Mission, Vision and Values

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

### Mission

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

### Vision

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

### Values

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

## Quality Assurance Performance Improvement Plan (QAPIP) Description

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

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

## Scope of the QAPIP

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

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

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

### **Quality Improvement (QI) Program**

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

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

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

#### **QI Staff Members' Assigned Activities and Professional Qualifications:**

##### **1. Board of Directors (BOD):**

- The BOD primary responsibility is to provide leadership, governance and oversight of the region. The Board is a policy setting body, the fiduciary of the Medicaid funds.

## 2. Chief Medical Officer (CMO):

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

### **Responsibilities include:**

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

### 3. DWIHN Psychiatrist

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

### 4. Director of Quality Improvement

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

### 5. Provider Network QI Administrator

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

6. Psychologist Behavior Treatment Reviewer

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

7. Clinical Specialist Performance Monitor

- Master's degree in nursing or social work preferred. Bachelor's degree in psychology, social work, or related human services required. Certification as an addiction drug counselor (CADC) or certification as advanced addiction drug counselor (CAADC) or an approved development plan by the Michigan Certification Board for addiction professional (MCBAP) required.
- Promotes and facilitates specific communication and coordination of care with providers and behavioral health practitioner(s).
- Supports discharge planning activities that include aftercare referrals and referrals to community resources.
- Facilitates complex care management services through treatment plan review and provider consultation.
- Conducts ongoing assessment of clinical status and functioning.
- Monitors providers for compliance.
- Facilitates communication with medical and behavioral health providers regarding the enrollee/member's treatment plan.
- Ensures the enrollee/member receives appropriate and medically necessary services thru out the continuum of care as well as coordination of care.
- Reviews targeted case management needs, vocational and/or housing assistance and interacts with providers as needed.
- Maintains accurate records of all communications regarding the authorization process in the clinical software system (MHWIN).
- Provides education and motivation to enrollee/members.

#### 8. Critical/Sentinel Event Reviewer:

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

#### 9. Registered Nurse Clinical Specialist

- Bachelor's Degree in Nursing with certification as Registered Nurse in the State of Michigan.
- Must meet credentialing qualification in at least one of the following: Qualified Mental Health Professional (QMHP), Qualified Intellectual Disabilities Professional (QIDP), Qualified Children Mental Health Professional (QCMHP).
- Three (3) years of work experience in behavioral healthcare, two years of progressively responsible experience in a community mental health setting, two years in clinical practice.
- Review of Critical/Sentinel Events to determine if the incident meets the criteria and definitions for a critical event, critical incidents, risk events, sentinel event, or media events and is related to a practice or standard of care.
- Review to classify a critical event or incident as either a) sentinel event, or b) non-sentinel event.
- Develop and update the "MH-WIN Procedural Guidance Manual for Reporting Critical Incidents/Events, Sentinel Events and Death Reporting Process".
- Documentation and reporting of high profile, media-reported and urgent incidents that meet the critical incident criteria.
- Develop Critical/Sentinel event face-to-face trainings for the provider network for accessing the Critical/Sentinel Event Module.
- Reporting of ALL deaths (expected and unexpected) along with the appropriate information to MDHSS within 24 hours of knowledge.
- Responsible for closure of assigned deaths in the MH-WIN Module.
- Review of investigations of records and information concerning the member including, but not limited to, the review of Individual Plans of Service (IPOS), progress notes, psychiatric evaluations, Behavior Management Plans, records of dispute resolutions, grievances and appeals, and recipient rights complaints.



### **Cultural and Linguistic Needs**

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

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

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

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

## Credentialing and Re-Credentialing

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

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

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

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

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

### **Framework for Quality Improvement**

1. **Find a Process to Improve**
2. **Organize to Improve**
3. **Clarify Current Knowledge of the Process**
4. **Uncover Causes of Process Variation or Poor Quality**
5. **State Plan Do Study Act (PDSA)**
  - i. **Plan the Improvement Process**
  - ii. **Do the Improvement, Data Collection, and Analysis**
  - iii. **Study the Results and Lessons Learned**
  - iv. **Act by Adopting, Adjusting, or Abandoning the Change**

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

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

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

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

### **Continuous Quality Improvement Activities**

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

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

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

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

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

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

At a minimum, the QAPIP specifies the following elements:

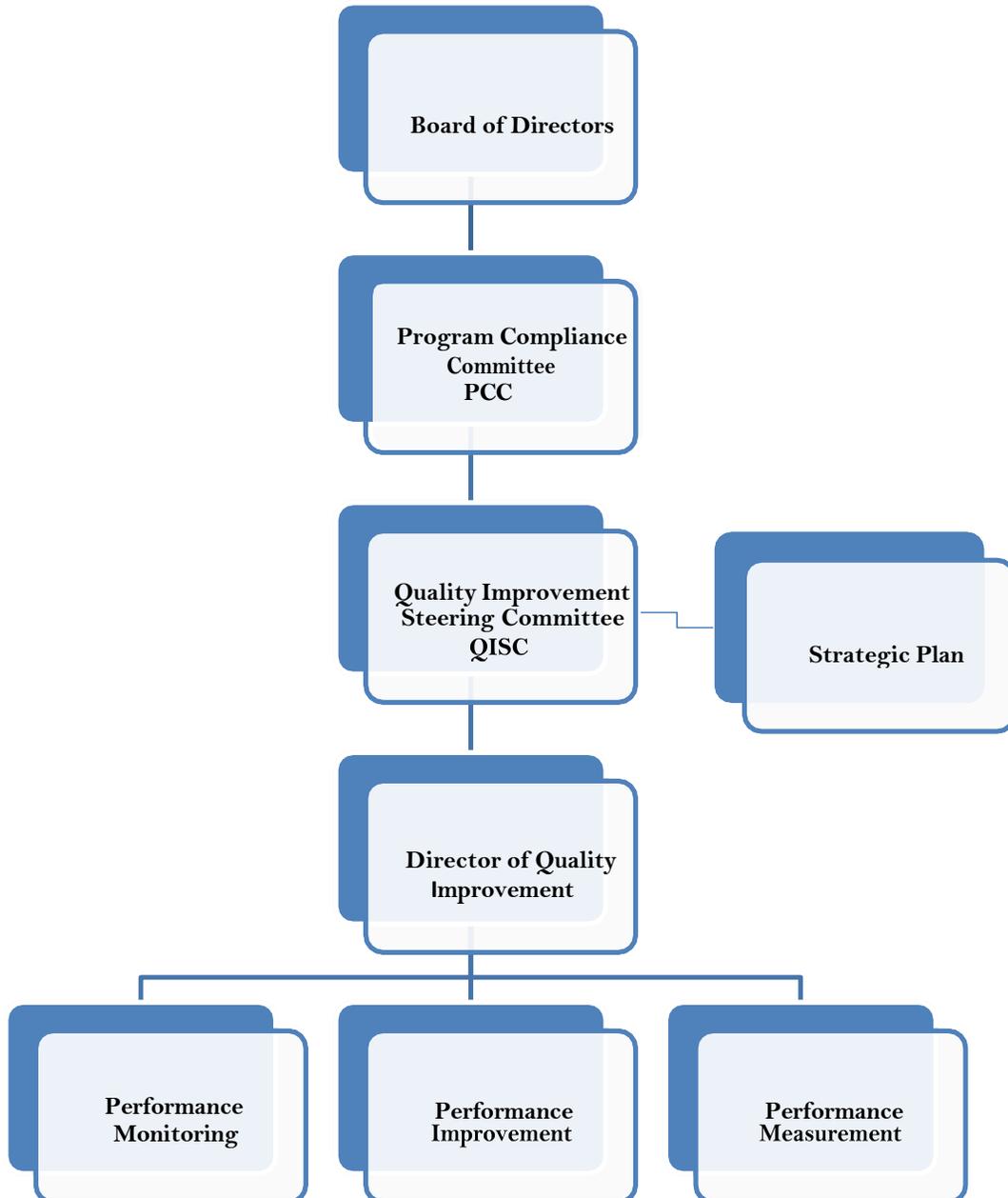
- a. An adequate organizational structure that allows for clear and appropriate administration and evaluation of the QAPIP.
- b. Responsibilities of the governing body for monitoring, evaluation and making improvements to care.
- c. Objectives and timelines for implementation and achievement.
- d. Role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

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

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

## SECTION 2: Leadership and Structure

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



## **GOVERNING BODY**

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

### **Director of Quality Improvement**

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

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

### **SECTION 3: Quality Improvement (QI) Unit**

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

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

#### **Performance Improvement**

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

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

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

## Performance Improvement Projects (PIPs)

### Clinical/Non-Clinical PIPs

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

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

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

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

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

In partnership with stakeholders Quality Improvement activities include:

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

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

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

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

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

This planned communication may take place through the following methods:

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

## **Critical/Sentinel, Unexpected Deaths and Risk Reporting**

DWIHN Reporting of Consumer Critical Event, Sentinel Event, and Death policy establishes the guidelines for reporting and reviewing possible Sentinel Events and/or Critical Incidents. The policy states that DWIHN will conduct administrative reviews and follow-up of Sentinel Events to determine if the event meets the criteria and definition for a critical event, critical incidents, risk events, sentinel event, media events, or risk thereof and is related to a practice or standard of care. The Sentinel Event Committee/Peer Review (SEC/PRC) Committee reports Sentinel Event findings for review and analysis, and document follow-up and system improvement efforts, as required by MDHHS practice guidelines. The SEC/PRC Committee also conducts review and analysis of sentinel event reports submitted by the CRSP/SUD Providers. The SEC/PRC submits no less than annually to the Governing Body a periodic summary and recommendations for action response and disposition. The SEC/PEC committee may require follow-up action on the part of the provider in the form of a Corrective Action Plan / Improvement Plan or Root Cause Analysis (RCA).

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

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

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

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

DWIHN has a process for analyzing additional critical events that put individuals at risk of harm. This analysis is used to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents. These events minimally include: actions taken by individuals who receive services that cause harm to themselves; actions taken by individuals who receive services that cause harm to others; two or more unscheduled admissions to a medical hospital (not due to planned surgery or the natural course of a chronic illness, such as when an individual has a terminal illness) within a 12-month period; police calls by staff of specialized residential treatment providers or other provider agency staff for assistance with an individual during a behavioral crisis situation regardless of whether contacting police is addressed in a behavioral treatment plan; and emergency use of physical management by staff in response to a behavioral crisis.

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

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

### **Member Experience and Services**

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

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

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

## Long-Term Services and Supports (LTSS)

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

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

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

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

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

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

### **Verification of Services**

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

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

### **Provider Network**

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

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

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

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

**Figure 1.**

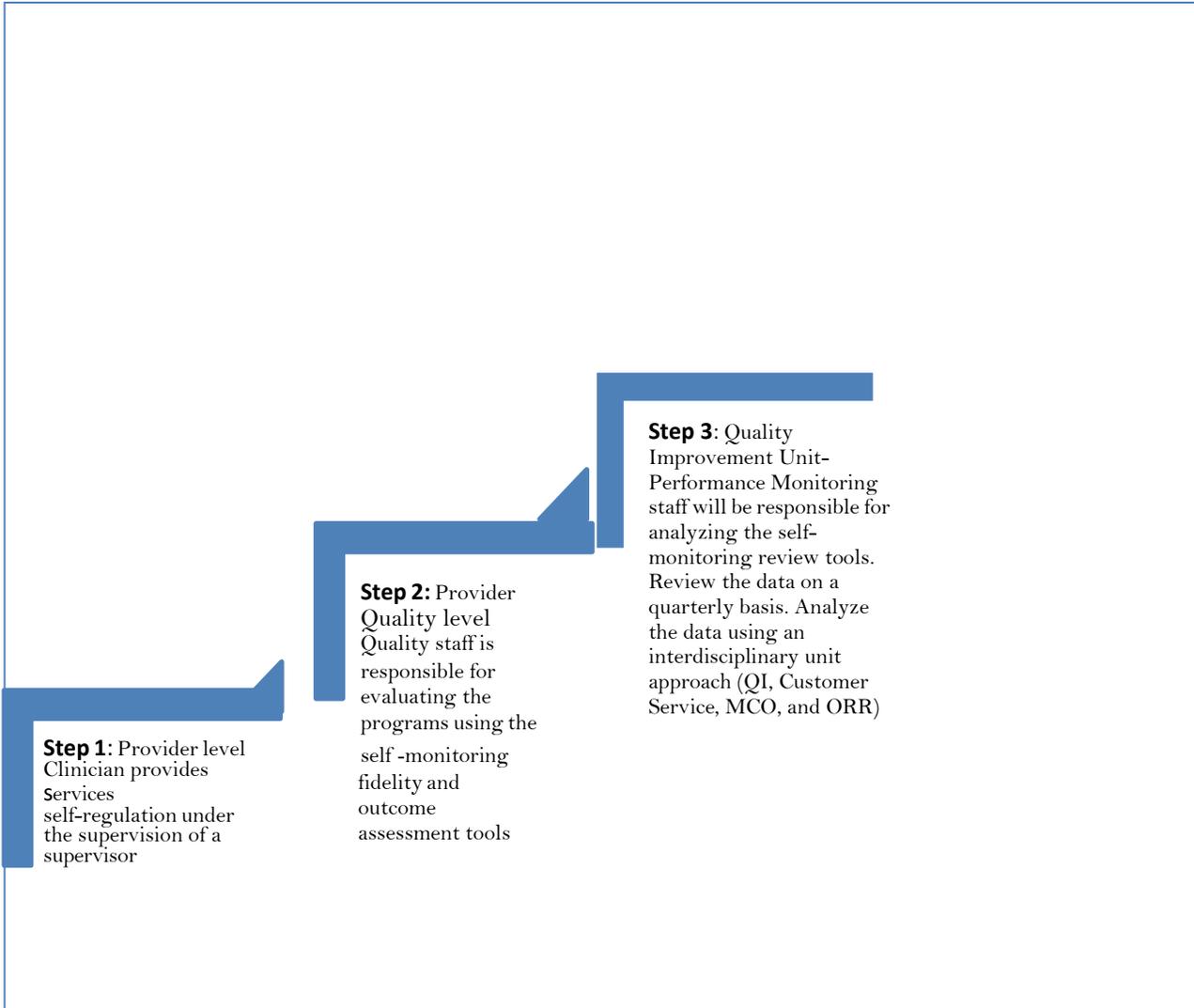


The Performance Monitoring Plan is geared to improve quality and measure our performance in the delivery of service and compliance with required standards. This plan requires the involvement, skills, expertise and input from DWIHN’s Service Provider Network and internal staff. Requiring self-regulation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

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

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

**Process Steps of Performance Monitoring Pathway (defined by QI)**

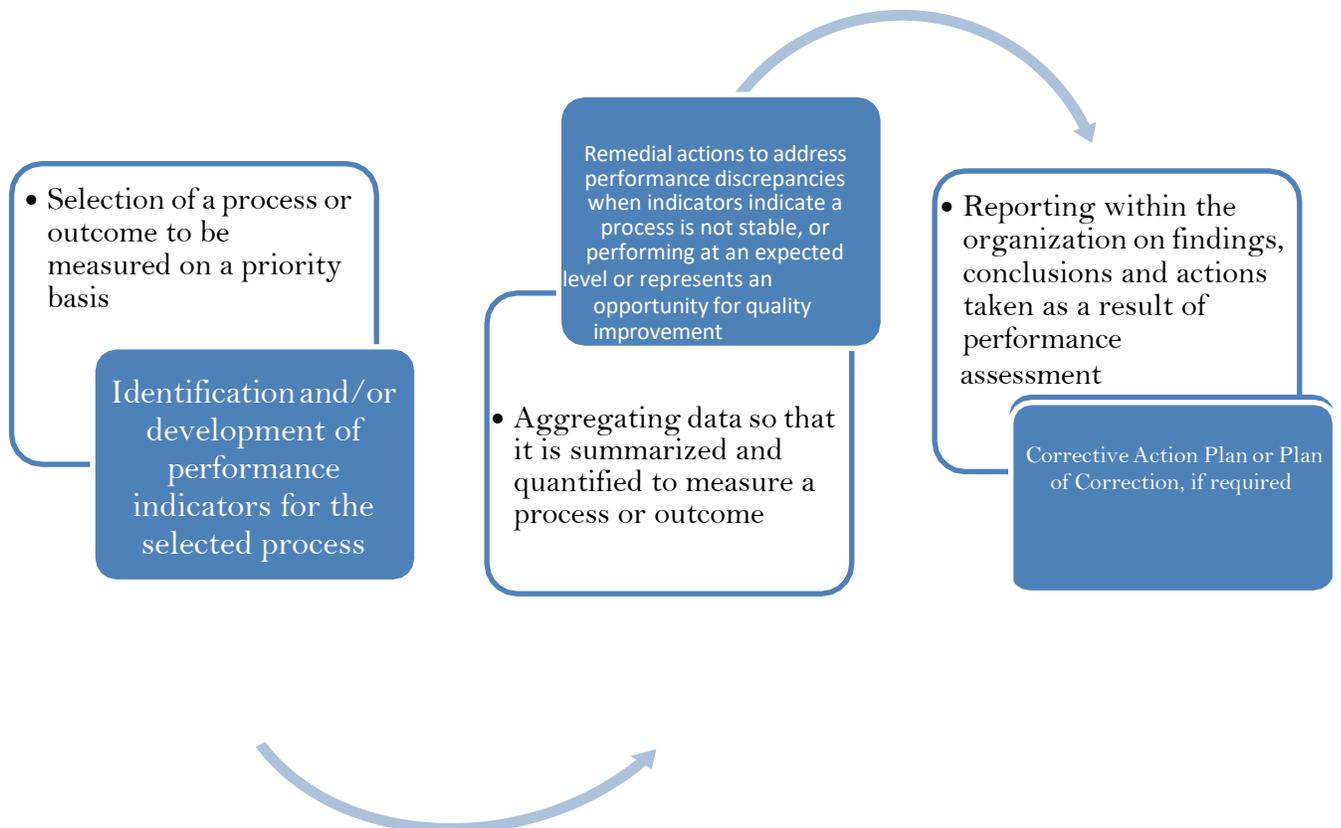


### Performance Measures

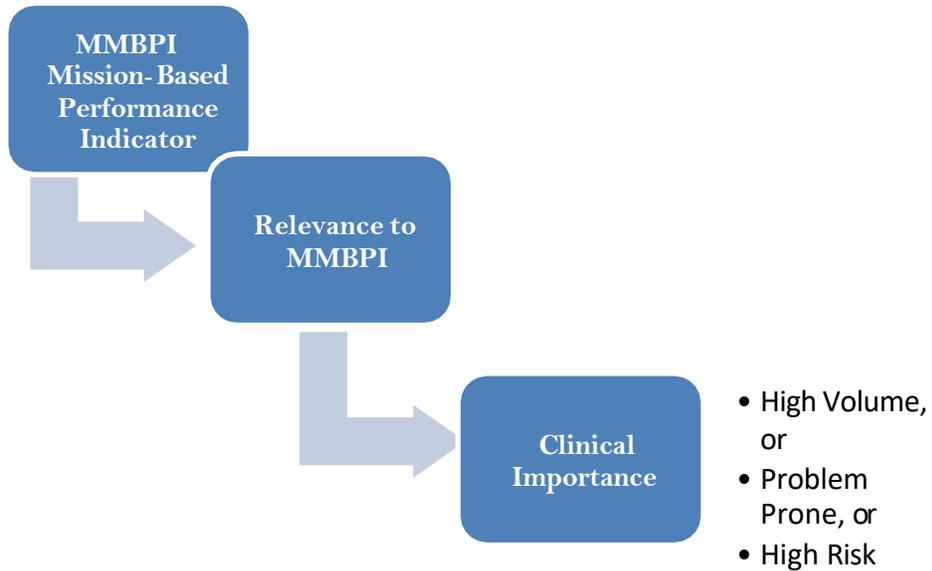
Performance measures is a critical component of the PDSA cycle. Performance Measures is the process of regularly assessing the data results produced by a program. The **purpose** of measurement and assessment is to:



Measurement and assessment **involve**:

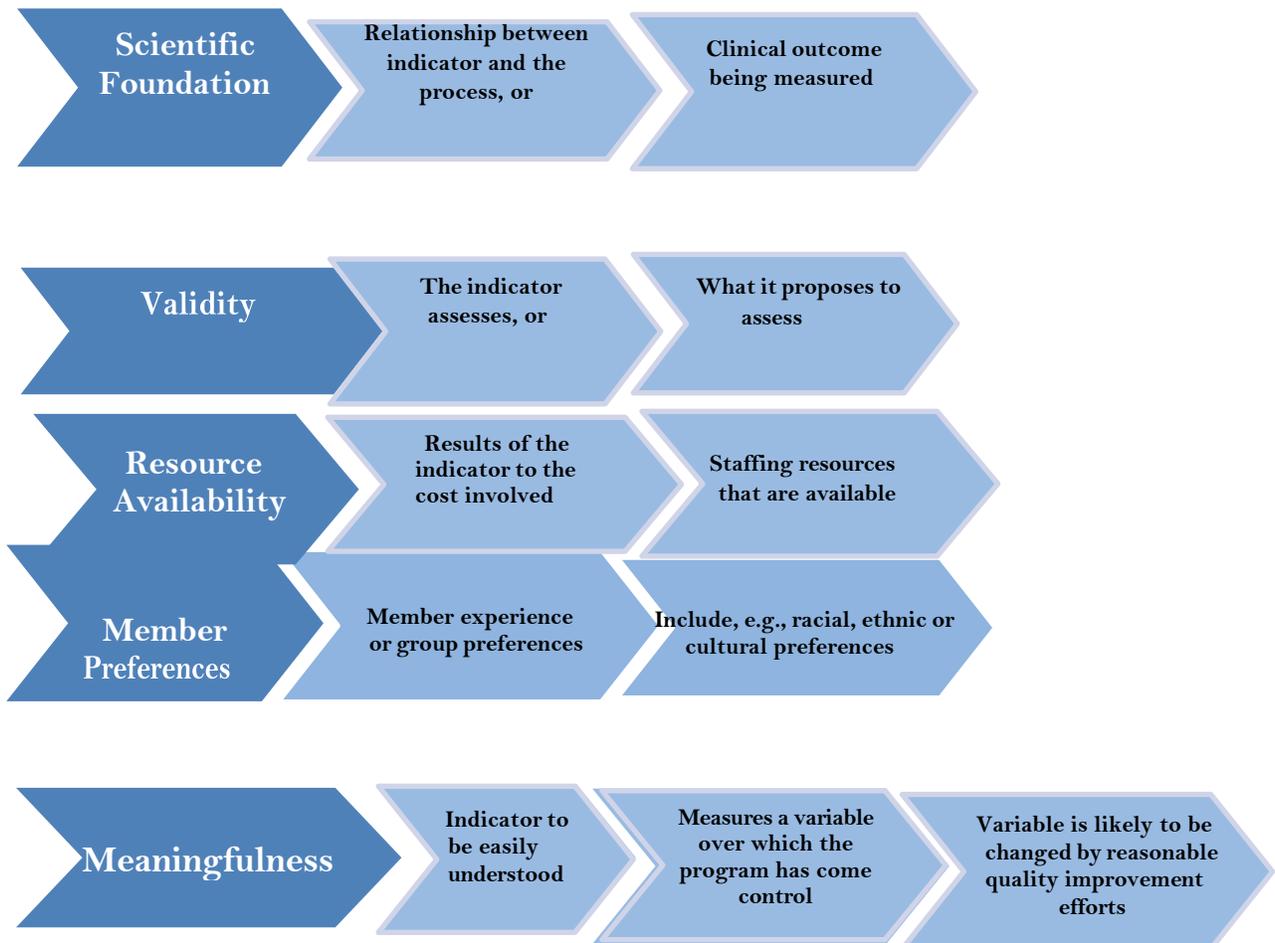


## Selection of a Performance Indicator



## Characteristics of a Performance Indicator

Factors to consider in determining which indicator to use include:



<b>Measure of Service</b>	
<b>Name</b>	<b><i>Michigan Mission Base Performance Indicators (MMBPI)</i></b>
<b>Definition</b>	<i>This includes the indicators found in the MDHHS Code Book.</i>
<b>Data Collection</b>	<i>The data is collected through MH-WIN, and the remainder is calculated by MDHHS.</i>
<b>Assessment Frequency</b>	<i>The Quality Improvement Steering Committee will assess information associated with the indicator on a monthly basis and submit to MDHHS Quarterly.</i>
<b>Measure of Service</b>	
<b>Name</b>	<b><i>Member Grievances</i></b>
<b>Definition</b>	<i>An expression of dissatisfaction with any aspect of the operations or activities by the Service Provider or DWIHN.</i>
<b>Data Collection</b>	<i>Primarily collected through MHWIN.</i>
<b>Assessment Frequency</b>	<i>The Customer Service Committee will assess information associated with the indicator on a Quarterly basis.</i>
<b>Measure of Service</b>	
<b>Name</b>	<b><i>Member Satisfaction</i></b>
<b>Definition</b>	<i>Measure of how services meet or exceed member expectation</i>
<b>Data Collection</b>	<i>MH-WIN, Survey, Member Questionnaire</i>
<b>Assessment Frequency</b>	<i>The Customer Service Committee will assess information associated with the indicator on a Quarterly basis.</i>
<b>Measure of Service</b>	
<b>Name</b>	<b><i>Clinical Practice Improvement</i></b>
<b>Definition</b>	<i>Measure of Model Fidelity or Measure of outcomes of persons served within various Evidence-Based, Practice-Based Evidence, Best Practices</i>
<b>Data Collection</b>	<i>Through Provider Data, MH-WIN</i>
<b>Assessment Frequency</b>	<i>The Quality Improvement Committee will assess information associated with the indicator on a Quarterly basis.</i>

<b>Measure of Service</b>	
<b>Name</b>	<b><i>Finance</i></b>
<b>Definition</b>	<i>Ensure financial solvency of DWIHN and Network Providers</i>
<b>Data Collection</b>	<i>Site Reviews, Audits, Financial Reports</i>
<b>Assessment Frequency</b>	<i>The Quality Improvement Steering Committee will assess information associated with the indicator on a Quarterly basis or as needed.</i>
<b>Measure of Service</b>	
<b>Name</b>	<b><i>Crisis Services</i></b>
<b>Definition</b>	<i>Completion of Crisis/Safety Plans as applicable for each member by Contracted Providers</i>
<b>Data Collection</b>	<i>MH-WIN, Performance Monitoring</i>
<b>Assessment Frequency</b>	<i>The Quality Improvement Steering Committee will assess information associated with the indicator on a Quarterly basis.</i>
<b>Measure of Service</b>	
<b>Name</b>	<b><i>7 Day Follow-up</i></b>
<b>Definition</b>	<i>Ensure appointments are scheduled and attended by members</i>
<b>Data Collection</b>	<i>Performance Indicator Module in MH-WIN</i>
<b>Assessment Frequency</b>	<i>The Quality Improvement Steering Committee will assess information associated with the indicator on a Monthly and Quarterly basis.</i>
<b>Measure of Service</b>	
<b>Name</b>	<b><i>30 Day Follow-up</i></b>
<b>Definition</b>	<i>Ensure appointments are scheduled with Mental Health Professionals and attended by Members.</i>
<b>Data Collection</b>	<i>MH-WIN, Performance Monitoring</i>
<b>Assessment Frequency</b>	<i>The Quality Improvement Steering Committee will assess information associated with the indicator on a Monthly and Quarterly basis.</i>

Measure of Service	
<b>Name</b>	<b><i>Critical Event/Sentinel Event/Death Reporting</i></b>
<b>Definition</b>	<i>Reporting of health and safety incidents and 911 calls by Contracted Providers</i>
<b>Data Collection</b>	<i>MH-WIN</i>
<b>Assessment Frequency</b>	<i>The Quality Improvement Steering Committee, Critical Sentinel Event, Peer Review and Death Review Committees will assess information associated with the indicator on a Monthly and Quarterly basis.</i>
Measure of Service	
<b>Name</b>	<b><i>Advocacy</i></b>
<b>Definition</b>	<i>Identify ways to improve community inclusion and integration.</i>
<b>Data Collection</b>	<i>MH-WIN, Site Review, Performance Monitoring, HCBS</i>
<b>Assessment Frequency</b>	<i>The Quality Improvement Steering Committee and Constituents Voice will assess information associated with the indicator on a Quarterly basis.</i>

### Performance Indicators Assessment

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

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

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

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

### **Behavioral Treatment Review**

DWIHN has delegated all contracted Mental Health (MH) Clinically Responsible Service Providers (CRSP) to have the Behavioral Treatment (BT) review process in place. The Behavior Treatment Plan Review Committee (BTPRC) requirements are included in the CRSP written contract. To date, DWIHN has a total of twenty (20) BTPRCs that are conducted at the MH CRSP. The QAPIP quarterly reviews analyses of data from the BTPRC where intrusive or restrictive techniques have been approved for use with members and where physical management or 911 calls to law enforcement have been used in an emergency behavioral situation. The data track and analyze the length of time of each intervention. The Committee also reviews the implementation of the BTPRC procedures and evaluate each committee's overall effectiveness and corrective action as necessary. The Committee compares system-wide key indicators such as psychiatric hospitalization, behavior stabilization, reductions or increases in use of behavior treatment plans.

### **SECTION 4: Committee Structure**

To promote quality throughout DWIHN's organization, DWIHN has created committees to provide oversight and implementation of all quality improvement activities.

The quality improvement activities are achieved through a complex infrastructure which includes key stakeholders and process owners, and cross-functional units and committees. Due to the Covid-19 global pandemic, committees have been utilizing virtual meeting platforms. The structure is depicted below:

#### **Program Compliance Committee (PCC)**

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

#### **Membership:**

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

#### **Function of the Committee:**

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

- Annual evaluation of the effectiveness of the QAPIP and recommends approval of reports to the Board.
- System-wide trends and patterns of key indicators.
- Opportunities for improvement.
- Studies in areas identified from data review as having the potential for affecting the outcomes of care and related quality concerns.
- Policies and Procedures.
- System-wide attainment of goal(s) and objective(s).
- Developing and approving the QAPIP description and evaluation.

- Establishing measurable objectives based upon priorities identified through the use of established criteria for improving the quality and safety of clinic services.
- Developing indicators of quality on a priority basis.
- Periodically assessing information based on the indicators, acting as evidenced through quality improvement initiatives to solve problems and pursue opportunities to improve quality.
- Establishing and supporting specific quality improvement initiatives.
- Reporting to the Full Board of Directors on quality improvement activities on a regular basis.
- Review of program operations.
- Recommend Board Actions to the Full Board of Directors.

### **Quality Improvement Steering Committee (QISC)**

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

#### **Membership:**

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

#### **Function of the Committee:**

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

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

### **Improving Practices Leadership Team (IPLT)**

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

#### **Membership:**

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

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

#### **Function of the Committee:**

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

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

### **Standing Committees**

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

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

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

### **Critical/Sentinel Events Committee (CSEC)**

The Critical/Sentinel Event process involves the reporting of all unexpected incidents involving the health and safety of the members within DWIHN's service delivery area. Incidents include, at a minimum, member deaths, medication errors, behavioral episodes, arrests, convictions, physical illness and injuries. The CSEC retains the right to make the final decision whether an incident is a Critical/ Sentinel Event. As applicable, when necessary to respond to questions/concerns of the CSEC others will be requested to attend.

#### **Membership includes but not limited to:**

- Chief Medical Officer
- Utilization Management
- Managed Care Operations
- Quality Improvement
- Substance Use Disorders Initiatives
- Office of Recipient Rights

**Function of the Committee:**

The mission and goal of the CSEC is to ensure the Contracted Providers and/or Clinically Responsible Service Providers (CRSP) conduct a thorough review of incidents with an action plan to ensure the incident does not reoccur or the risk of the incident reoccurring is minimized.

The CSEC uses a four-tiered system of peer review activity. In the first tier, the Critical Events are reviewed by QI Critical/Sentinel Event Liaison for data collection, reviewed for quality of care issues, request for additional documents, completeness of the information and notification of high-risk critical incidents to DWIHN's QI Director and the DWIHN's Administration.

In the second tier, the Critical/Sentinel Events are reviewed by the Chief Medical Officer, Chief Clinical Officer and the QI Critical/Sentinel Event Liaison for clinical issues, standards of care and potential Sentinel Events.

In the third tier, the Critical/Sentinel Events are reviewed by DWIHN's Peer Review Committee, if needed, as a peer review activity. Findings can include requests for corrective action plans, if needed. Repeated deficits or failures to correct identified deficits may result in recommendations for performance sanctions as defined by DWIHN policy, procedures and contracts.

In the fourth tier, the data collection is reviewed by DWIHN's Critical/Sentinel Event Committee for policy review and implementation, patterns, trends, compliance, education and improvement and presentation to DWIHN PCC.

**Death Review Committee (DRC)**

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

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

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

**Membership includes but not limited to:**

- Chief Medical Officer
- Clinical Practice Improvement
- Managed Care Operations
- Quality Improvement
- Office of Recipient Rights
- Integrated Health Care
- Substance Use Disorders

**Function of the Committee:**

The mission and goal of the DRC is to ensure that a thorough review of the Member's death has been conducted by the Member's respective Service Provider, CRSP, Recipient Rights and Clinical Practice Improvement Units. All reviews are conducted in accordance with DWIHN's Death Reporting Policy and procedures, state and federal laws and regulations that govern death review activities.

**Peer Review Committee (PRC)**

The PRC Committee is a peer review activity responsible for the clinical peer review of critical incidents involving, at a minimum, Member deaths, Critical/ Sentinel Events, incidents involving the media or special requests from DWIHN's Chief Medical Officer or Administration. All peer review activities are privileged, confidential and are in accordance with the state and federal laws and regulations that govern peer review activities. As applicable, when necessary to respond to questions/concerns of the PRC Committee other persons will be requested to attend.

**Membership:**

- Chief Medical Officer
- Clinical Practice Improvement
- Managed Care Operations
- Quality Improvement
- Office of Recipient Rights
- Integrated Health Care
- Substance Use Disorders

**Function of the Committee:**

The mission and goal of the PRC Committee is to ensure the Service Providers and CRSP conduct a thorough review of incidents and provide an action plan that will ensure similar incidents do not reoccur and that the risk of reoccurring is minimized. The goal of the PRC Committee is to review the processes at the Service Provider and CRSP when conducting a thorough clinical review of the incident in accordance with DWIHN's Peer Review Policy and Procedures. All Peer Review activities are privileged, confidential and are in accordance with state and federal laws and regulations that govern Peer Review activities.

## **Behavioral Treatment Advisory Committee (BTAC)**

DWIHN's Behavioral Treatment Advisory Committee is charged with the oversight of nine (9) Behavioral Treatment Plan Review Committees (BTPRC) in the network. The committee takes the lead for implementing a systematic approach to monitor service providers and compliance with the MDHHS standards for BTPRC. The committee reviews system-wide BTPRC trends and patterns compared to key indicators such as psychiatric hospitalization, behavior stabilization, reductions or increases in the use of interventions, crisis plans, and behavior treatment plans. The representatives from the network providers are invited for the case validation review process at the BTAC as part of continuous quality improvement at the PIHP level. The committee submits quarterly BTPRC data analysis reports to MDHHS.

### **Membership:**

The committee consists of DWIHN's Chief Medical Officer, licensed psychologist, Member, DWIHN staff, provider representatives and Office of Recipient Rights (ORR). The representative of DWIHN's ORR is required to attend each Behavior Treatment Review Committee (BTRC) on Behavior Treatment Plan Requirements for the service provider network.

Each of the providers BTRC consists of a licensed psychologist, a licensed physician/psychiatrist and DWIHN's ORR who assigns a representative. Each committee sends representative(s) to the monthly DWIHN's Behavior Treatment Advisory Committee.

### **Function of the Committee:**

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

- Percent of provider Behavior Management committees with active Recipient Rights representation.
- Types of challenging behaviors resulting in intrusive and/or restrictive interventions.
- Percent of Member exhibiting challenging behaviors per the client record with behavior treatment plans.
- Types of interventions used.
- Frequency and duration of interventions used.
- Frequency of review of behavior management plans.
- Percent of interventions matching behavior management plans.
- Percent of charts labeled appropriately.
- Number of Critical/Sentinel Events involving challenging behaviors.
- Percent of care staff at all levels trained in behavior management (i.e., positive behavior management, the culture of gentle teaching, management of challenging behaviors, etc.).
- Percent of care staff at all levels who demonstrate the required behavior management competencies.
- Number of behavior management related Office of Recipient Rights complaints.

### **Credentialing Committee**

The purpose of the committee is to delineate and describe the functions and oversight of DWIHN's Credentialing Verification Organization (CVO) and the responsibilities of the Service Providers, and to implement credentialing/re-credentialing functions.

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

#### **Membership:**

- Chief Medical Officer
- Network Providers
- DWIHN Staff

### **Risk Management**

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

#### **Membership:**

- Chief Financial Officer
- Chief Medical Officer
- Corporate Compliance Officer
- Deputy CEO/COO
- Others as needed

#### **Function of the Committee:**

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

### **Cost Utilization Steering Committee**

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

#### **Membership:**

- Chief Financial Officer
- Deputy Financial Officer
- Chief Information Officer
- Deputy CEO/COO
- Chief Medical Officer

#### **Function of the committee:**

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

### **Compliance Committee**

The Compliance Committee shall meet, at a minimum, on a bi-annual basis during the fiscal year. However, the Compliance Officer can schedule additional meetings as deemed necessary. A majority of the Committee constitutes a quorum for the transaction of business. The Committee shall act by the affirmative vote of a majority of the Committee Member present at a duly held meeting.

#### **Membership:**

- Corporate Compliance Officer
- Deputy CEO/COO
- Chief Financial Officer
- Chief Medical Officer

**Function of the Committee:**

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

**Customer Service Committee**

The purpose of the committee is to provide procedural and operational guidance on Customer Service functions to DWIHN, the Access Center, Crisis services vendor, and Service Providers. The Customer Service Committee meets on a quarterly basis.

**Membership:**

- Customer Service Director
- Grievance Coordinator
- Appeals Coordinator
- Provider Customer Services, Grievance, and Appeal staff
- Others as needed

**Function of the Committee:**

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

### **Recipient Rights Advisory Council (RRAC)**

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

#### **Membership:**

Is broadly based so as to best represent the varied perspectives of the CMHSP's geographical area. At least 1/3 of the Membership shall be primary Member or family Member, and of that 1/3, at least 1/2 shall be primary Member.

#### **Function of the committee:**

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

### **Access Committee (AC)**

The Access Committee is charged with developing strategies and working within the organization to provide oversight for the timeliness standards set by our Regulatory agencies. Data along with operational obstacles, and strategies to address challenges will be discussed and action steps will be developed to ensure availability. Recommendations would include documentation and implementations of provider expectation, identifying and addressing barriers, corrective action when those expectations are not met around access standards. The Committee will ensure quality of care monitoring is being developed by setting up additional monitoring mechanisms around access standards. i.e. monitoring access complaints received, % of Availability of appointments within a standard established, etc.

**Membership includes but not limited to:**

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

**Function of the committee:**

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

**Research Advisory Committee (RAC)**

The purpose of the committee is to implement a research proposal review process, recommend research and evaluation aligned with DWIHN's strategic priorities, and to oversee the protection of any human subjects/members and staff involved in research initiatives. The RAC shall meet at least quarterly or as often as necessary to carry out its charge.

**Membership:**

- Chief Financial Officer
- Chief Medical Officer
- Quality Improvement
- Clinical Practice Improvement
- Utilization Management
- Service Providers

**Function of the committee:**

- Act as a collaborative body to encourage the development of research and evaluation proposals within the framework of a research agenda informed by DWIHN's strategic priorities.
- Provide recommendations regarding research and evaluation projects.
- Encourage and promote the utilization of research-based practice.

### **Constituent's Voice**

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

#### **Membership:**

The diverse group of Member, advocates and providers meets monthly. Generally, meetings are held at DWIHN on the fourth Friday of each month from 10:00am -12:00pm.

#### **Function of the Constituent's Voice:**

The CV provides oversight for hosting an annual conference that focuses on trending community inclusion issues. The education of stakeholders about community inclusion, i.e. personally, valued participation and interactions with others. The solicitation of funds and sponsorships for the mini-grant project – The George Gaines & Roberta Sanders Fund for Community Inclusion, which was established in 2015. The body also sponsors various advocacy and community efforts to advance inclusion. Events include the annual Michigan Walk-A-Mile in My Shoes event and voter registration drives.

### **Quality Improvement Teams, Ad Hoc Committees and Workgroup**

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

## Utilization Management (UM)

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

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

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

## Practice Guidelines

DWIHN service providers network utilize established practices, as approved by the Michigan Department of Health and Human Services (MDHHS), or as endorsed or mandated by DWIHN. DWIHN establishes preferred practices based on the state of the literature in related fields; collaboration with our academic partners; research conducted within our system; practices endorsed by MDHHS; and practices listed by the Substance Abuse and Mental Health Services Administration (SAMHSA). DWIHN's Improving Practices Leadership Team (IPLT) has ultimate responsibility for ensuring effective, evidence-based practice which is accomplished by the development or adoption of robust clinical guidelines. All clinical practice guidelines are presented to the DWIHN's IPLT for approval. The clinical practice guidelines are reviewed and updated at least every two (2) years or more frequently if national guidelines change during that two (2) year period. DWIHN expects its contracted practitioners to adopt these guidelines in their practice and encourages the use of evidence-based practices but recognizes the inability of the guidelines to address all individual circumstances. DWIHN monitors providers compliance with clinical guidelines through reports, treatment chart reviews, and/or process indicators. DWIHN supports its members in self-management of their conditions by making practice guidelines available on the website and through specific quality improvement initiatives/activities.



## **SECTION 5: Quality Improvement Evaluation**

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

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

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

### **Plan Actions for 2021 and 2022**

In FY 2021, 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.
- Telehealth services have emerged as essential technology for providing services to our members during Covid-19. It is imperative to ensure adequate and efficient services are being provided to the people we serve and that proper monitoring of this service delivery is accomplished.
- 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.
- Improve member and provider satisfaction.
- Conduct reviews through virtual monitoring to ensure that telehealth services are compliant in accordance with regulatory standards.
- Ensure a high-quality network through credentialing, peer review and contracting processes.

- 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.
- Demonstrate and communicate DWIHN's commitment to improving progress toward influencing network-wide safe clinical practices.

### **Upcoming Goals for Fiscal Year Ending, September 30,2021**

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

- Maintain NCQA accreditation.
- Continue coordinated regional response to COVID-19 pandemic, including expansion of the use of telehealth for a broad array of supports/services.
- Establish an effective Crisis Response System and Call Center.
- Continuously improve the quality, appropriateness, availability, accessibility, coordination and continuity of health care services to members across the continuum of care.
- Continue implementation transition of Home and Community Based Services Waiver.
- Improve member and provider satisfaction.
- Conduct reviews through virtual monitoring to ensure that telehealth services are compliant in accordance with regulatory standards.
- Ensure a high-quality network through credentialing, peer review and contracting processes.
- Establish and revised/improved regional standardized contract and provider performance monitoring protocols for autism service providers, fiscal intermediary services, specialized residential providers and inpatient psychiatric units.
- Continue to collaborate with providers to share ideas and implement strategies to improve care coordination and quality of service.
- Improve and manage member outcomes, satisfaction and safety.
- Maintain excellent compliance with state and federal regulatory requirements, and accreditation standards.
- Ensure DWIHN's organizational initiatives related to cultural competency and diversity for members and providers meet the needs of DWIHN members.
- Address regional role in statewide training and provider performance monitoring reciprocity activities.

- Continue efforts to participate in children/family outreach by attending community events, schools, and working with children service providers to increase mental health awareness, information, and access to services.
- Continue efforts on children services. In 2022, DWIHN will begin a campaign/initiative called “***Mental Health Care-Putting Children First***”. We are going to extend our scope and resources to reach the over 285,000 school-aged kids we have in Wayne County.
- Support DWIHN in establishing improved performance metrics for services and supports and for MDHHS incentive payment metrics (including follow-up after hospitalization for mental illnesses, follow-up to persons with a SUD diagnosis following contact with an Emergency Room; identification and follow up activities related to health disparities; better support for veterans and expanded population health and performance monitoring metric.
- Demonstrate and communicate DWIHN’s commitment to improving progress toward influencing network-wide safe clinical practices.
- Support DWIHN strategic planning efforts related to becoming a Certified Community Behavioral Health Home (CCBHC), Behavioral Health Homes (BHH) and increase Opioid Health Home (OHH) provider services.
- Continue to increase the training of providers, health care workers, jail staff, drug court staff, community organizations and members of our region on how to use Naloxone to reverse opioid overdose.