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PROGRAM COMPLIANCE COMMITTEE MEETING
Wednesday, February 8, 2022
St. Regis Hotel, 1st Floor Conference Room
1:00 p.m. – 3:00 p.m.

AGENDA

I. Call to Order

II. Moment of Silence

III. Roll Call

IV. Approval of the Agenda

V. Follow-Up Items from Previous Meeting - ***None***

VI. Approval of the Minutes – January 11, 2023

VII. Report(s)
A. Chief Medical Officer
B. Corporate Compliance - ***None***

VIII. Quarterly Reports
A. Autism Spectrum Disorder (ASD)
B. Managed Care Operations
C. Residential Services
D. Substance Use Disorder (SUD)

IX. Strategic Plan Pillar – Quality

X. Quality Review(s)
A. QAPIP Annual Evaluation FY 22 ***(PowerPoint)***
B. QAPIP Annual Evaluation & Work Plan FY 21/22
C. QAPIP Work Plan FY 22/23

XI. Chief Clinical Officer's Report

Board of Directors

Angelo Glenn, Chairperson
Karima Bentounsi
Jonathan C. Kinloch

Kenya Ruth, Vice-Chairperson
Dorothy Burrell
Kevin McNamara

Dora Brown, Treasurer
Lynne F Carter, MD
Bernard Parker

Dr. Cynthia Taueg, Secretary
Eva Garza Dewaelsche
William Phillips

Eric W. Doeh, President and CEO

XII. Unfinished Business

A. **BA #23-26 (Revised 2)** – Substance Use Disorder (SUD) Prevention Services
B. **BA #23-27 (Revised 2)** – Substance Use Disorder (SUD) Treatment Services
C. **BA #23-35 (Revised)** – American Rescue Plan Act (ARPA)

XIII. New Business
(Staff Recommendations)

A. **BA #23-56** – Leaders Advancing and Helping Communities (LAHC), Community Health, Workforce and Development Training
B. **BA #23-57** – Biz Analytix Technology, LLC

XIV. Good and Welfare/Public Comment

Members of the public are welcome to address the Board during this time up to two (2) minutes ***(The Board Liaison will notify the Chair when the time limit has been met)***. Individuals are encouraged to identify themselves and fill out a comment card to leave with the Board Liaison; however, those individuals that do not want to identify themselves may still address the Board. Issues raised during Good and Welfare/Public Comment that are of concern to the general public and may initiate an inquiry and follow-up will be responded to and may be posted to the website. Feedback will be posted within a reasonable timeframe (information that is HIPAA related or of a confidential nature will not be posted but rather responded to on an individual basis).

XV. Adjournment

PROGRAM COMPLIANCE COMMITTEE

MINUTES **JANUARY 11, 2023** **1:00 P.M.** ***IN-PERSON MEETING***

MEETING CALLED BY	I. Dr. Cynthia Taueg, Program Compliance Chair at 1:00 p.m.
TYPE OF MEETING	Program Compliance Committee
FACILITATOR	Dr. Cynthia Taueg, Chair
NOTE TAKER	Sonya Davis
TIMEKEEPER	
ATTENDEES	**Committee Members:** Dorothy Burrell; Commissioner Jonathan Kinloch; William Phillips; and Dr. Cynthia Taueg **Committee Members Excused:** Dr. Lynne Carter **Staff:** Brooke Blackwell; Jacquelyn Davis; Judy Davis; Eric Doeh; Dr. Shama Faheem; Sheree Jackson; Sharon Matthews; Cassandra Phipps; April Siebert; Maria Stanfield; Yolanda Turner; Leigh Wayna; and Dan West **Staff (Virtual):** Sharon Matthews; Shirley Hirsch and Andrea Smith

AGENDA TOPICS

II. Moment of Silence

DISCUSSION	The Chair called for a moment of silence.
CONCLUSIONS	Moment of silence was taken.

III. Roll Call

DISCUSSION	The Chair called for a roll call.
CONCLUSIONS	Roll call was taken by Lillian Blackshire, Board Liaison. There was a quorum. R. Taueg introduced DWIHN's newest board member, Karima Bentounsi, a Health Care Executive; CEO/President for the last 15 years, most recently as the President/CEO of the Detroit Medical Center, Adult Central Campus (Detroit Receiving Hospital, Harper Hospital, Hutzel Hospital and the Cardiovascular Institute).

IV. Approval of the Agenda

DISCUSSION/ CONCLUSIONS	The Chair called for a motion to approve the agenda. **Motion:** It was moved by Mr. Phillips and supported by Mrs. Burrell to approved the agenda. Dr. Taueg asked if there were any changes/modifications to the agenda. There were no changes/modifications to the agenda. **Motion carried.**

V. Follow-Up Items from Previous Meetings

DISCUSSION/ CONCLUSIONS	A. **Customer Service's Quarterly Report** – Provide update on the data breach – Sheree Jackson, Corporate Compliance Officer reported that the 23 members' (not 18 as stated in the report) have called to inquire about the letter that went out regarding the data breach. No breaches have been identified from the members or providers. The Chair stated that this concludes the follow-up and no further reports are needed to the committee unless there are new developments. B. **Residential Services' Quarterly Report** – Provide update for homeless population during winter months – Shirley Hirsch, Director of Residential Services reported that there were 51 members that DWIHN has provided emergency homeless services for; in October there were 21 consumers and 19 consumers in November and December which were served through our preplacement facilities that are open 24/7 to accommodate our consumers that are requiring homeless/emergent services. Eric Doeh, President/CEO informed the committee that during the break, DWIHN had some communications with the City of Detroit regarding a situation at Hart Plaza which involved a number of homeless persons. DWIHN worked with several of our providers to provide services to those persons. There were about 47 people impacted by those transitions. Discussion ensued.

VI. Approval of the Minutes

DISCUSSION/ CONCLUSIONS	The Chair called for a motion to approve the November 9, 2022 meeting minutes. **Motion:** It was moved by Mrs. Burrell and supported by Commissioner Kinloch to approve the November 9, 2022 meeting minutes. Dr. Taueg asked if there were any changes/modifications to the November 9, 2022 meeting minutes. There were no changes/modifications to the meeting minutes. **Motion carried.**

VII. Reports

DISCUSSION/ CONCLUSIONS	A. **Chief Medical Officer** – Dr. Shama Faheem, Chief Medical Officer submitted and gave an update on the Chief Medical Officer's report. Dr. Faheem reported: 1. ***Behavioral Health Education –*** DWIHN has continued its' outreach efforts for behavioral health services through interviews in magazines and newspapers regarding Holiday Stress, December 2022. 2. ***Crisis Centers –*** DWIHN continues to work on our Crisis Center projects. We recently completed our consultation with RI International and their report is being finalized, which then can be shared with our Board and Stakeholders. The State is currently drafting the Operational Guidelines for CSU and DWIHN has been a part of their pilot with regular meetings regarding staffing, building, security, pharmacy and metrics. 3. ***Quality Department –*** DWIHN continues to meet the standards for PI#1 (Children and Adult), PI#4b (SUD) and PI #10 (Children); PI #2a (Access of services or Biopsychosocial within 14 days of request) increased by 6.7% from the previous quarter and PI #10 (Recidivism or Readmission within 30 days) has shown a slight improvement from the previous quarter. This remains an opportunity for ongoing improvement. Staff will continue with its' efforts to meet the standard and evaluate the effectiveness of the interventions. DWIHN has received full compliance (100%) with all

reportable areas for the HSAG-PIP (Reducing the Racial Disparity of African Americans seen for Follow-up Care within 7 Days of Discharge from a Psychiatric Inpatient Unit). The next scheduled reporting remeasurement period for DWIHN's PIP to HSAG will include data from 1/1/23-12/31/23. DWIHN has received the draft FY 22 HSAG Compliance Review report with an overall score of 83%. The Quality team will continue to work with each department to assure implementation of the CAPs. HSAG will do the final review (Year 3) in the summer of 2023 and a final score will be aggregated. DWIHN received full compliance with the implementation of a Plan of Correction for MDHHS' Full Waiver Review of DWIHN's HSW, CPW, SEDW and SUD services. There was a total of 3,598 Medicaid Claims randomly selected and reviewed by the Quality team for FY 22 and 3,549 were validated (98.63%). This is an increase of 193% claims reviewed compared to FY 21. A total of 49 (1.36%) of claims were not reviewed based on various reasons noted in the submitted report.

4. ***Improvement in Practice Leadership Team (IPLT) –*** Important topics were discussed during the December 2022 meeting including updates to Discharge and Re-engagement. The goal for the updates is to improve our member re-engagement in services and assure they receive the optimal care needed. The Clinical department has undertaken the effort to revise and improve the Clinical Practice Guidelines in collaboration with our providers. Evidence-based guidelines from national organizations are being reviewed for all disability designations and diagnoses and staff is in the process of bringing up to providers for feedback. The goal is to finalize both by March 2023.
5. ***Integrated Health Care*** – DWIHN is closely monitoring the HEDIS Measures and providing education to our providers. The HEDIS scorecard was presented to the CRSP monthly meetings and individual meetings with 10 CRSP where FUH data was also shared. This department created an educational presentation on HEDIS Measures and definitions for CRSPs Medical Directors. On June 16, 2022, staff are working with Henry Ford Health Plan on a new project of monitoring individuals who utilized the emergency room department or inpatient psychiatric unit and how to perform data sharing. DWIHN's I.T. and PCE are developing a database so that the number of members can be tracked. Staff continues their care coordination efforts with health plans where joint case reviews are done and improvement in members' compliance is being observed. Staff continue to provide Complex Case Management services and currently have 11 members. Staff have also been working on the State defined Pay for Performance metrics with other departments with goals to garner maximum incentives.

During the CMO's report, Mr. Doeh, President/CEO corrected the number of homeless individuals served for last year. It was reported in the Residential Services' follow-up item that the number of individuals served last year was 51 and it should have been 5,190 individuals (unduplicated) who identified as being homeless were served last year for both behavioral services and SUD services in the provider network. The Chair opened the floor for discussion. There was no discussion.

B. **Corporate Compliance Report** – Sheree Jackson, Corporate Compliance Officer submitted and gave an update on the Corporate Compliance report. Mrs. Jackson reported that the Compliance department conducted and completed 39

investigations from March – December 2022. This includes 22 providers referred by the Office of Inspector General (OIG). The remaining 17 referrals were provided by internal departments for further review. The Compliance department identified an overpayment in the amount of $133,880.15.
The Chair opened the floor for discussion. The question was raised by Mr. Phillips as to what DWIHN was doing to prevent the data breach from occurring again. Mrs. Jackson informed the committee that the data breach was from one of our outside vendors. The vendor has become high-tech certified which is allows them to become compliant and they have an accreditation body to monitor what's going on as far as data breaches. When that happens, the provider has to put in place just as DWIHN does, policies and procedures that are rolled out to prevent this from happening in the future. They have continued to provide credit monitoring as well as 24/7 hour services through Experian for all of our members that call in. Mrs. Jackson stated that she has ongoing calls with the providers every quarter to make sure that if anything occurs with DWIHN members that we are notified during those calls. They review the different policies that have been put into place and the different measures that have been put into place to prevent this from reoccurring are discussed. It was suggested by the committee that a cyber security company should review the breach and be included in the calls pertaining to the data breach.

The Chair noted that the Chief Medical Officer's and Corporate Compliance reports has been received and placed on file.

VIII. Quarterly Reports

A. **Adults Initiatives** – Marianne Lyons, Director of Adults Initiatives submitted and gave highlights of the Adult Initiatives' quarterly report. Ms. Lyons reported:

1. ***Evidence-Based Supported Employment/Individual Placement and Support*** – There were 262 referrals, 173 admissions, 108 obtained competitive employment with an average hourly wage of $14.25 and out of the 108, 15 were returning citizens; and 29 individuals transitioned from EBSE services to a lower level of care after successfully completing their employment goals during this quarter. Monthly meetings were held to provide updates, address service delivery issues/concerns as well as technical assistance and training on fidelity standards.
2. ***Project-WC Jail-IST/Project-Jail Diversion*** – There were 217 AOTs processed and 147 of those had an assigned provider who was given notice of the order with instructions for documentation during Q4. There was a review of all AOT orders without an assigned provider and those was assigned a provider for AOT oversight. Any member without an assigned provider will now automatically be assigned by a clinician. AOT data is now processed on a smartsheet for use by DWIHN and the Behavioral Health unit at Probate Court. There were 418 jail releases in Q4; 155 members were linked with providers for post-release follow-up; 21 were not in MH-WIN because of a mental health designation from jail mental health and may not have met DWIHN's criteria; and 20 were released to a hospital for mental health treatment or other correctional facility.
3. ***Assertive Community Treatment (ACT)*** – Staff monitored eight (8) ACT programs. Admissions/discharges regarding the appropriateness of the level of care determinations, fidelity of the program and case consultations regarding recidivistic members were discussed.

4. ***Med Drop*** – Staff facilitated follow-up monthly meetings with all of our pilot program providers for Med Drop. The new Med Drop process was discussed with providers and feedback was provided as well as any strengths/weaknesses with implementing the program in their agency. Staff also had follow-up monthly meetings with Genoa Pharmacy/Med Drop to obtain an update on DWIHN's Pilot Providers that are participating in the program. There are 51 current active clients enrolled in Med Drop; there was a 73% reduction in the number of Med Drop clients admitted to a psychiatric hospital; and a 25% reduction in jail admissions for clients while participating in the program compared to the number of hospital and jail admissions for the program in the 12 months prior to entering the program.
5. ***Patient Health Questionnaire (PHQ-9)*** – 98.9% of adults who had a PHQ-9 completed an intake assessment; 62.6% scored a 10 or higher and are then required to complete additional screenings and had a follow-up PHQ-9 screening completed for FY 22, Q4. The follow-up screenings increased by 84% since last quarter.
6. ***Outcomes Improvement Committee (OIC)*** – This is a peer-related group of providers that offer clinical recommendations to high-risk members throughout the network. There were 25 referrals made to the OIC. Bi-monthly meetings take place with providers where case consultation and follow-up are provided.
7. ***Other Activities*** – Staff participates in the IPLT internal meetings, which is required by MDHHS to ensure that providers have the opportunity to provide feedback on policies and procedures regarding evidence-based and promising practices for DWIHN's provider network. It meets monthly and consists of several internal departments and external providers with subject matter expertise. Staff participates in the Coding workgroup to discuss new or changed billing codes and requirements in order to use those codes. Staff also participates in NCQA follow-up meetings and Hospital Liaison meetings. Adult Initiatives and Utilization Management have made a change in the Med Drop pilot program, instead of a member having to attend two meetings for the program, they only have to attend the first initial meeting and then Genoa Pharmacy or Med Drop will meet with that individual without having to wait for a case manager to become available to schedule that appointment. Since that change, we are now up to 62 members in Med Drop and 14 pending referrals.

Dr. Taueg opened the floor for discussion. There was no discussion.

B. **Crisis Services –** Daniel West, Director of Crisis Services submitted and gave highlights of the Crisis Services' quarterly report. Mr. West reported that there was a 35% increase in the number of requests for service for children and the number of overall requests decreased by 3% for adults for Q1, FY 22/23. The diversion rate for children increased by 6% this quarter. The Crisis Stabilization Unit at COPE saw a decrease in the number of members served compared to Q4 (714) to Q1 (653) and Team Wellness saw an increase in members served for Q1 (707) compared to last year Q4 (366). It was indicated by Team Wellness that the reason for the increase in numbers at the crisis stabilization unit was that there was an increase in the number of individuals in the emergency rooms as well as an increase in the number of DPD drop offs. Data showed that there was a 35% increase from Q4 to Q1 in the number of individuals who were dropped off at the unit by DPD.

1. ***FY 22/23 Q1 Accomplishments*** – Hospital Liaison staff were involved in a total of 467 cases receiving crisis services; overall diversion rate from an inpatient level of care was 26%; 40 crisis alerts received and 20% of those

cases were diverted to lower levels of care this quarter. DWIHN received 343 AOT orders and the Community Law Enforcement Liaison has established working relationships with probate court to ensure compliance with AOTs and transport orders within the network this quarter. DWIHN's mobile outreach clinician continues to partner with Wayne Metro and Black Family Development and acquired several other working relationships with the community to promote access to services for DWIHN members. Contracted screening entities are utilizing a pre-admission review (PAR) disposition amendment to ensure evidence-based practices reflects disposition decision-making through coordination with PCE.

8. ***FY 22/23 Q1 Area of Concern*** – DWIHN continues to work toward solidifying another crisis residential site to promote stabilization in the community
9. ***Plans for FY 22/23 Q2*** – Continue efforts to establish processes to address recidivism; work toward establishing specific reporting methods to analyze the effectiveness of mobile outreach events and resources; onboard and train newly hired liaison to address process/procedures within discharge planning and transitions in the community and continue working relationships with the provider network; and ensure communication with probate court as a tool to promote stabilization of members in the community. Jacquelyn Davis, Clinical Officer added that there is a tab on our website where people that want DWIHN to attend their events can fill out a request and our Communications department will make arrangements for those requests.

Dr. Taueg opened the floor for discussion. Discussion ensued.

C. **Innovation and Community Engagement** – Andrea Smith, Director of Innovation and Community Engagement submitted and gave highlights of the Innovation and Community Engagement's quarterly report. Mrs. Smith reported that during the first quarter, staff spent a lot of time closing out the previous quarter which includes a lot of grant reports that were due to the State as well as the Federal Government for various projects. They are working on revising our model with the Detroit Police Department, so the numbers that are reported today will only include October and November and updated numbers will be provided in the next report. During the two months referenced, DPD encountered 559 individuals through the DWIHN/DPD Mental Health Co-Response Unit. The Detroit Homeless Outreach Team (D-Hot) reported 45 individuals that were connected to services. The Unsheltered Population Response Team (UPRT) is a team of law enforcement officers that encounter individuals who are unsheltered, they connect them with the City of Detroit's Homeless Outreach teams which attempt to assist with getting the individual whatever services are needed. DWIHN was invited by Chief White to participate in a roundtable and press conference with DPD to reintroduce our co-response with a five-point program expansion. This means that we are expanding mental health, first aid training as well as the crisis intervention team training. The Co-Response team will be housed in one location (2nd Precinct) instead of individual precincts and will officially launch on Tuesday, January 17, 2023. There will be two shifts (11:00a.m.- 7:00p.m. and 7:00p.m. – 3a.m.). Behavioral health specialists will be onsite and ready to respond to calls with mental health or substance use related issues. We have launched a pilot for the introduction of a virtual behavioral assessment which means an officer can call and get support for a person who is willing to talk to a specialist via a mobile device. The Jail Navigator program, previously funded by the Flynn Foundation is now being funded by MDHHS. There were 18 referrals and five (5) of those individuals

	were accepted into the program (others declined and decided to wait out their days in jail or did not meet the criteria as far as having a mental health diagnosis or substance use disorder). We continue to expand our partnership with the 36th District Court. If someone who completes the Navigator program or is not interested, we will refer them to Judge Holmes' Mental Health Court Docket. We are also looking to hire a court assessor, who will screen individuals who have been referred to Judge Holmes Court for either mental health court or short treatment court. Dr. Taueg opened the floor for discussion. There was no discussion. D. **Utilization Management** – Leigh Wayna, Director of Utilization Management submitted and gave highlights of the Utilization Management's quarterly report. Ms. Wayna reported that there was a slight increase Habilitation Supports Waiver (HSW) this quarter (93.4%) compared to the last quarter (93.2%). Meetings continue to occur between staff and providers to try and figure out how we can collaboratively work together to increase those enrollments. A staff person was promoted from a clinical specialist position into a manager of the HSW position and an assistant was hired as well to help with the data and clerical pieces. Several of DWIHN departments, hospitals and outpatient providers have been working together to try and decrease the length of stay, recidivism and trying to find better and more effective ways to support our members in the community in their lower levels of care and outpatient services. Staff continue to have weekly case consults with our Medical Director and Dr. Rosen to shape and discuss different case snags that we have with our hospitalizations and peer reviews as well. Staff is updating and consolidating the standard utilization guidelines and SUG List to make sure that they are on the website correctly and user friendly. Ms. Wayna and her team are looking to reduce the outpatient timeframes from 14-days to a lower number of days for lower levels of care. They are looking at the barriers and the things they might need to reduce that timeframe. The department is looking to hire a grievance coordinator to help with audits and appeals. Dr. Taueg opened the floor for discussion. Discussion ensued. Mr. Doeh added that we are averaging roughly around 10 days in hospitalization, which contributes to hospitalization costs. This pilot will give us the opportunity to see if we can get someone stable within that three to five-day period which will greatly reduce hospitalization costs, set up something where there is an incentive for a provider to within those different networks, get them stable and into transitional housing as opposed to paying astronomical hospitalization costs. The pilot is usually about three to six months to determine the success rate or if it should be expanded. The Chair noted that the Adult Initiatives, Crisis Services, Innovation and Community Engagement, and Utilization Management's quarterly reports have been received and placed on file.

IX. Strategic Plan Pillar - Quality

DISCUSSION/ CONCLUSIONS	***The Strategic Plan Quality Pillar report was deferred to the Program Compliance Committee meeting on February 8, 2023.***

X. Quality Review(s) -

DISCUSSION/ CONCLUSIONS	A. **QAPIP Work Plan FY 22 –** April Siebert, Director of Quality Improvement submitted and gave an update on the QAPIP Work Plan FY 22. Ms. Siebert reported: 1. ***Goal II – Access Pillar (Quality of Clinical Care and Service) - Michigan Mission Based Performance Indicators (MMBPI)*** – The 4th quarter Performance Indicator data was submitted to the Michigan Department of Health and Human Services (MDHHS) on January 3, 2023. Indicator 2a (Access of services or Biopsychosocial within 14 days of request) increased form 36%(Q3) to 44%(Q4). Standards for PI#1 (Children and Adult), 4b (SUD) and PI#10 (Children) continue to be met. There has been an improvement in PI#10 (Recidivism or RE-admission within 30 days) from 17.79%, Q3 (Adult) to15.85%, Q4 demonstrating an overall compliance of 15.15%. Staff will continue with the efforts to meet the standard and evaluate the effectiveness of the interventions. The highest improvement has been our members with Severe Mental Illness (SMI) for the Adult population (51.89%) and the Intellectual Developmental Disability (I/DD) Adult population (46.67%) organizations providing services to children with Severe Emotional Disturbances (SED) continue to remain a focused area for improvement during Q1 to Q4 for PI#2a. 2. ***Goal V – Quality Pillar (Safety of Clinical Care) Performance Monitoring Activities: Home and Community Based Services (HCBS)*** – DWIHN is working with MDHHS to implement the required Home and Community-Based Services (HCBS) Transition Tracking for the members of DWIHN who are residing in homes that are not HCBS compliant. This is a Federal mandate to ensure that our residential providers are making sure that individuals who are receiving services have an opportunity to make decisions about their lives and are supported. Quality and the Residential departments are working together to ensure that those requirements are implemented within our system. The target date is March 17, 2023. The transition planning and the process have identified 54 members as being in residential settings and not eligible for funding to provide HCBS services after March 17, 2023 not March 17, 2022 as stated in the report. All transition planning will occur through the person-centered planning process and will be consistent with all Medicaid requirements. An update will be provided in April or May. Dr. Faheem added that there is a lot of work that goes behind the scene in terms of achieving that compliance with the Home and Community Based Final Rule. There is a category of individuals that the State has asked DWIHN to move them out of certain residential homes because they were deemed noncompliant; we were given four pathways that require monthly updates to the State in terms of what the status is. The Quality and HCBS' leads are working on that area. The HCBS lead has reached out to CMS and requested an extension on the timeframe and if they are approved, they will let the PIHPs know, otherwise the deadline will be March. *3.* ***Goal VII – External Quality Reviews (Quality of Clinical Services)*** a. *Compliance Review* – The final Compliance Review report has been received with an overall compliance score of 85% for Year 2. Staff will continue to work internally with each department to assure implementation of the Corrective Action Plans (CAPs). HSAG will do the final review (Year 3) in Summer of 2023 and a final score will be aggregated.

	b. *Performance Improvement Project (PIP)* – DWIHN received 100% full compliance with all reportable areas for the HSAG's PIP (Reducing the Racial Disparity of African Americans seen for Follow-up Care within 7-days of Discharge from a Psychiatric Inpatient Unit). The next scheduled reporting re-measurement period for DWIHN's PIP to HSAG will include data from 1/1/23 – 12/31/23. c. *MDHHS 90-Day Follow-up Waiver Review of DWIHN's HSW, CPW, SEDW and SUD services* – DWIHN received full compliance with the implementation of the Plan of Correction. The follow-up review involved evaluation of the current status of the Corrective Action Plans was submitted by DWIHN in the response to the Full Site Review that was conducted March 14 – April 22, 2022. Dr. Taueg opened the floor for discussion. There was no discussion.

XI. Chief Clinical Officer's (CCO) Report

DISCUSSION/ CONCLUSIONS	Melissa Moody, Chief Clinical Officer submitted and gave highlights of the Chief Clinical Officer's report. Mrs. Moody reported: 1. **COVID-19 & Inpatient Psychiatric Hospitalization** – There were 689 inpatient hospitalizations and five (5) COVID-19 positive cases for the month of December 2022. 2. **COVID-19 Intensive Crisis Stabilization Services** – There were 442 members that used the COVID-19 Intensive Crisis Stabilization services for the month of December 2022, a 9.6% decrease compared to November 2022 (489). 3. **COVID-19 Recovery Housing/Recovery Support Services** – There was a 122% increase of COVID-19 Recovery Housing/Recovery Support Services from November 2022 (19) to December 2022 (67). 4. **Residential Department – COVID-19 Impact** – There was a total of four (4) COVID-19 members and no related deaths for the month of December 2022. 5. **COVID-19 Michigan Data** – As of January 3, 2023, the total number of COVID-19 cases in Michigan is 2,988,654 with 40,767 deaths, 63.9% of individuals have received the first dose and 59.2% are fully vaccinated; Wayne County reported 349,589 COVID-19 cases and 5,051 deaths, 71.4% of individuals have received the first dose and 65.8% are fully vaccinated; and The City of Detroit reported 170,363 COVID-19 cases with 3,801 deaths, 48% of individuals have received the first dose and 41% are fully vaccinated. 6. **Integrated Healthcare Services** – ***Behavioral Health Home (BHH)*** – 399 members currently enrolled in the BHH services. Community Living Services has been added as a BHH provider and currently in the process of adding Psygenics as well. This will result in a total of seven (7) BHH partners for DWIHN. DWIHN has also opened this up to our CRSP Network in an effort to provide these integrated services to more members; ***Opioid Health Home (OHH)*** – 344 members currently enrolled in OHH services, a reduction noted (October 394) due to data clean-up and closures and 80 currently being enrolled; ***Certified Community Behavioral Health Clinic – State Demonstration (CCBHC)*** – 3,383 members currently enrolled. The State demonstration model launched on 10/1/21 and The Guidance Center is the designated provider for Region 7. Baseline outcome data has been established for year one and during year two, outcomes will be a major focus including outcome incentives. 7. **Residential Services** – There was a total of 2,914 members currently being serviced in residential settings (2,076 in licensed settings and 838 in unlicensed

settings). There were 251 referrals to a residential CRSP services in the month of December 2022; 48% were referred from CRSPs providers and 36% were referred by local hospitals; 645 authorization requests and 90% were reviewed and approved within 14 days of request; there were three home closures that resulted in 11 members being moved to other home settings in the month of December 2022. The department continues to see an increase in placement needs for members aging out of the Foster Care system and LGBTQI+ communities. Staff is working with identified CRSPs providers to meet this increased service need. DWIHN is currently reviewing current specialized residential facilities to develop a service gap analysis of over-and under-utilized facilities.

8. **Children's Initiative Services** – ***School Success Initiative (SSI)*** – DWIHN's I.T. representative attended the December meeting to offer support for utilizing the MH-WIN system and a representative from PCE finalized the requested SSI reports. ***Children's Outreach, Access and Prevention Activities –*** Children's Initiatives' Director met with the Detroit Police Department, 3rd Precinct to discuss plans for the "Here Me Out" Campaign. The goals include training police, parents and youths about sexual assault, awareness via panel discussions and social media, enforcement to issue warrants and assist police when questioning victims, response team to share trauma resources and assist with developing a resource list of trauma related services. Staff met with Wrap Around providers to discuss SED Waiver capacity challenges and options to expand SED Waiver services to the additional Wrap Around providers. Feedback regarding the reimbursement rate for SED Waiver services, additional coordination of care and administrative components with SED Waiver services were expressed. Ms. Phipps participated in the MDHHS Subcommittee to discuss developing Therapeutic Foster Care Oregon (TFCO) services as a Medicaid service. Staff hosted the Annual Report "Encouraging One Another Through Change" to the Community on December 1, 2022. Our President/CEO, Eric Doeh gave opening remarks, Ms. Phipps shared highlights and accomplishments and Pastor Genetta Hatcher presented the keynote message. Various community partners were in attendance and the program is available on the website.
9. **Substance Use Services** – DWIHN issued a RFQ for both Substance Use Disorder (SUD) Prevention and Treatment services for the purpose of creating a list of qualified vendors to provide services to fulfill commitment to the delivery of substance abuse programs to Wayne County communities. The list will be valid for five (5) years and only approved and qualified providers who meet the qualifications will be placed on the RFQ for services on October 1, 2023. Consolidated Appropriations Act, 2023 was amended to include several elements in a legislative package that will increase resources for SUD services.

The Chair opened the floor for discussions. Cassandra Phipps, Director of Children's Initiatives informed the committee that the Annual Report to the Community kickoff was not recorded but they do have videos of parents, youth, advocates and youth peer support specialists that were interviewed and shared their experience about receiving services. The program is available on our website. The committee requested a printed copy of the Annual Report to the Community "Encouraging One Another Through Change". ***(Action)***

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XII. Unfinished Business

DISCUSSION/ CONCLUSIONS	***Commissioner Kinloch moved to bundle board actions A through D. Motion failed for lack of a second.*** A. **BA #22-66 (Revised)** – HPS Consulting Services for NCQA – HPS Consulting, LLC – Staff requesting board approval for a professional contractual agreement with Diana Hallifield dba HPS Consulting, LLC to extend the previous purchase order term to July 31, 2023 and increase the requested amount by $98,125.00 for an amount not to exceed $146,875.00 to provide clinical care consultative support for the National Committee for Quality Assurance (NCQA) Re-Accreditation. The Chair called for a motion on BA #22-66 (Revised). **Motion:** It was moved by Commissioner Kinloch and supported by Mr. Phillips to move BA #22-66 (Revised) to Full Board for approval. Dr. Taueg opened the floor for discussion. There was no discussion. **Motion carried.** B. **BA #23-07 (Revised)** – Providers Network System FY 2022/23 – Staff requesting board approval to add two newly credentialed providers to the Provider Network System for the fiscal year ending September 30, 2023 and there is no budget increase due to re-allocation of funds. This will allow for the continued delivery of behavioral health services for individuals with Serious Mental Illness, Intellectual/Developmental Disability, Serious Emotional Disturbance and Co-Occurring Disorders. The Chair called for a motion on BA #23-07 (Revised). **Motion:** It was moved by Commissioner Kinloch and supported by Mr. Phillips to move BA #23-07 (Revised) to Full Board for approval. Dr. Taueg opened the floor for discussion. There was no discussion. **Motion carried.** C. **BA #23-26 (Revised)** – Substance Use Disorder (SUD) Prevention Services Network FY 23 – COVID-19 Grant – Staff requesting board approval to accept granted funding from MDHHS for the SUD Prevention programs. MDHHS has also granted additional funding in the COVID-19 Prevention to provide media, outreach and evidence-based programming services. The Chair called for a motion on BA #23-26 (Revised). **Motion:** It was moved by Commissioner Kinloch and supported by Dr. Taueg to move BA #23-26 (Revised) to Full Board for approval. Dr. Taueg opened the floor for discussion. There was no discussion. **Motion carried.** D. **BA #23-27 (Revised)** – Substance Use Disorder (SUD) Treatment Services Network FY 23 – COVID-19 Grant Staff requesting board approval to accept an increase in funding of the SUD Treatment program allocated to DWIHN by MDHHS. The additional COVID-19 funding will provide treatment and recovery support continuum services, including various evidence-based services and supports for individuals, families and communities. In addition, the funding will allow providers to continue to work with the SUD population on efforts to facilitate and support services. The Chair called for a motion on BA #23-27 (Revised). **Motion:** It was moved by Commissioner Kinloch and supported by Dr. Taueg to move BA #23-27 (Revised) to Full Board for approval. Dr. Taueg opened the floor for discussion. There was no discussion. **Motion carried.**

XIII. New Business: Staff Recommendation(s)

DISCUSSION/ CONCLUSIONS	A. **BA #23-51** – Mental Health First Aid (MHFA) – Staff requesting board approval to enter into a contract with various vendors (listed in board action) for the continuation of Mental Health First Aid and QPR-Question, Persuade, Refer trainings. It is requested that the contracts utilizing General Fund beginning January 1, 2023 and continue through September 30, 2023. The cost and fees for professional services to DWIHN will not exceed $550,000.00. The Chair called for a motion on BA #23-51. **Motion:** It was moved by Commissioner Kinloch and supported by Mr. Phillips to move BA #23-51 to Full Board for approval. Dr. Taueg opened the floor for discussion. There was no discussion. **Motion carried.** B. **BA #23-54** – Infant and Early Childhood Mental Health Consultation (IECMHC) Expansion Grant – Staff requesting board approval for one-year contact effective January 1, 2023 through September 30, 2023 for the Infant and Early Childhood Mental Health Consultation (IECMHC) Expansion Grant for an amount not to exceed $211,655.00. The Chair called for a motion on BA #23-54. **Motion:** It was moved by Commissioner Kinloch and supported by Mr. Phillips to move BA #23-54 to Full Board for approval. Dr. Taueg opened the floor for discussion. There was no discussion. **Motion carried.**

XIV. Good and Welfare/Public Comment

DISCUSSION/ CONCLUSIONS	***There was no Good and Welfare/Public Comment to review this month.***

ACTION ITEMS	Responsible Person	Due Date
1. **Chief Clinical Officer's Report** - Provide a printed copy of the Annual Report to the Community "Encouraging One Another Through Change" to the committee.	Cassandra Phipps Lillian Blackshire	**TBA**

The Chair called for a motion to adjourned the meeting. **Motion:** It was moved by Mrs. Burrell and supported by Mr. Phillips to adjourn the meeting. **Motion carried.**
ADJOURNED: 2:30 p.m.
NEXT MEETING: Wednesday, February 8, 2023 at 1:00 p.m.

Program Compliance Committee Meeting
Chief Medical Officer's Report
Shama Faheem, MD
February 2023

Behavioral Health Education:

DWIHN has continued outreach efforts for behavioral health services

- Ask the Doc Digital addressing various mental health topics
- Interview for CBS on crisis services for youth

Integrated Health Care (IHC):

IHC Department takes the lead with MDHHS Pay for Performance Incentive withhold. DWIHN is monitored on various areas and submit period reports throughout the year.

FISCAL YEAR	$ INCENTIVE AVAILABLE	$ INCENTIVE EARNED	$INCENTIVE LEFT UNEARNED	PERCENTAGE WITHOLD INCENTIVE EARNED
2020	$5,587,166.34	$4,160,433.51	$1,426,722.83	74.4%
2021	$6,263,634.46	$5,724,480.08	$539,154.38	91.4%
2022	$6,433,496.39	$5,823,728.19	$609,768.20	90.5%

From FY 20 to 21, we observed a 15 % improvement in amount earned. From FY 21 to FY 22, the total amount increased but the potential amount that could have been earned also went up so DWIHN ended up with similar percentage.

CONTRACTOR-only Pay for Performance Measures (45% of total Withhold)

	TOTAL WITHHOLD AMOUNT	TOTAL WITHHOLD UNEARNED AMOUNT	AVAILABLE POINTS	POINTS EARNED
P.1 Identification of beneficiaries who may be eligible for services through the Veteran's Administration.	$723,768.35	$0	25	25
NARRATIVE REVIEW:				
Excellent description of totals comparison from BHTEDS to Veteran Navigator. Report noted deeper analysis into why members of different branches seek services at different levels and attempts to improve outreach at all levels. BHTEDS completion rate for these fields remained strong.				

	TOTAL WITHHOLD AMOUNT	TOTAL WITHHOLD UNEARNED AMOUNT	AVAILABLE POINTS	POINTS EARNED
P.2 Increased data sharing with other providers.	$723,768.35	$0	25	25
NARRATIVE REVIEW:				
DWIHN reports successful implementation of sending daily ADTs whenever a consumer begins or ends treatment with a clinically responsible service provider.				

	TOTAL WITHHOLD AMOUNT	TOTAL WITHHOLD UNEARNED AMOUNT	AVAILABLE POINTS	POINTS EARNED
P.3 Initiation, Engagement and Treatment (IET) of Alcohol and Other Drug Dependence	$1,447,536.68	$0	50	50

CONTRACTOR-only Pay for Performance Measures (25% of total Withhold)

	TOTAL WITHHOLD AMOUNT	TOTAL WITHHOLD UNEARNED AMOUNT	AVAILABLE POINTS	POINTS EARNED
P.4 Increased participation in patient-centered medical homes.	$1,608,374.10	$0	100	100
NARRATIVE REVIEW:				
MDHHS likes how DWIHN works closely with Wayne County Probate Court to coordinate services for individuals needing behavioral health services. MDHHS is impressed with the decrease in recidivism rate for hospital admissions and readmissions.				

	TOTAL WITHHOLD AMOUNT	TOTAL WITHHOLD UNEARNED AMOUNT	AVAILABLE POINTS	POINTS EARNED
CONTRACTOR -only TOTAL	$4,503,447.48	$0	200	200

MHP/Contractor Joint Metrics (30% of total withhold)

	TOTAL WITHHOLD AMOUNT	TOTAL WITHHOLD UNEARNED AMOUNT	AVAILABLE POINTS	POINTS EARNED
J.1 Implementation of Joint Care Management Processes.	$675,517.12	$0	35	35

	TOTAL WITHHOLD AMOUNT	TOTAL WITHHOLD UNEARNED AMOUNT	AVAILABLE POINTS	POINTS EARNED
J.2.1 Follow-up after Hospitalization (FUH) within 30 days.	$386,009.78	$237,544.48	20	7.69

AGES	STANDARD	AET	BCC	HAR	MCL	MER	HAP MID	MOL	PRI	THC	UNI	UPP
6-20	70%	N/S	67	N/S	N/S	82	N/S	78	N/S	N/S	82	N/S
20-64	58%	49	57	N/S	52	55	54	62	40	53	58	N/S

	TOTAL WITHHOLD AMOUNT	TOTAL WITHHOLD UNEARNED AMOUNT	AVAILABLE POINTS	POINTS EARNED
J.2. 2 Follow-up after Hospitalization (FUH) within 30 days stratified by race/ethnicity.	$386,009.79	$96,502.45	20	15

	TOTAL WITHHOLD AMOUNT	TOTAL WITHHOLD UNEARNED AMOUNT	AVAILABLE POINTS	POINTS EARNED
J.3 Follow-up after (FUA) Emergency Department visit for Alcohol and Other Drug Dependency within 30 days stratified by race/ethnicity.	$482,512.22	$275,721.27	25	10.71

	TOTAL WITHHOLD AMOUNT	TOTAL WITHHOLD UNEARNED AMOUNT	AVAILABLE POINTS	POINTS EARNED
MHP/CONTRACTOR JOINT METRICS TOTAL	$1,930,048.91	$609,768.20	100	68.4

Scores from HEDIS Scorecard as of October 2022 due to claims lag.

	Measure	Measure Name	Eligible	Total Complian	Non Compliar	HP Goal	Year to Date
2	AMM	Antidepressant Medication Management Acute phase	4549	2110	2439	77.32	46.38
3	AMM	Antidepressant Medication Management Continuation Phase	4549	1355	3194	63.41	29.79
4	FUH	Follow-Up After Hospitalization for Mental Illness Adults	4228	1996	2232	58	47.21
5	FUH	Follow-Up After Hospitalization for Mental Illness Children	372	241	131	70	64.78
6	SAA	Adherence to Antipsychotic Medications for Individuals With Schizoph	4758	2778	1980	85.09	58.39
7	SSD	Diabetes Screening for People With Schizophrenia or Bipolar Disorder	7400	4261	3139	86.36	57.58

We are closely monitoring HEDIS measures and providing education to provider. There has been decline in the scores and this was addressed with CRSP Medical Directors during Quarterly meeting in January. PIPs have been created around these HEDIS measures and new interventions are being reviewed given decline in scores.

Quality Department:

Highlights:

- For indicator 2a (Access of services or Biopsychosocial within 14 days of request), the reporting percentage increased from Q3(37.8%) to (44.6%) final. The preliminary score for Q1 is noted at 45.1% which is a 0.5 percentage point increase from Q4. The average score for the state is noted at 51.03% for Q3**.**

- DWIHN continued to meet the standards for PI#1 (Children and Adult), 4b (SUD) and PI#10 (Children). We have shown a slight improvement in PI#10 (Recidivism or Readmission within 30 days) from Q3 17.79% (Adult) to Quarter 4 final results at (15.89%) for adults, with an overall compliance score of 15.19%, the standard is 15% or less. The preliminary score for Q1 Adults is noted at 14.73%. This remains as an opportunity of ongoing improvement. We will continue with the efforts to meet the standard and will continue to evaluate the effectiveness of the interventions.

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

Performance Monitoring Activities: QI staff reviewed (92) network providers during the FY. These reviews consisted of administrative, case records, and comprehensive staff reviews. The completed reviews were inclusive of the Clinically Responsible Service Providers (CRSP), and Substance Abuse Disorder (SUD) treatment and prevention providers. Additional reviews occurred with (17) Autism providers, (59) B3 providers, and (8) Inpatient Hospital settings. Plans of correction were required for providers with review scores less than 95%. Follow-up validation reviews were completed on those providers to ensure the implementation of the plan. Monitoring of trends and practices to improve quality outcomes was also exhibited through CRSP Self-monitoring Audits. Data from these provider self-reviews were analyzed on a quarterly basis by performance monitoring staff and consultation was provided as needed.

CRSP Self-monitoring Audits : Monitoring of trends and practices to improve quality outcomes was also exhibited through CRSP Self-monitoring audits. Data from these provider self-reviews

were analyzed on a quarterly basis by performance monitoring staff and consultation was provided as needed. Results from the provider self-reviews are as follows:

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

Autism Results

DWIHN QI staff conducted on-site and remote reviews of case records to ensure full compliance with the ASD regulatory requirements. The results from the reviews demonstrated that the average clinical score for the Autism provider has increased when compared to last fiscal year from 76% to 83% in FY2022. The average staff review score has also increased from 91% in FY2021 to FY2022 (95%). In addition, DWIHN has also implemented provider quarterly self-reviews that have contributed to improved performance. This process has allowed plan engagement and case monitoring to ensure each case is moving through the benefit in a streamlined process.

Crisis Centers:

DWIHN continues to work on our Crisis Center projects. Construction is expected to complete by fall of 2023. We will be working closely with MDHHS to acquire certification once Certificate of occupancy is received. Our Chief of Crisis is working to reviewing policies, procedures and focusing on hiring staff in phased approach. DWIHN continues to work on the planning of other Crisis Centers to meet the need.

Case Reviews and Consultations: DWIHN services members with high acuity and needs. In order to assure highest clinical standards are met, DWIHN has initiated several forums where providers are able to get peer review and consultation on complex cases. Behavior Treatment Advisory Committee and Outcome Improvement Committee are examples of DWIHN's effort to support our network with information on Evidenced Based Treatment. DWIHN has also started an internal case coordination and review process with developing High Priority Case Consultation and Collaboration group where different departments review cases collectively to address potential barriers in care. BTAC is lead by Quality Department and OIC and High priority Case Consult by Clinical Practice Improvement Department.

Improving in Practice Leadership Team: IPLT continues to meet monthly. Currently the main focus of IPLT is to revise its Clinical Practice Guidelines. Extensive literature search was conducted by our Clinical Officer and myself for common behavioral health disorders with intentions of providing our Network with resources on clinical guidelines and best practices. Though the standard for reviewing it is every 2 years, DWIHN reviews it internally on an annual basis. The guidelines were presented to IPLT members that include providers, in Jan 2023. They were given opportunity to provide feedback and draft version was shared. Draft guidelines were also presented to CRSP Medical Directors in Jan 2023 for feedback. They will be presented again next week at IPLT for final voting on approval and implementation by March.

Med Drop Program:

Current Active Participants
FY 2022- Started the year (10/1/21) at 34 participants.
FY2023- Started the Fiscal Year (10/1/22) with 51 participants.
As of February 1, 2023, we have 55 participants.

Number of Drops per month:
Started the FY 2022-- October 2021= 754 drops.
Ended the FY 2022 – September 2022= 1015 drops successful (84%) of the 1208 drops scheduled.
Rest of the CY:
October 2022- 1157 (85%) successful drops of the 1352 scheduled drops.
November 2022- 1008 (67%) successful drops of the 1492 scheduled drops.
December 2022- 1114 (67%) successful drops of the 1656 scheduled drops

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Autism Dept Executive Summary
Q4 FY 2022

- DWIHN ASD Benefit continues to grow each quarter with 2302 open cases at the end of Quarter 4 FY 2022.

- Although this data is representative of Q4 FY 22 it is important to note that based on the growing number of children enrolled in the ABA benefit, DWIHN will need to expand its network through the Request for Qualification (RFQ) procurement process which is currently ongoing

- Referral data for ADOS-2 diagnostic evaluation in the 4th quarter indicates an average of 195 diagnostic evaluations scheduled with the most scheduled at 204 appointments.

- During FY 22 Q4 staffing challenges were noted by DWIHN Autism providers. However, the supplemental rate increase was beneficial the ABA network in hiring and recruiting additional staff.

- In an effort to support the provider network and ensure members are engaged with treatment, DWIHN issued a change to the Autism Spectrum Disorder (ASD) service authorization guidelines request during Q4. Effective immediately caregiver training can be requested outside the standard Autism bundle when requesting authorization. This is in effort to ensure that families receive services while organization identify a staff person to deliver the ABA intervention.

- Additionally, to ensure DWIHN continues to provide equitable access to all Wayne county eligible ABA beneficiaries, the Autism Department expanded the ABA provider network to additional site locations in Westland and Woodhaven.

- The Autism Department focused on DWIHN Network Provider feedback in relationship to coordinating care during August of 2022 which resulted in DWIHN increasing the Service Utilization Guidelines (SUG) for ABA Behavior Treatment from 10% to 20%.

- This increase will also support DWIHN's performance improvement project for NCQA re-accreditation.

- DWIHN provided a Service Delivery Expansion Survey to determine capacity of ABA providers in network to immediately accept members waiting for ABA services. As a result four additional providers, already contracted to deliver services within the ABA network, were able to expand to build better capacity.

- DWIHN-ASD department also added one additional intellectual and or developmental disability (I/DD) CRSP to deliver supports coordination to children receiving the ABA benefit. This was in effort to increase the number of supports coordinators that work with the Autism network or providers and to increase timeliness.

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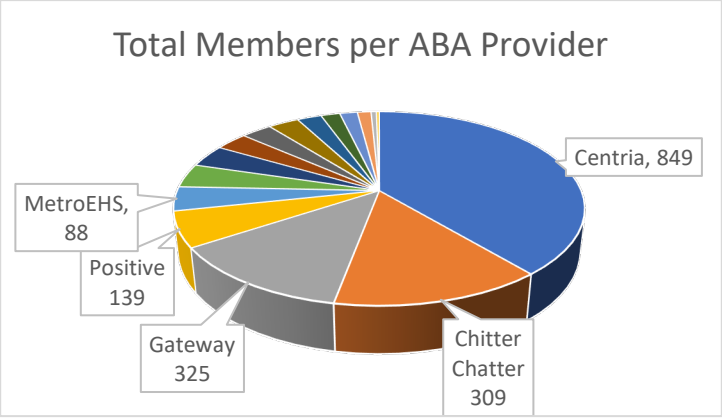
Autism Spectrum Disorder Benefit

4th Quarter Fiscal Year 2022

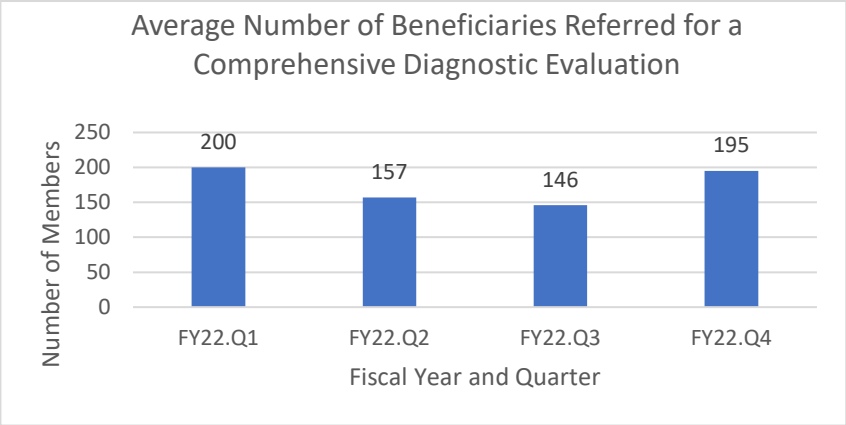
ABA Provider Network Summary

DWIHN ASD Benefit continues to grow each quarter with 2302 open cases at the end of Quarter 4 FY 2022. Currently Centria Healthcare has the largest number of enrollees with the second largest provider being Chitter Chatter. The provider with the least number of enrollees at this time is Strident Healthcare which is due to them being recently contracted with DWIHN for ABA service. Strident is the newest ABA providers added to DWIHN as a result of the previous Request for Proposal (RFP). Although this data is representative of Q4 FY 22 it is important to note that based on the growing number of children enrolled in the ABA benefit, DWIHN will need to expand its network through the Request for Qualification (RFQ) procurement process which is currently ongoing.



Referral Summary

Referral data for ADOS-2 diagnostic evaluation in the 4th quarter indicates an average of 195 diagnostic evaluations scheduled with the most scheduled at 204 appointments. The least amount scheduled was at 172 appointments. The increase in referrals during this period was most likely due to children returning to school in September.



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Quarter 4 FY 22 Network Updates

July 2022

- The ABA providers reported staff shortages which has impacted the timeliness standard to access ABA services within the 90-day NCQA performance improvement project goal.

  Solution(s):

  - DWIHN met individually with the ABA providers to offer solutions to staffing shortages which included discussion on the rate increase offered to help recruit and retain staff. With the DWIHN one-time supplemental rate increase for claims submitted through March 31, 2022 and a second installment for claims submitted April 1-June 30, 2022, providers should be able to recruit staff.
  - In an effort to support the provider network and ensure members are engaged with treatment, DWIHN issued a change to the Autism Spectrum Disorder (ASD) service authorization guidelines request. Effective immediately, caregiver training (97156) can be requested by itself when requesting authorization so that families can receive services while a staff person awaits assignment.
  - Additionally, to ensure DWIHN continues to provide equitable access to all Wayne county eligible ABA beneficiaries, the Autism Department expanded the ABA provider network to additional site locations that had limited access to service in Westland and Woodhaven.
  - DWIHN hosted a Parent Engagement presentation which focused on the importance of parent engagement, the different strategies to get and keep the parents/families committed to the ongoing treatment and the covering different research and aides available to understand the role of the parent in a successful treatment program.
  - DWIHN-ASD department increased the timeliness measures for diagnostic evaluation reports to 10-buisness days rather than 10-calendar days for evaluations that recommend approval for the Autism benefit. This was done in effort to help reduce the strain on the diagnostic evaluation providers.

August 2022

- On average, ABA providers reported they had a small amount of members that needed to be linked to Behavior Technicians for services and potentially will have more capacity next month to accept referrals from the Diagnostic Evaluators.

  Solution(s):

  - DWIHN's one-time supplemental rate increase for claims submitted through March 31, 2022 and a second installment for claims submitted April 1-June 30, 2022, seems to have improved providers' capacity to hire staff.
  - The Autism Department focused on DWIHN Network Provider feedback in relationship to coordinating care during August of 2022 which resulted in DWIHN increasing the Service Utilization Guidelines (SUG) for ABA Behavior Treatment from 10% to 20%.
    - By increasing direct supervision of Behavior Technicians, it is likely that providers will see an improvement in staff retention and quality of service delivery.
    - This increase will also support DWIHN's performance improvement project for NCQA re-accreditation.

September 2022

- ABA providers reported challenges coordinating care between the clinically responsible service providers (CRSP) case manager or support coordinator assigned to the children on their caseloads.
- **Solution(s):**
  - DWIHN provided a Service Delivery Expansion Survey to determine capacity of ABA providers in network to immediately accept members waiting for ABA services.
    - DWIHN added Team Wellness as an additional ABA CRSP to avoid delays in service arrays. Team Wellness has been trained on linking ABA services for eligible beneficiaries seeking access for the Autism benefit.
    - ABA providers within the network came forward to expand up to four different locations to build better capacity.
  - The ASD department established a provider workgroup which met four times to develop solutions to reduce coordination challenges.
    - As a result, the ASD Department established a main contact and imbedded a process for overseeing changes in the case holder which is now located in the member's electronic medical record (EMR) under the section labeled Program Assignment.

        - Additionally, coordination of care documentation was streamlined and added to MWHIN to reduce paperwork, improve efficiency and communication between Behaviorist and CRSP.
    - For providers that are experiencing capacity concerns, DWIHN-ASD department offers support in linking children and families to providers with current availability to avoid delay in treatment.

Detroit Wayne Integrated Health Network (DWIHN)
1st Quarter Report - October – December 2022
Contract Management --Managed Care Operations (MCO)

EXECUTIVE SUMMARY

MCO Mission:

To partner with competent, caring behavioral health providers in the improvement of the lives DWIHN is entrusted to serve.

MCO Departmental Standards

- Provide excellent customer service to providers, other DWIHN departments and external organizations.
- Develop and maintain efficient operation
- Comply with and/or exceed regulatory, accreditation and ICO standards.

MCO Operations:

- Department consists of 2 units, Contracting and Credentialing
- 21 staff members

FY 22/23 Contracts

- Management of over 400 contracts
- Credentialing and Re-credentialing of over 4,000 providers/practitioners

New Providers Changes to the Network /Provider Challenges:

- Providers continue to be challenged with staffing shortages
- DWIHN's CRSP Meetings and Access Committee closely monitors impact of staffing shortages and works with providers to develop strategies to address.
- DWIHN has an Onboarding Process to facilitate the evaluation and vetting of new providers
- RFPs are used as a strategy to recruit providers/programs in significant shortage

Merger/Closures Data:

- 15 closures during 1st Quarter FY 22-23
    - 4 licensed, residential homes
    - 9 unlicensed
    - 2 outpatient providers

*Note closures are managed by DWIHN's Closure Process to ensure a smooth transition of members to other contracted services to ensure continuity of care.

Service Availability Challenges/Network Initiatives

- The most common challenge faced by providers is the staffing shortage crisis impacting providers, resulting in long wait times, downsizing, home/service/program closures.
- The following network initiatives remain in place to address network challenges: Training and educating providers
    - Increasing our standardized rate by 5% for FY23
    - Issuing 4 payment incentives for FY22 and retention payments to the network to assist providers with retaining staff due to the staff shortage.
    - Advocating at the State level to reduce the overburden reporting requirement.
    - Seeking opportunities to automate and streamline process/procedures
    - Meeting with providers to understand their needs and find solutions to the needs

.

MHWIN system maintenance and cleanup

- MCO is responsible for maintain the provider data/information in MHWIN, inclusive of fee schedules.
- Procedures are in place to maintain accuracy and integrity of data.
- Provider data migrates to DWIHN's Online Provider Directory.

Internal /External-Training Meetings Held:

a. Met with 16 of our Clinically Responsible Service Providers (CRSP) regarding the performance indicators most providers continue to experience staff shortages in the intake department for new intakes as well as ongoing services they provide
b. Access Committee Meetings are held monthly to discuss and develop strategies to address network adequacy and provider gaps in services.
c. Weekly meetings with Continuum of Care Board (COC), to discuss HUD/Homeless projects.

PIHP Email Resolutions and Phone Provider Hotline:

- MCO manages providers' information requests and request for issues resolution submitted by phone line and/or email.
- Procedure in place to address information requests and issues resolution within 1 business day.

New Provider /New Programs:

- MCO developed an Onboarding process which includes prospective providers submitting application to become a DWIHN contracted provider.
- Each provider is screened to determine if they meet DWHIN's initial criteria.
- Once initial criteria are met the prospective provider is evaluated for inclusion in the DWIHN provider network. The evaluation process includes a review by the Access Committee.

Provider and Practitioner Survey 2022

- Provider and Practitioner surveys conducted annually to assess providers experience with DWIHN.

Provider Meetings and Trainings Meetings

- Ongoing scheduled trainings and meetings
- Adhoc meetings scheduled when necessary

High Priority Initiatives

- Supporting DWIHNs Mission, Vision and Strategic Pillars/Initiatives
- Streamlining Onboarding Process
- Imbedding MDHHS, NCQA and ICO standards in MCO departmental operations

Submitted by Sharon Matthews, Interim Director/Contract Management 2/1/23

Detroit Wayne Integrated Health Network (DWIHN)
1st Quarter Report
October – December 2022
Contract Management --Managed Care Operations (MCO)

MCO MISSION:

To partner with competent, caring behavioral health providers in the improvement of the lives DWIHN is entrusted to serve.

MCO supports the following DWIHN Strategic Pillars:

- Customers: Having an adequate number of providers/practitioners to service our consumers
- Access: We are accessible to our consumer(s) via our 24/7 call center, with a drop call ratio of less than under 5%, even with the crisis.
- Quality: Monitoring and training the providers under this time have been laxed by the state but we are still monitoring and supporting our providers and direct care workers to ensure safe and quality service is provided to our consumers.

MCO Departmental Standards

- Provide excellent customer service to providers, other DWIHN departments and external organizations.
- Develop and maintain efficient operation
- Comply with and/or exceed regulatory, accreditation and ICO standards.

MCO Operations:

There are 21 staff employees in the department and 10 are which consist of Provider Network Managers and Credentialing Specialist. MCO provides oversight in credentialing and managing approximately 356 contracted providers (excluding 51 SUD contracts which are managed in the SUD division) for outpatient, inpatient, residential, specialty programs with approximately 1,084 homes licensed (534) and unlicensed (550). This oversight also includes the responsibility for managing the HUD Housing Contracts, Supported Employment, Michigan Rehabilitation Services Contract and five DHS Outstation Contracts where Medicaid Applications are processed for DWIHN members. The network is comprised of an efficient and effective number of providers that improve the quality of life for all of our members.

FY 22/23 Contracts

Over 400 Outpatient and Residential Contracts were fully executed. The contracts extended the contractual relationships with existing providers. The contracting process is a collaborative effort between Legal and MCO.

New Providers Changes to the Network /Provider Challenges:

The impact of the Covid -19 is still being experienced. Residential and Outpatient providers continue to struggle with staff shortages to maintain staff in homes as well as maintain outpatient services. As we monitor and notice changes in the network we add more providers to our network based on need. Request for Proposals (RFP) are also utilized as a means recruiting new providers, particularly in areas of shortages (e.g. Autism). In 1st Qtr. of FY 22-23 there was a total of 7 new

service additions. 3 new providers were added to the DWIHN network, 2 contracted outpatient providers added new services and 2 contracted residential providers added new homes.

Providers/Practitioner Credentialing:

Medversant is DWIHN's CVO, Credentialing Verification Organization.
There over 4,000 practitioners in the DWIHN network. As of December 2022, a total of 2538 credentialing applications were processed by Medversant and approved by the DWIHN Credentialing. Currently 2538 files are under the Virtual Review Committee 's review.

Practitioner Credentialing Applications 4168
Facility Credentialing Applications 348
Files in Virtual Review Committee (VRC) 2538
Practitioners Approved 2372
Facilities Approved 166

Merger/Closures Data:

Listed below are the summary of closures that have occurred during the 1st Quarter of FY 22-23. Please note YTD closures for the FY22/23 totaled 19 closures which were mostly unlicensed home related closures. In comparison with the previous quarter, 4th Quarter FY 21-22 there were five less fewer closure. Note fewer closures of licensed residential homes also.

All providers are required to give provide a 30-day notice prior to closing and DWHIN is required to report closures to MDHHS within 7 days of notice. MCO has a very structured process that facilitate the closure and / or termination of providers. The facilitation of the closure is carried out by the assigned PNM. It should be noted that HSAG commended DWIHN for this process.

Provider Closure/Mergers FY 22-23					
Description	1st Qtr.	2nd Qtr.	3rd Qtr.	4th Qtr.	YTD Totals
Licensed-Residential Homes	4				4
Unlicensed /Private Home Services (SIL's)	9				9

Clubhouse services	0				0
Outpatient-services, SUD services	2				2
Provider Organization Merger(s)	0				0
Total	15				15

Network Initiatives

Although our network continues to experience challenges with staffing we continue to support the network through the following initiatives:

a. Training and educating providers
b. Increasing our standardized rate by 5% for FY23
c. Issuing 4 payment incentives for FY22 and retention payments to the network to assist providers with retaining staff due to the staff shortage.
d. Advocating at the State level to reduce the overburden reporting requirement.
e. Seeking opportunities to automate and streamline process/procedures
f. Meeting with providers to understand their needs and find solutions to the needs

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Service Availability

The most common challenge faced by providers is the staffing shortage crisis impacting providers, resulting in long wait times, downsizing, home/service/program closures.

MHWIN system cleanup of provider records/Online Provider Directory:

The following gaps were identified and addressed over the last quarter the MCO team continues to clean up records in MHWIN.

a. The addition of provider business hours to facilitate migration to the Online Provider Directory.

Internal /External-Training Meetings Held:

a. Met with 16 of our Clinically Responsible Service Providers (CRSP) regarding the performance indicators most providers continue to experience staff shortages in the intake department for new intakes as well as ongoing services they provide
b. Access Committee Meetings are held monthly to discuss and develop strategies to address network adequacy and provider gaps in services.
c. Weekly meetings with Continuum of Care Board (COC), to discuss HUD/Homeless projects.

PIHP Email Resolutions and Phone Provider Hotline:

For the 1st Quarter of FY 22-23 , we received/answered and resolved provider related concerns. There were 100 emails and 15 phone messages from providers with concerns related to claims billing, IT concerns, Procedure Code changes, Single Case agreements, and changes with the FY 2022 State Code/Modifier changes.

New Provider /New Programs:

MCO developed an Onboarding process which includes prospective providers submitting application to become a DWIHN contracted provider. Each provider is screened to determine if they meet DWHIN's initial criteria. Once initial criteria are met the prospective provider is evaluated for inclusion in the DWIHN provider network. The evaluation process includes a review by the Access Committee.

Provider and Practitioner Survey 2022

The Provider/Practitioner survey is a way for DWIHN to get feedback from providers and practitioners on how well we are doing as a manager of care, this survey also helps us identify any gaps in process or procedures as well as reveal any areas for improvements.
This survey allows us to gain a better understanding of how we can support and maintain a strong provider network that will provide high quality supports and services to our members. The Provider Survey was released to providers in September and October. The practitioner will be released the 2nd quarter of FY 22-23. Strategic Planning conducts the surveys. MCO analyzes the surveys. Survey results will be presented in the 2nd Quarter FY 22-23 Quarterly Report. Note that an Ad Hoc Survey Committee was established to review the survey instrument resulting in the reduction of questions from 76 to 36 without compromising the intent and/or integrity of the survey instrument. It is anticipated that the streamlining of the survey will increase the response rate.

Provider Meetings and Trainings Meetings

There were several informative and training meetings held with the providers during the 1st Quarter of FY 22-23. During these meetings DWIHN staff train and update providers are advised of DWIHN's policies, procedures and initiatives

- In December 2022 -Outpatient and Residential Providers Meeting:
- In November 2022 CRSP Provider Meetings

High Priority Initiatives

- Supporting DWIHNs Mission, Vision and Strategic Pillars/Initiatives
- Streamlining Onboarding Process
- Imbedding MDHHS, NCQA and ICO standards in MCO departmental operations

Submitted by Sharon Matthews, Interim Director/Contract Management 2/1/23

Residential Executive Summary
1st Quarter (Date Range); 10/1/22 – 12/31/22

# of Members Serviced in Residential	2,883
Licensed settings	2,054
Unlicensed settings	829

# of Licensed Facilities	622
# of Unlicensed Facilities	754

# of Residential Facility Closures			**14**
# of Members			53
2-AMI	3-IDD	Licensed facilities	5
3-AMI	6-IDD	Unlicensed facilities	9

- Reasons for closures include APS/ORR complaints reported by MCO, DCW staff shortage, rent increase, and homeowner's decision to sell property

# of Referral Requests	864
AMI Requests	483
IDD Requests	381

CRSP	412
Inpatient Hospitals	305
Emergency Departments	52
Residential Assessments in Specialized Settings	45
Nursing Homes	16
SD-to-Specialized Residential Services	14
Crisis Residential (Oakdale House)	13
Youth Aging Out (DHHS)	4

Referral Trends

- Significant increases from identified referral agents.

ED referrals QTR 1 – **52**
- Several cases during holiday break (11/27-11/29/22)

IDD CRSP referrals for members from family home QTR 1 – **47**
- APS referral for three IDD adult siblings residing in deplorable conditions
- Medical emergencies for caregivers

Nursing Homes/Sub-acute Rehabilitation QTR 1 – **16**

Self-Directed-to-Specialized Residential services QTR 1 – **14**

DHHS foster care aging out into adult services QTR 1 – **4**

Department Highlights

- Department-led discussion re: specialized residential settings for youth aging out of DHHS foster care (10/27/22)
- Department volunteers for DWIHN Access Call Center Project Clean Up (10/9/22)
- Residential redevelopment of Medical Coordination Forms/Process flows (11/2/22)
- Residential Dashboard access & review with IT (11/2/22)
- Development of tracking system specialized residential facilities for under- and over-utilization (Ongoing)
- Residential staff provided coverage the holiday (12/27-29/22)

Department Goals

Staffing

- Continue to review referral patterns and trends- identifying gaps
- Continue to review residential staffing needs- onboarding replacement of two Residential Care Specialists
- Explore areas of Wayne County facility requests
- Review and redefine current residential structure
- Maximize Residential unit assessment potential
- Develop staff competencies
- Utilize data to support development of specialized residential sites
- Embrace HCBS dictates-develop smaller home-like settings
- Overview and reinstatement of DWIHN pre-placement facilities and providers with quarterly meetings to review policies and procedures.
- Development reporting mechanism to highlight member success
- Develop mechanism to determine need for after-hours Residential Services
- Develop reporting mechanism review report for out-of-county case transfers back into Wayne County

Substance Use Disorders

Opioid deaths in Wayne County are increasing from 2020 to 2021, the total number of deaths involving any type of opioid has increased dramatically in Wayne County. Every person makes a difference. DWIHN continue to provide free Narcan training to anyone in the Wayne County Community. The Narcan training have expanded to include Faith-Based organizations, Barber Shops, Hair and Nail Salons. Placing certified peer recovery coaches in emergency rooms in some hospital have increased services. DWIHN is also working with the mobile units to expand their services to include harm reduction tools ie fentanyl test strips, deterra bags in high risk areas and areas that are considered hot spot areas. DWIHN continues to train first responders, its providers, drug court staff, inmates/jail staff and the community on how to reverse an opioid overdose. DWIHN is increasing the number of providers that can train and distribute Naloxone in the community. We have also purchased emergency Naloxone boxes for all provider agencies to have located in a common area in the event the Narcan is needed.

Naloxone Saves in Wayne County from 1st Quarter of FY23

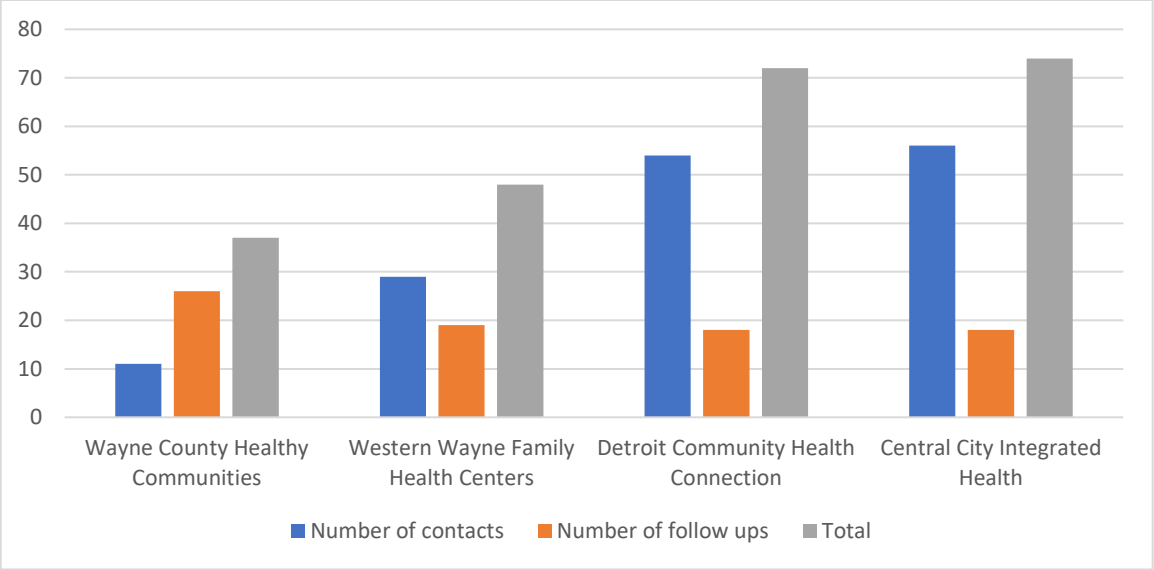
Month	Successful Narcan Saves	Unsuccessful Narcan Saves
October 22	7	1
November 22	8	1
December 22	15	0
Total	**30**	**2**

The medical examiners provisional data suggest that drug overdose deaths declined by 8.2% in 2018 from 2017 in Wayne County. We saw the following: Decrease in whites by 17.6% and Increase in African American by 4%, Arab Americans by 200%, Latinos by 9.5% and Asian Americans had an increase of 2 to 3%.

or Wayne County there appear to be 187 drug overdose deaths during the first 3 month of 2022., it appears that there were 235 such deaths in the same period in 2021.

The difference in number of deaths could be due to under-reporting recent deaths (haven't decided cause of death yet and so the report could still be revised) or real decline. These deaths reflect where decedents were found, not where they lived prior to their death

Peers in FQHCs, Urgent Care and other outpatient settings increase access to treatment



Service providers are implementing screenings in four community partner locations, the majority of screenings this month were done at Detroit Community Health Connection and Central City Integrated Health

Name	Number of contacts	Number of follow ups	Total
Wayne County Healthy Communities	*11*	*26*	*37*
Western Wayne Family Health Centers	*29*	*19*	*48*
Detroit Community Health Connection	*54*	*18*	*72*
Central City Integrated Health	*56*	*18*	*74*
Detroit Medical Center	232	161	393
TOTAL	**150**	**81**	**231**

State Opioid Response (SOR) Programs

Mobile Units

Mobile units act as a triage and take services directly to consumers. In this quarter,
580 consumers served by mobile unit
14 referrals to SUD by mobile units
11 drug screens by mobile units
75 peer supports by mobile units
186 naloxone kits distributed on mobile

SBIRT Screenings

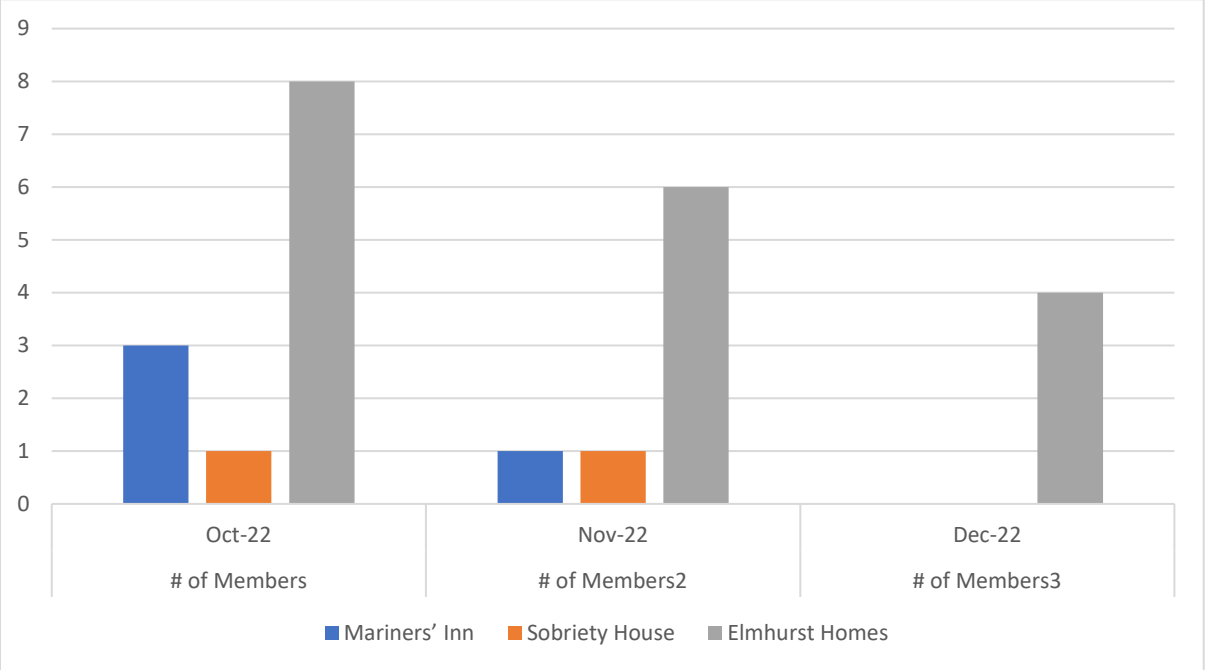
Screening Brief Referral and Intervention programming partners with organizations that do not screen for substance use disorder and implements screenings and referrals.

October	653
November	452
December	375
Total:	**1,480**

Gambling Disorder Residential Treatment Program (GDRTP) 4th Quarter Report

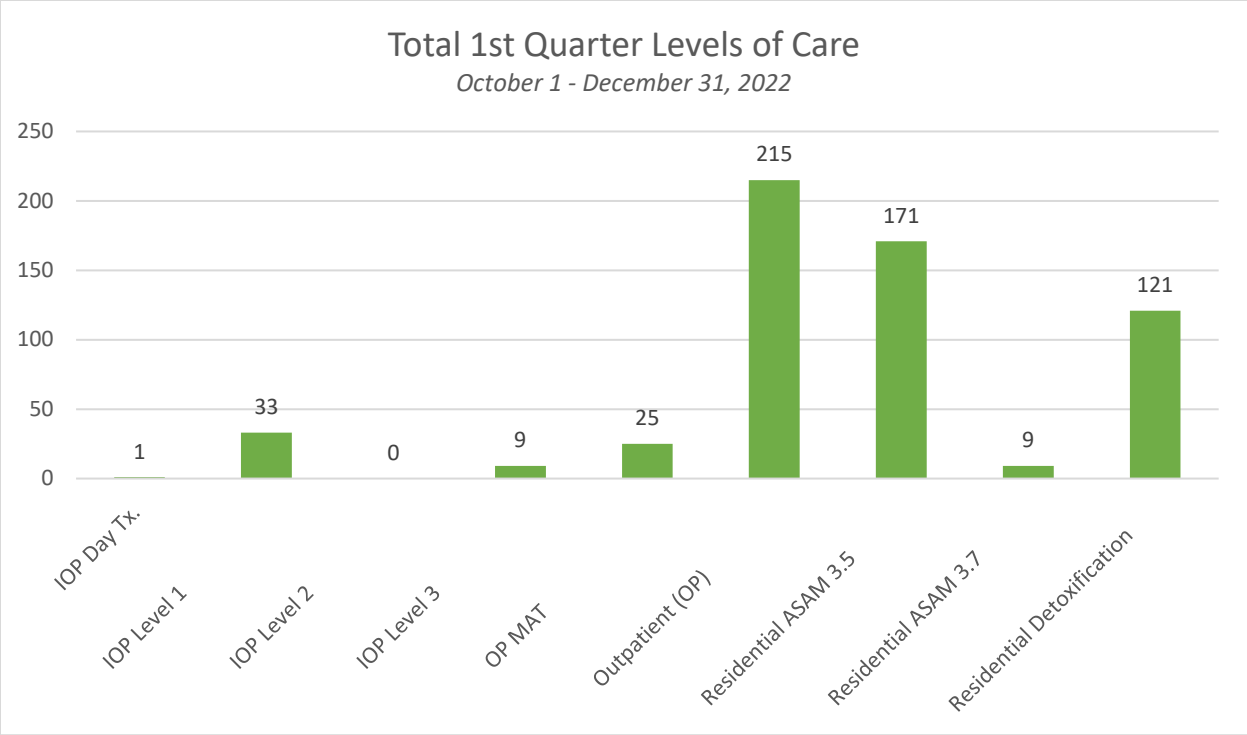
Mariners Inn, Sobriety House and Elmhurst Home provide residential treatment to consumers with Gambling Disorders. All staff completed the 30-hour Gambling Disorder training. 6 new staff have requested the gambling training.

COVID has continued to present challenges to Outreach services in nearby Casinos. to increase program awareness and referrals they connect with Parole/Probation Officers digitally and are working on connecting with casinos.



Name	# of Members October 2022	# of Members October 2022	# of Members December 2022
Mariners' Inn	*3*	*1*	0
Sobriety House	*1*	*1*	0
Elmhurst Homes	*8*	*6*	4
TOTAL	**12**	**8**	**4**

TOTAL: 24 members for the quarter up 2 members from the last quarter.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200
150
100
50
0
1
33
0
9
25
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171
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IOP Day Tx.
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OP MAT
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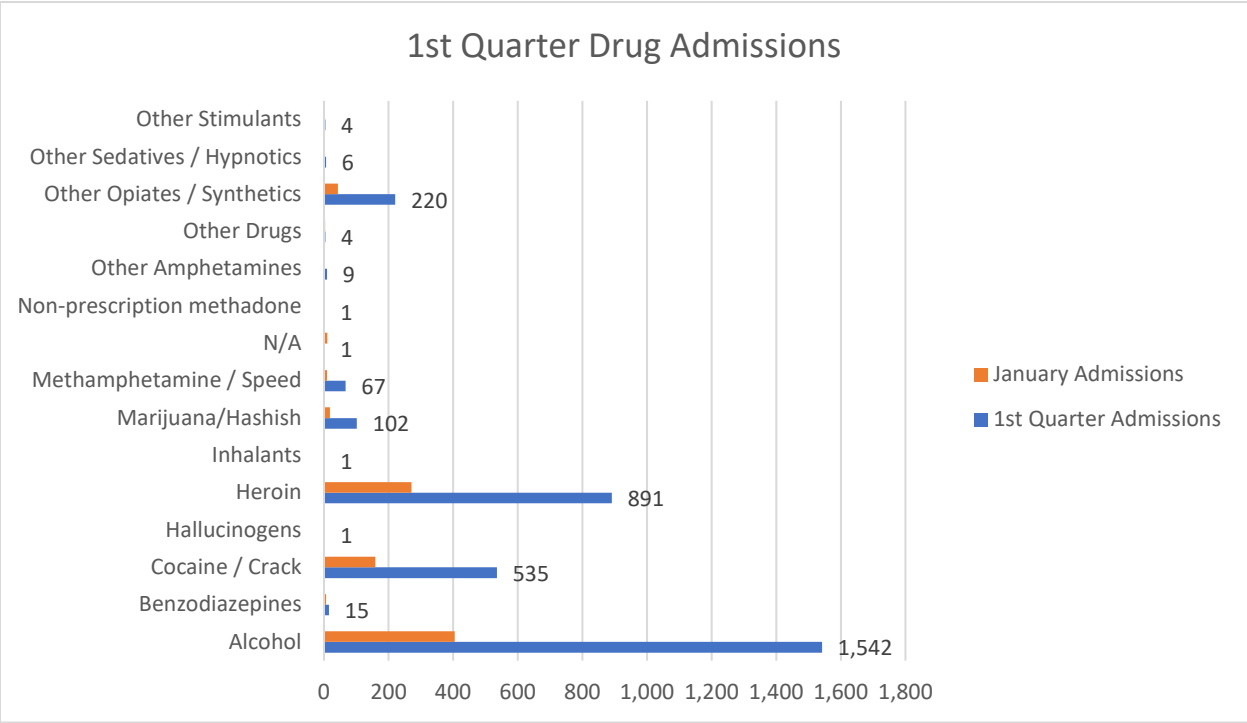
1st Quarter Drug Admissions
Other Stimulants
Other Sedatives / Hypnotics
Other Opiates / Synthetics
Other Drugs
Other Amphetamines
Non-prescription methadone
N/A
Methamphetamine / Speed
Marijuana/Hashish
Inhalants
Heroin
Hallucinogens
Cocaine / Crack
Benzodiazepines
Alcohol
4
6
220
4
9
1
1
67
102
1
891
1
535
15
1,542
0
200
400
600
800
1,000
1,200
1,400
1,600
1,800
January Admissions
1st Quarter Admissions

Detroit Wayne Integrated Health Network (DWIHN)

Substance Use Disorders (SUD)

Quarterly Report (October – December 2022)

Substance Use Disorders

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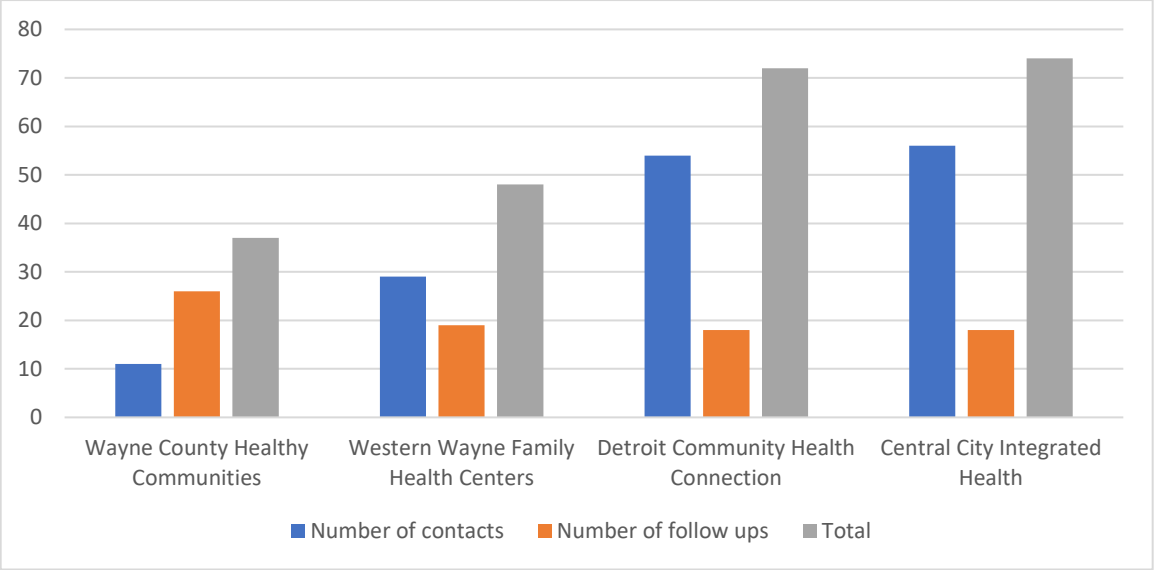
City of Detroit Opioid Settlement Funds

We have also started conversation with the City of Detroit, Director of Behavioral Health regarding the Opioid Settlement Funds in which they have successfully received monetary compensation funding to address the Opioid Crisis. We are scheduling a meeting for next week. The goal is to provide guidance and some expertise on services that are necessary in the city of Detroit.

Peers in FQHCs, Urgent Care and other outpatient settings increase access to treatment



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Total:	**1,480**

Evidence Based Prevention Programming

DWIHN has four providers under the SOR Grant that have partnered with local schools and approved partners to implement evidence-based prevention curriculums for the students. 253 participants were serviced this quarter.

Opioid Use Disorder and Stimulant Use Disorder Services

DWIHN has two providers under the SOR Grant that implement OUD and Stimulant Use Disorder (StUD) services. The following chart is representative of individuals served for the quarter.

Participants identified OUD	Participants identified StUD
40	46

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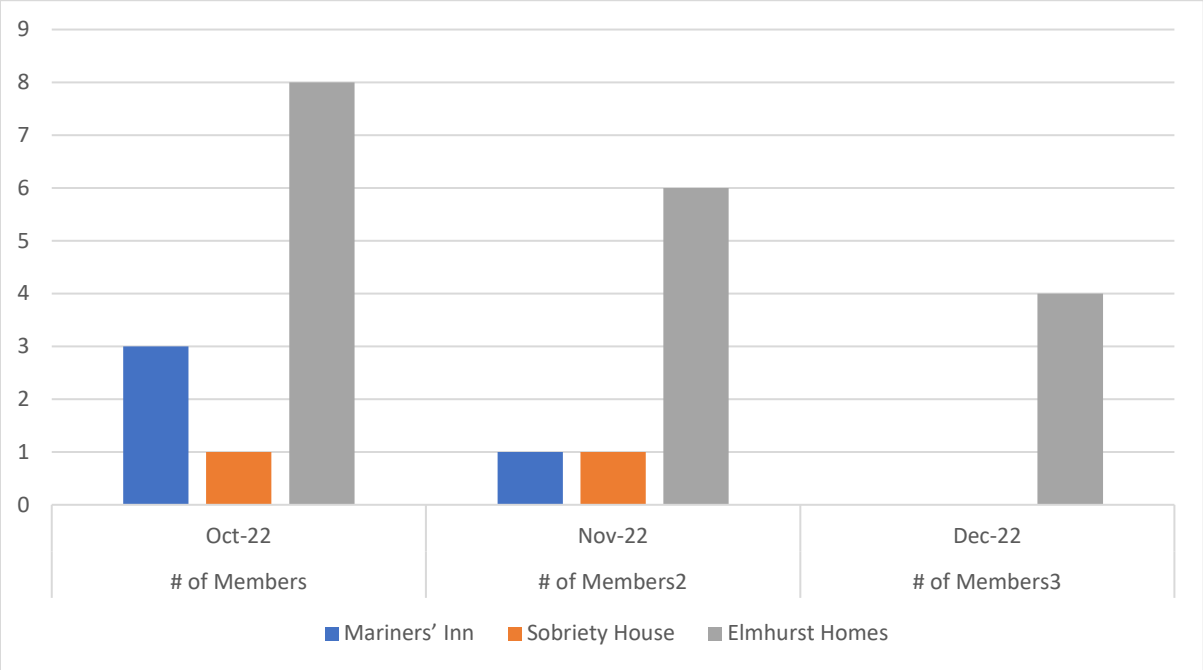
Detroit Wayne Integrated Health Network (DWIHN)

Substance Use Disorders (SUD)

Quarterly Report (October – December 2022)



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Elmhurst Homes	*8*	*6*	4
TOTAL	**12**	**8**	**4**

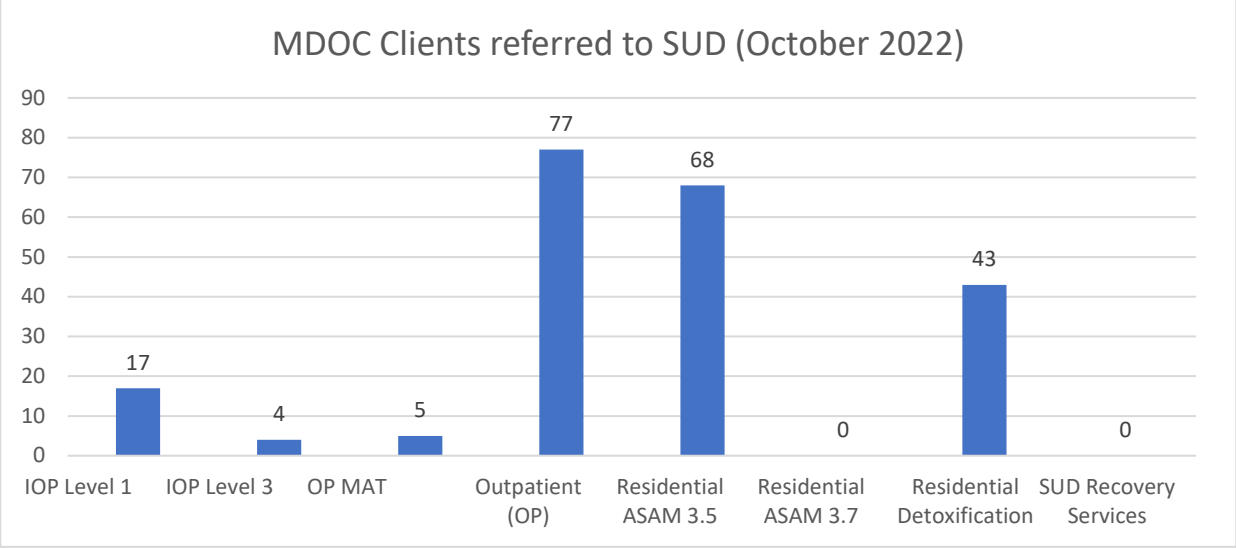
TOTAL: 24 members for the quarter up 2 members from the last quarter.

MDOC Program 4th Quarter Report

The Michigan Department of Corrections (MDOC) and DWIHN has joined in a collaborative effort that will ensure that MDOC offenders with Substance Use Disorder receive medically necessary services from DWIHN SUD Provider Network.

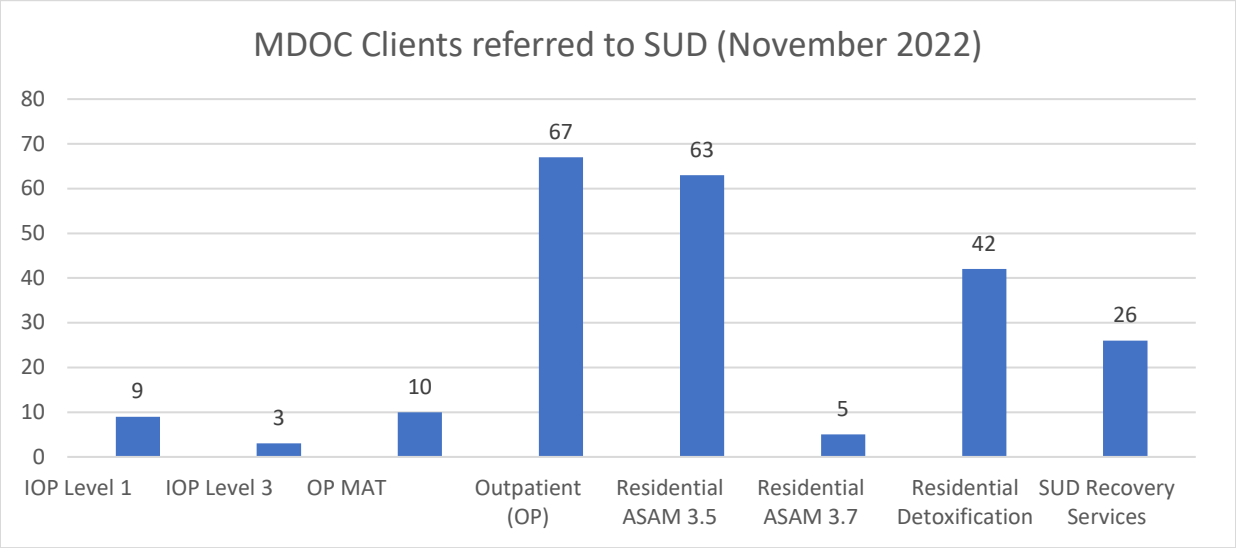
Each MDOC individual that contacts the Access Center are considered a priority population for screening and admission for substance use disorder treatment services due to the public safety needs related to their MDOC involvement and are screened and referred to treatment within 48 hours from contacting Access.

During the month of October 260 calls were made to the access center from MDOC 236 calls were referred to a level of care.



The majority of MDOC clients were placed in outpatient care closely followed by residential treatment.

During the month of November 304 calls were made to the access center from MDOC 225 calls were referred to a level of care.



Similarly to October the majority of MDOC clients were placed in outpatient care closely followed by residential treatment.

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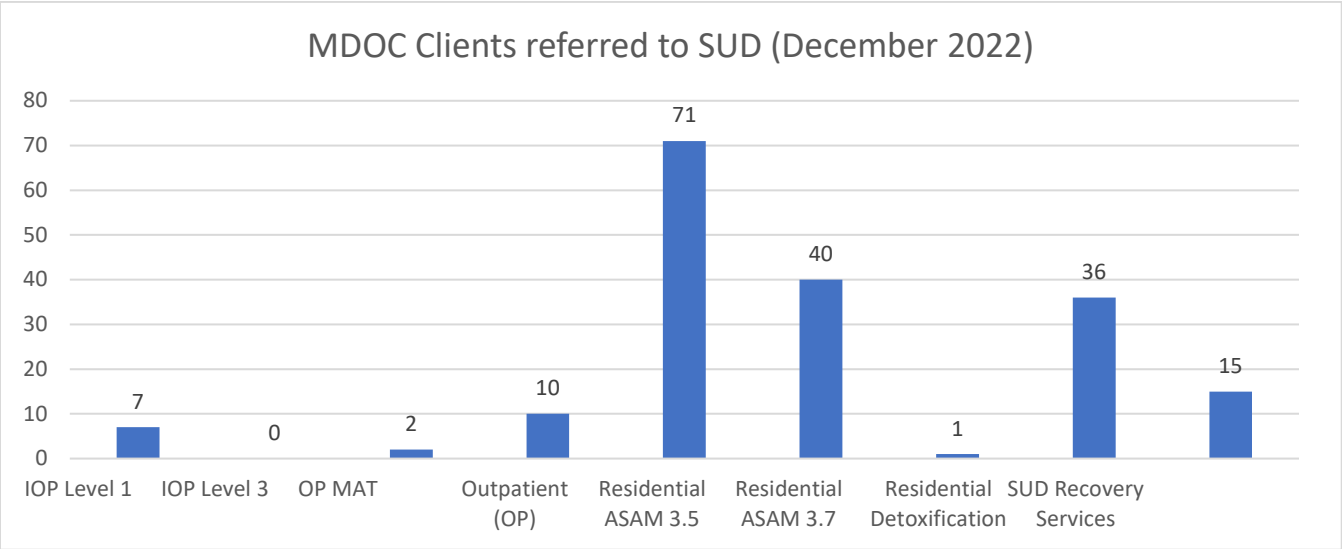
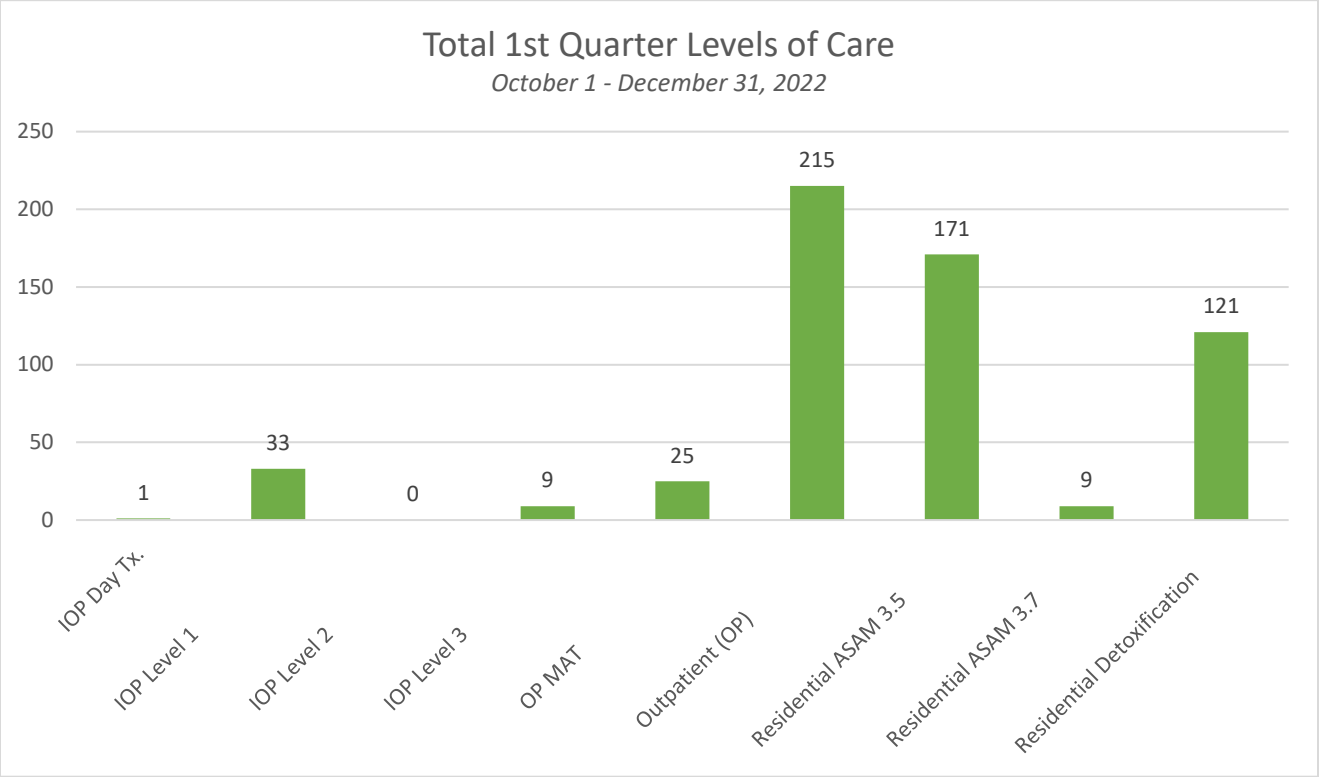


In December the majority of clients were placed in residential treatment services.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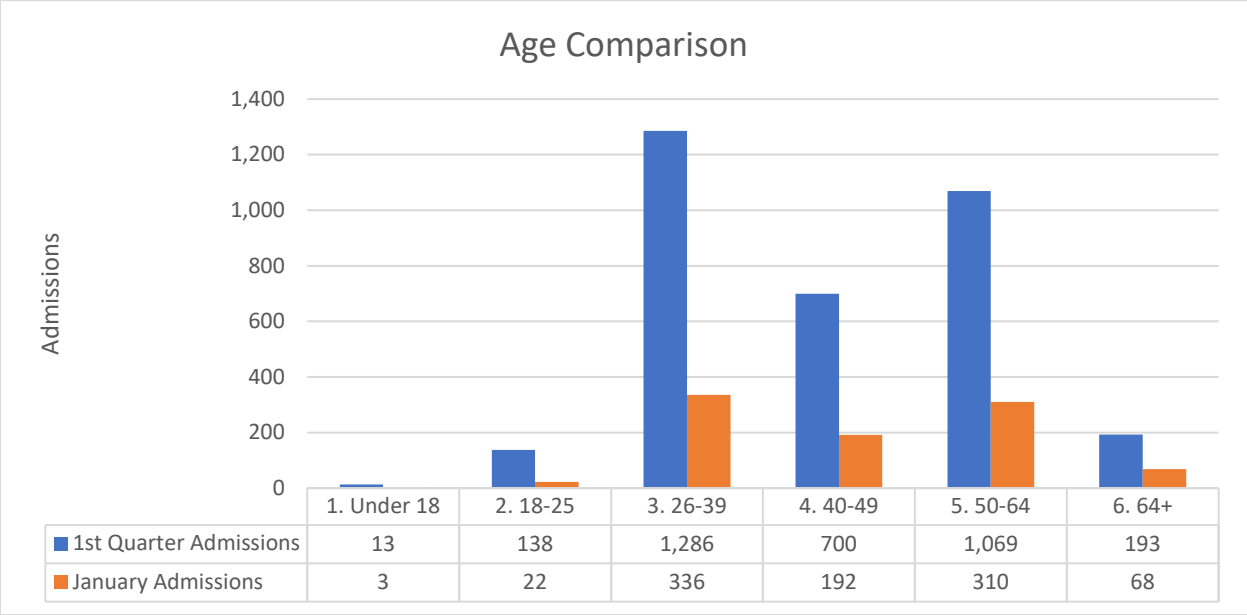
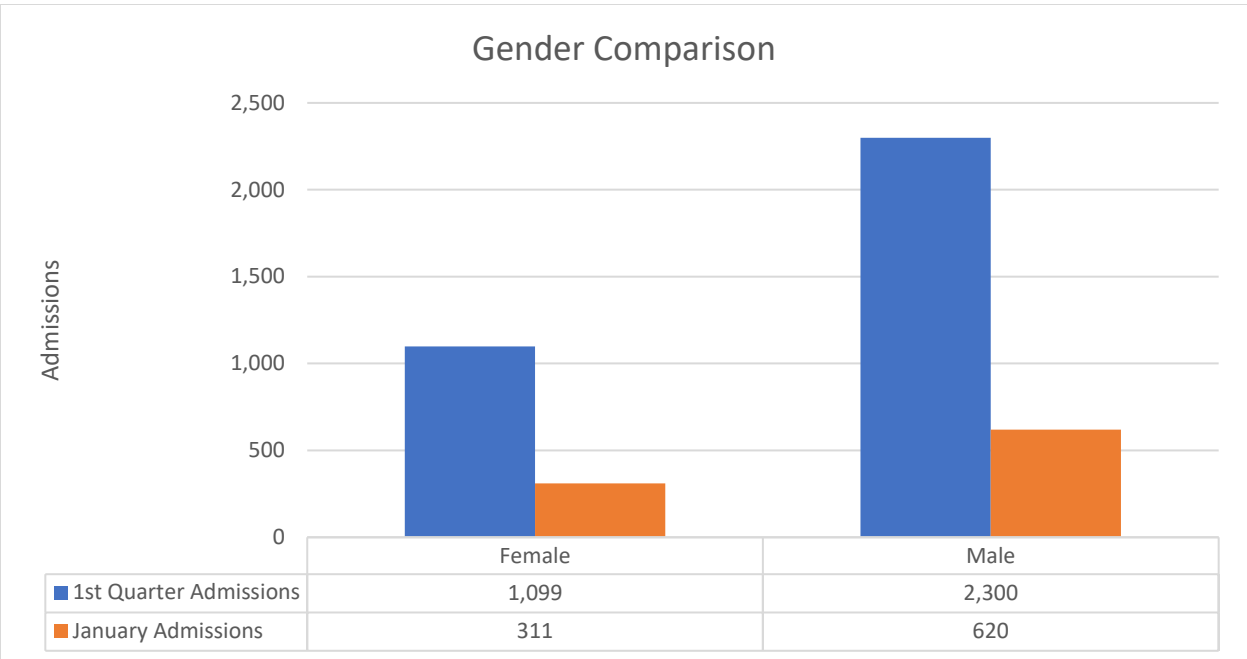


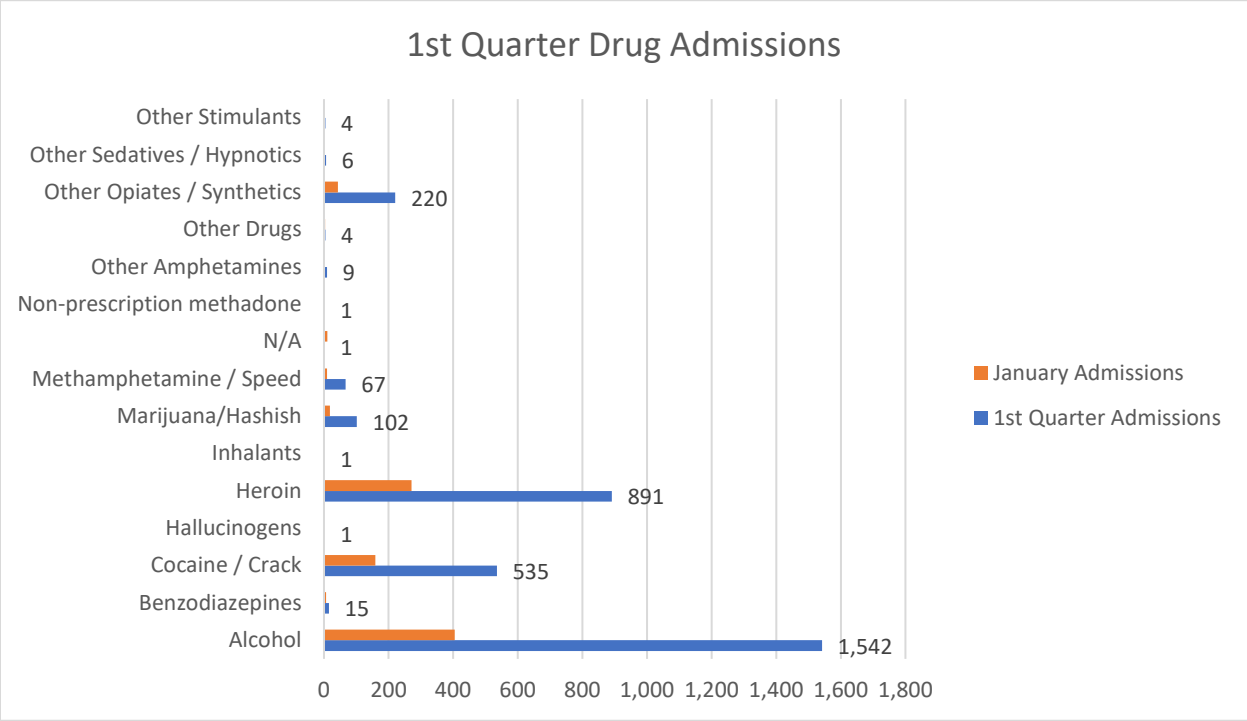
	1. Under 18	2. 18-25	3. 26-39	4. 40-49	5. 50-64	6. 64+
1st Quarter Admissions	13	138	1,286	700	1,069	193
January Admissions	3	22	336	192	310	68

The majority of MDOC clients that were screened were age 26-39

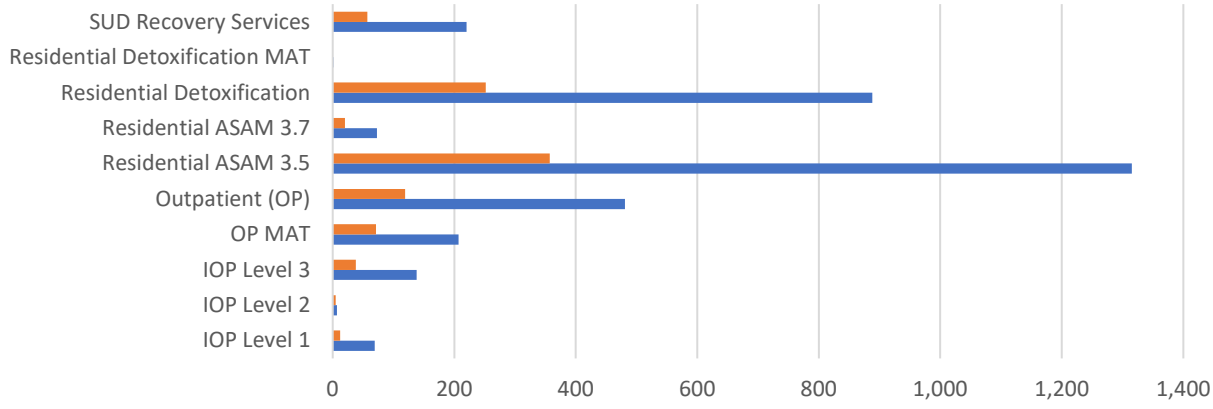


	Female	Male
1st Quarter Admissions	1,099	2,300
January Admissions	311	620

The majority of MDOC clients screened were male



Alcohol was the primary substance of MDOC screens followed closely by heroin.



	IOP Level 1	IOP Level 2	IOP Level 3	OP MAT	Outpatient (OP)	Residential ASAM 3.5	Residential ASAM 3.7	Residential Detoxification	Residential Detoxification MAT	SUD Recovery Services
January Admissions	12	5	38	71	119	357	20	252	0	57
1st Quarter Admissions	69	7	138	207	481	1,315	73	888	1	220

Prevention Quarterly Narrative Report

Narrative:

Quarterly report October 1-December 31, 2022 for Prevention Services, Synar, Gambling Prevention, Priority and COVID data.

Prevention Services

Observations were provided to the following providers this quarter Arab American & Chaldean Council, Care First, Hegira Programs, Livonia Save Our Youth (makeup from September Zoom), Piast Institute/Hamtramck Community Drug Free Coalition, Positive Images, The Guidance Center/SUDDs Coalition, Westland Youth (City of). Overall outcomes and concerns were discussed with each. **Number of Persons Served by for Individual and Population Based for 1st Quarter 2023**

Number of Persons Served by Type of Intervention

PIHP Region: Region 07 - Detroit Wayne Integrated Health Network
Provider Agency: Multiple
Gambling Related: No
Date Range: 10/01/2022 - 12/31/2022

Intervention Type	Number of Persons Served by Individual- or Population- Based Program or Strategy	
	A. Individual-Based Programs and Strategies	B. Population-Based Programs and Strategies
Selective	5349	0
Universal-Direct	6087	0
Universal-Indirect	0	12318
Indicated	824	0
Total	**12260**	**12318**

Providers Program Data

Some of the following data is not indicative of pre and posttest unless listed in the Adolescent Survey Data column. The data does reflect the number of individuals that received evidence-based programming to positively influence past 30-day use, perception of harm, perception of parental disapproval, and perception of peer disapproval.

Monthly Priority Quarterly Report

Provider Data December 2022	Past 30 Day Use	Perception of risk/harm of use	Perception of parental Disapproval of use	Perception of Peer Disapproval of Use	Adolescent SurveyData
Alcohol	1639	80%	90%	60%	Survey
Tobacco	-	60%	93%	61%	Survey
Marijuana	-	45%	47%	43%	Survey
Prescription Drugs	-	38%	78%	46%	Survey
Gambling	-	15%	65%	25%	Survey

February 8 2022

Strategic Plan – QUALITY PILLAR

Program Compliance Committee Status Report

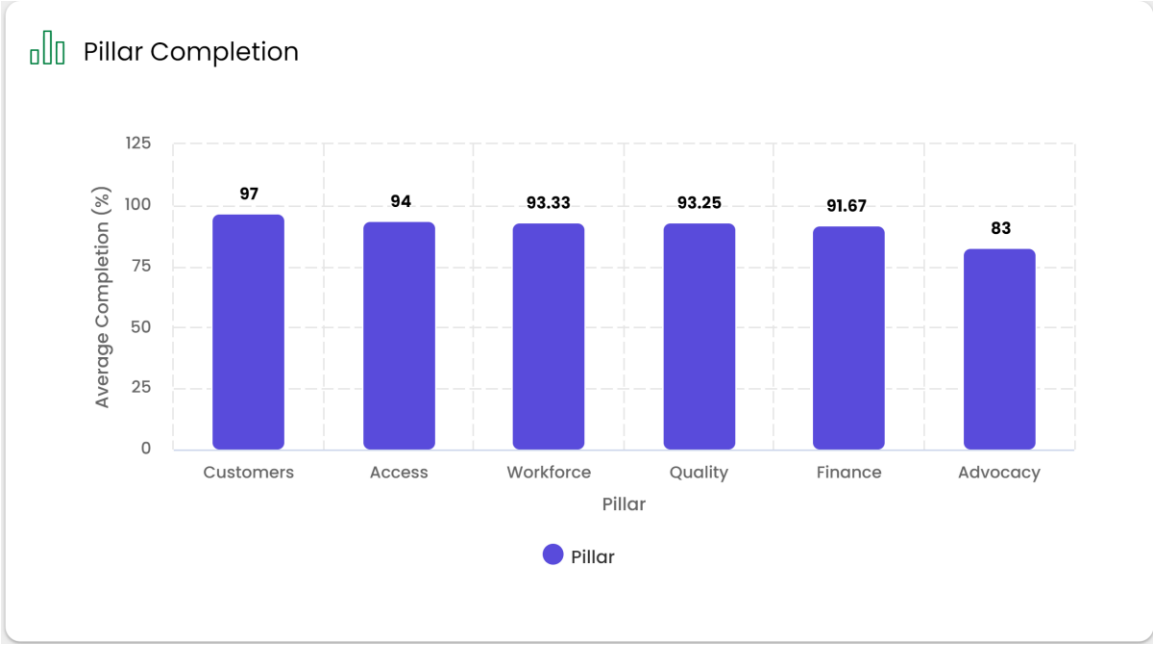
Table of Contents

To our board members:

Our commitment to social responsibility includes a dedication to transparency, collaboration and stakeholder engagement as a core component of our business and sustainability strategy, our monthly reporting process, and our activities within the county.

Our Strategic Planning Status Report is our report to our board members. It tells how we are performing against key indicators that measure our performance against the Access, Customer and Quality Pillars and impact in the areas that matter most to our stakeholders.

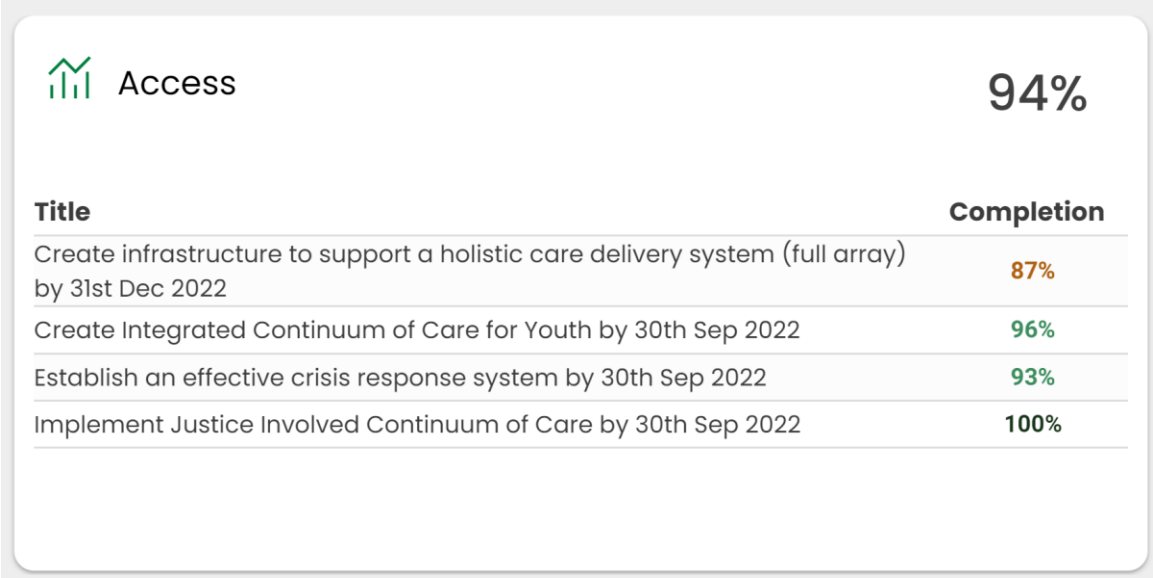
Pillar Dashboard Summary



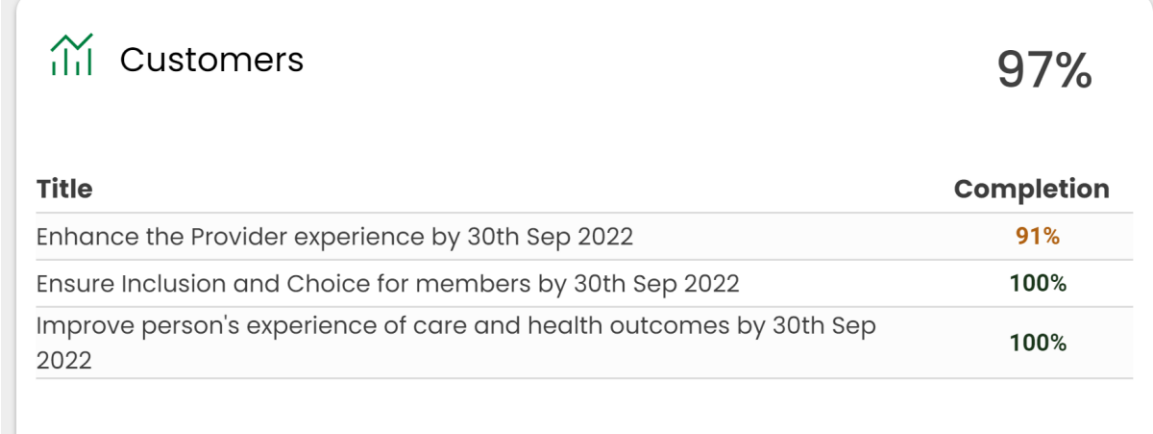
There are three (3) pillars that are under the governance of the Program Compliance Committee: Access, Customer and Quality.

Summary of Pillar Status

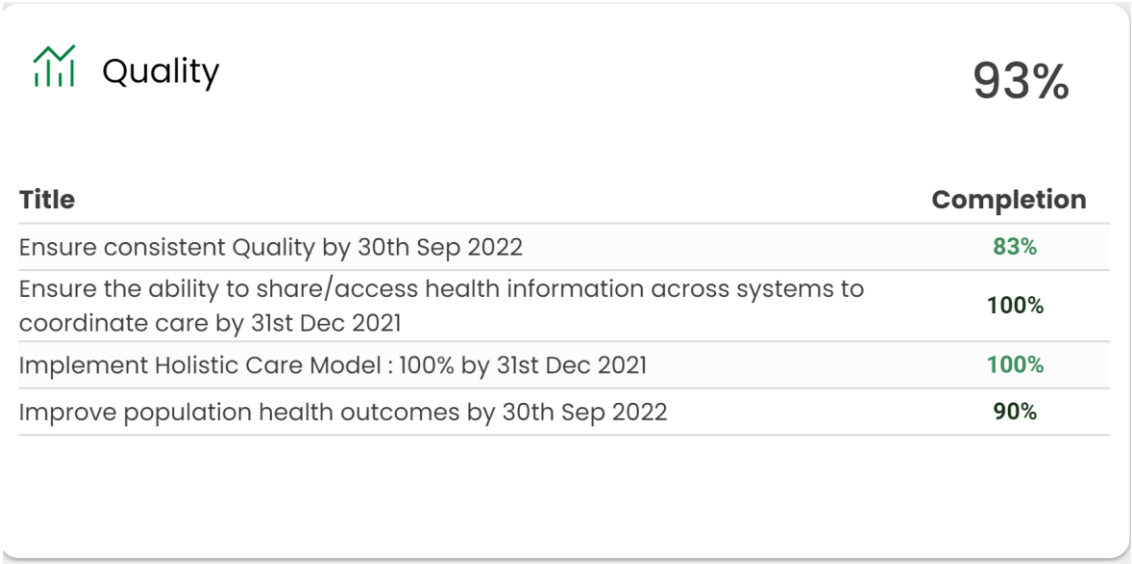
Access Pillar is presented under the leadership of Jacquelyn Davis, Clinical Officer. Overall, we are at 94% completion on this pillar. There are four (4) goals under this pillar. They currently range from 87% - 100% completion.



Customer Pillar is presented under the leadership of Michele Vasconcellos, Director of Customer Service. Overall, we are at 97% completion on this pillar. There are three (3) goals under this pillar. They range from 91% - 100% completion.



Quality Pillar is presented under the leadership of April Siebert, Director of Quality. Overall, we are at 93% completion on this pillar. There are four (4) organizational goals. They range from 83% to 100% completion for the high-level goals.



A detail report of this pillar will follow.

Quality Pillar

Detailed Dashboard

Program Compliance Committee Meeting

February 8, 2023

22
GOALS

88%
GOAL COMPLETION

Draft Not started Behind On Track Nearly There Overdue Complete → Direct Alignment ⇢ Indirect Alignment

DWIHN FY 2020 - 2022 STRATEGIC PLAN

QUALITY

Goal	NCQA Standards	Owner	Co-owners	Tracking T...	Update	Task	System Updates	Current Completi...
Ensure consistent Quality	Quality of Clinical Care Safety of Clinical Care		-	Child Goal Average			**Allison Smith** on 04/09/2020: Progress: 0% ▶ **15.78%**	**83%** **82.65 / 100** 17% behind

Goal	NCQA Standards	Owner	Co-owners	Tracking T...	Update	Task	System Updates	Current Completi...
Achieve NCQA Re-Accreditation : 100 Unit	Quality of Clinical Care Safety of Clinical Care	Allison Smith | Strategic Planning Project Manager	Tania Greason	Manual Slider	NEW **Allison Smith:** **Update:** Successful reaccreditation was achieved with DWIHN receiving Full 3-Year MBHO. The new 3-year strategic plan will include a goal to attain re-accreditation status by the next onsite in2024. Areas that were not 100% will be a strong focus of attention: • **QI:** Health Services Contracting, Availability of Practitioners and Providers, Accessibility of Services, Member Experience, Complex Case Management, Effectiveness of the QI Program • **CC**: Continued Access to Care • **UM:** Appropriate Professionals, Delegation of UM **Challenges:** *No value* *08/01/2022*		**Allison Smith** on 06/03/2021: Progress: 89.6 unit ▶ **92.49 unit**	**92%** **92.49 / 100 Unit** 8 Unit behind
Address gaps in care based on Annual Needs Assessment : 100%	Quality of Service	April Siebert | Director of Quality Improvement	Tania Greason	Task Completion	NEW **Allison Smith:** **Update:** The following is a summary of the Priority Needs and Planned Actions based on the feedback received from the Needs Assessment survey. The top 5 priority needs identified by the respondents were: 1. Workforce Shortage 2. Increase Access to Services 3. Increase Support for Families With Children	**Needs Assessment FY2022** Due: 04/30/2022 April Siebert ☑ **FY2022 Needs Assessment will review data for FY2021.** **Perform FY 2021 Needs Assessment (Capacity Planning)** Due: 12/31/2020 April Siebert ☑ **Quality will look at the 2020 data to assess**	NEW **Allison Smith** on 08/01/2022: ✓ Completed Task **Needs Assessment FY2022 assigned to Director of Quality Improvement (April Siebert)**	**100%** **100 / 100%** -

	4. Basic needs and resources (i.e. housing, food, paying for utilities, and access to technology 5. Issues around health disparities and health outcomes. Attached is a brief explanation of the issue (in order of priority), the reason for the priority, and what action is being planned in that area. **Challenges:** *No value* *08/01/2022*	**who we served, and what gaps in services need to be addressed in 2020.** **This task can be marked complete once the report is sent to MDHHS. Upload the file here.**			
		Perform 2020 Needs Assessment (Capacity Planning) Quality will look at the 2019 data to assess who we served, and what gaps in services need to be addressed in 2020. **This task can be marked complete once the report is sent to MDHHS. Upload the file here.**	Due: 12/31/2020	April September	☑

Current Completi...

Goal	NCQA Standards	Owner	Co-owners	Tracking T...	Update	Task	System Updates	Current Completi...
Assist Utilization Management in developing a system that helps tracks over and under Utilization : 100%	Quality of Service	Manny Singla | CNO/CIO	-	Manual Slider	**Nasr Doss:** We now have Health Information Exchange (HIE) process that transfers various datasets from the major CRSP systems to MHWIN. IT also worked and still working (because this is a Continuous quality improvement matter) with UM and Residential departments on generating various authorizations reports to assist them to analysis over and under utilization. **Challenges:** *No value* *03/03/2021*		**Nasr Doss** on 03/03/2021: Progress: 95% ▶ **100%**	**100%** **100 / 100%** -
Deliver Annual HEDIS measures to support NCQA requirements : 100%	Quality of Clinical Care Safety of Clinical Care	Manny Singla | CNO/CIO	Jacquelyn Davis	Manual Slider	**Allison Smith:** Currently, the Vital Data system is up and running in production mode and is capable of generating all NCQA required HEDIS measures. **Challenges:** *No value* *01/12/2022*		**Allison Smith** on 01/12/2022: Progress: 95% ▶ **100%**	**100%** **100 / 100%** -
Ensure all BH Providers receive 80% or greater on Risk Assessment/Sc Card : 100%	Quality of Clinical Care Quality of Service Members' Experience	June White | Director of Network Management	Manny Singla	Manual Slider	**NEW** **Allison Smith:** **Update:** Monthly assessments of the Risk Scorecard prompted additional refinements in the assessment of the data The IT group is working on the inclusion of the following components into the overall Risk Score. 1. Quality annual audits 2. Customer Service Reviews 3. Adjustments to the Michigan Mission Based Performance Indicators 4. BH-TEDs records **Challenges:** *No value* *08/01/2022*		**NEW** **Allison Smith** on 08/01/2022: Progress: 75% ▶ **85%**	**85%** **85 / 100%** 15% behind

Goal	NCQA Standards	Owner	Co-owners	Tracking T...	Update	Task	System Updates	Current Completi...
Ensure all eligible network providers (organizations) are Credentialed/Re Credentialed : 361 Providers	Quality of Service	Ricarda Pope-King | Director of Credentialing	Junae Tabb	Manual Slider			**NEW** **Allison Smith** on 02/01/2023: Progress: 151 Providers ▶ **166 Providers**	**46%** **166 / 361 Providers** 195 Providers behind
Ensure compliance with monitoring standards : 100%	Quality of Clinical Care Safety of Clinical Care	April Siebert | Director of Quality Improvement	-	Child Goal Average			**NEW** **Allison Smith** on 08/04/2022: Progress: 0% ▶ **87.97%**	**78%** **78.15 / 100%** 22% behind
Ensure fidelity Reviews	Quality of Clinical Care Safety of Clinical Care	Shama Faheem | Chief Medical Officer	Ebony Reynolds	Child Goal Average	**Sherry Scott:** **Update:** Annual fidelity reviews have been completed for all 9 ACT providers for 2020 and 2021. Attached are the ACT providers scores for 2020 and 2021. **Challenges:** *No value* *04/04/2022*		No activity recorded	**45%** **45.16 / 100** 55% behind
Ensure Practitioners are credentialed/re in 60 days FY 2021 : 100%	Quality of Service	Ricarda Pope-King | Director of Credentialing	Junae Tabb	Task Completion	**Ricarda Pope-King:** All Clinically responsible Service Providers and Autism providers have been trained in ProviderSource. After the roster is sent from MHWIN outreach is conducted and the link for the practitioner application is sent. **Challenges:** Barrier is that providers do not enter correct data elements in MHWIN therefore it prevents the Credentialing Specialist from sending a clean list to Medversant for outreach *09/30/2020*	**Microsite Training For Non-Responders** Due: 09/30/2021 Ricarda Pope-King ☐ **100% of the Providers, the did not attend, Microsite Training will be re-scheduled. If they are no call or no show their Contract Manager will be notified.** **Action Plan for Non-Responders** Due: 09/30/2021 Ricarda Pope-King ☐ **60% of practitioners identified as non-responders will complete**	**Allison Smith** on 01/12/2022: Progress: 0% ▶ **82.86%**	**83%** **82.86 / 100%** 17% behind

NCQA Standards	Owner	Co-owners	Tracking T...	Update	Task			System Updates	Current Completi...
					the ProviderSource application by 9/30/2021 starting the credentialing process				
					Institute process: Providers update MH-WIN Staff Record DWIHN instituted a new process for Providers to update their staff record in MH-WIN directly so that the manual process of sending a monthly roster can be discontinued.	Due: 01/04/2021	Richard a Pope-King	☑	
					This is the Credentialed individuals that are from the accredited providers.				
					Wellplace credentialed all non-accredited practitioners for FY2020 Upload the verification/ report showing all non-accredited practitioners were completed	Due: 12/31/2020	Self Determination Provider Network Administrato	☑	

NCQA Standards	Owner	Co-owners	Tracking T…	Update	Task		System Updates	Current Completi…
					FY 2020 by Wellplace. **This is made up of Jail Health, and perhaps one or two other providers that actually provide clinical services.**	r (Unappointed)		
					Follow-up Monitoring to Credentialing POCs **Starting Monday 6-29-20 DWIHN Credentialing Unit will notify CRSPs that follow-up monitoring occur over the next 3 months. Approximate schedule:** • **15 due into MH-WIN July 13** • **15 July 27** • **15 August 10** • **20 August 24**	Due: 09/30/2020	Richarda Pope-King ☑	
					Final Report September 30, 2020 to Credentialing Committee **Attach the**	Du	Ric ☑	

NCQA Standards	Owner	Co-owners	Tracking T...	Update	Task			System Updates	Current Completi...
					Timeliness Report of the Wellplace Practitioner Files Cred/ReCred done FY18 - Current Review and create a report on the Timeliness of the Wellplace Practitioner Files that were Credentialed or Re-Credentialed during FY 18 (start of look back 2/28/2018) though end of June 2020. DWIHN Cred team needs to understand/ identify the specific individuals that will now be re-credentialed now using Medversant.	Due: 07/31/2020	Richard a Pope-King		
					Get the WORKBOOK from Wellplace that they submitted to NCQA.				
					Develop Timeliness Report in Medversant - Practitioner Credentialing	Due: 07/31/2020	Richard a Pope-King	☑	

NCQA Standards	Owner	Co-owners	Tracking T...	Update	Task	System Updates	Current Completi...
					Work w/Medversant (michael) to develop a report to track timeliness to track how long it takes from the time a practitioner sends a complete application until the Credentialing letter being sent to the Practitioner takes.		
					Resolve any reporting errors from Medversant (Clean/Unclean) Review the 8 unclean files from Medversant that are suspected "false negatives". Report findings of "Test Files" FALSE NEGATIVES. Ensure that Medversant has a fix for moving forward so that our process is shored up before moving onto the next batch. Due: 07/02/2020 Richard a Pope-King	☑	

NCQA Standards	Owner	Co-owners	Tracking T...	Update	Task			System Updates	Current Completi...
					Define a Practitioner Credentialing Process/Workflow The Practitioner Credentialing Process/Workflow needs to be agreed upon in the Medversant/Credentialing weekly meeting. Once agreed upon, this needs to be codified in Procedure with PolicyStat and attached to the overarching policy.	Due: 06/26/2020	Richarda Pope-King	☑	
					Send POC to 59 of 61 CSPs & Receive response to POCs Where there were deficits identified in the files, POCs were submitted to the CRSPs. Areas of concern across the verified files: • lack of verification of	Due: 05/29/2020	-	☑	

NCQA Standards	Owner	Co-owners	Tracking T...	Update	Task	System Updates	Current Completi...
					highest degree • lack of continuing education (CEUs) • signed release of information forms • credentialing applications • updated resumes		
					Monitor CRSP compliance using standard checklist Credentialing unit verify/monitor the submission of a sample the of the Credentialing Files from the CRSPs (400 files) from the 61 CRSPs.	Due: 03/31/2020	Richard a Pope-King ☑
					Verify 15% of Roster subissions DWIHN verify a sample of the rosters submitted to to ensure only individuals with identified credentials are included	Due: 10/01/2019	Richard a Pope-King ☑

NCQA Standards	Owner	Co-owners	Tracking T...	Update	Task			System Updates	Current Completi...
					to make sure they have appropriate staff on roster that could/should be credentialed.				
					MCO send Wellplace non-accredited provider list for FY 2020 All non-accredited providers will continue to be reviewed by Wellplace annually per contract for Credentialing Compliance. The Credentialing Function will continue to be performed by Wellplace until Medversant has been fully implemented. Wellplace will receive a list of unaccredited providers at a minimum annually and more often if needed.	Due: 09/30/2019	Self Determination Provider Network Administrator (Unappointed) ☑		
					Implement standard Credentialin	Due: 09/	Richarda ☑		

NCQA Standards	Owner	Co-owners	Tracking T…	Update	Task			System Updates	Current Completi…
					g Checklist system-wide DWIHN standardized the Credentialing Checklist to be used by every CRSP for Credentialing purposes as long as they are a delegate. Once Medversant is fully operationalized the delegate will no longer have to fill out the checklist as this automated by the CVO,.	26/2019	Pope-King		
					Obtain roster of all licensed practitioners Accredited Providers Request roster of all licensed practitioners from accredited provider organizations. This was initially BH providers not the SUD providers.	Due: 08/09/2019	Richarda Pope-King	☑	

Goal	NCQA Standards	Owner	Co-owners	Tracking T...	Update	Task	System Updates	Current Completi...
Ensure Practitioners are credentialed/re in 60 days FY 2022	Quality of Service	Ricarda Pope-King | Director of Credentialing	-	Child Goal Average	NEW **Allison Smith:** **Update:** The Q3 and Q4 Credentialing report will be delivered by November 15, 2022 to MDHHS. **Challenges:** *No value* *08/01/2022*		NEW **Allison Smith** on 08/04/2022: Progress: 0% ▶ **46.75%**	**71%** **70.8 / 100%** 29% behind
FY20 - Meet the External Quality Review (EQR) Standards	Quality of Clinical Care Safety of Clinical Care	April Siebert | Director of Quality Improvement	Tania Greason	Child Goal Average	**Tania Greason:** **Performance Improvement Project (PIP) Increase Diabetes Screening for members with Schizophrenia or Bipolar Disorder who are dispensed Atypical Antipsychotic Medications.** Overall, (85) percent of all applicable evaluation elements received a score of Met. However, The identification and prioritization of barriers through causal/barrier analysis and the selection of appropriate active interventions to address these barriers are necessary steps to improve outcomes. DWIHN's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the DWIHN's overall success in achieving the desired outcomes for the PIP. The three areas in which DWIHN received a Partially Met and/or Not Met include the following: • DWIHN failed to describe the eligible population in the denominator description rather than listing the exclusion criteria (Partially Met). • DWIHN failed to demonstrated improvement in the study indicator result (Not Met). • The study indicator did not achieve statistically significant improvement over the baseline (Not Met). **Performance Measure Validation (PMV)** DWIHN met all required reportable areas during the HSAG Performance Measure Validation (PMV) review for FY20, with the exception of BH-TEDS Data Elements (*Disability		NEW **Allison Smith** on 08/04/2022: Progress: 0% ▶ **94%**	**94%** **94 / 100%** 6% behind

NCQA Standards	Owner	Co-owners	Tracking T...	Update	Task	System Updates	Current Completi...

Designation) during the HSAG Annual Review Validating that DWIHN's systems and processes successfully captured critical data elements needed to calculate performance indicators in alignment with MDHHS' expectations and codebook. In FY19, DWIHN implemented several quality improvement initiatives to address challenges and improve indicator rates. In June 2019, DWIHN initiated a Performance Indicator Provider and Internal Workgroup to review past performance, address challenges to improving rates, and define quality improvement initiatives. This workgroup meets quarterly and includes both DWIHN staff members and members of its provider network. Additionally, we worked with PCE to enhance the reporting module within MH-WIN that allows the provider to review the performance indicator data prior to submission to the PIHP. This system and process change was designed to address data quality issues and address the completeness and accuracy of information impacting performance. Finally, DWIHN develop a Recidivism Workgroup to review and implement interventions targeted at addressing non-compliance with Indicator #10.

Compliance Review

DWIHN received a total compliance score of (79) percent across all standards reviewed during the 2018–2019 compliance monitoring review, which was equal to the statewide average. DWIHN scored above (90%) indicating strong performance in the following areas: QAPIP Plan and Structure, Members' Rights and Protections, and Coordination of Care standards. DWIHN scored (75) percent, (75) percent, (67) percent, (81) percent, (56) percent, and (50) percent respectively in the Quality Measurement and Improvement, Practice Guidelines, Staff Qualifications and Training, Utilization Management, Credentialing, and Confidentiality of

NCQA Standards	Owner	Co-owners	Tracking T...	Update	Task	System Updates	Current Completi...

Health Information standards, indicating that additional focus is needed in these areas. DWIHN's performance measure rates were above the MDHHS established MPS for one of the two reportable indicators, indicating strengths in this area. DWIHN's MPS related to timely preadmission screening for psychiatric inpatient care for new Medicaid members for children was not met, indicating opportunities for improvement in this area.

Challenges: **Performance Improvement Project (PIP) Increase Diabetes Screening for members with Schizophrenia or Bipolar Disorder who are dispensed Atypical Antipsychotic Medications.**

DWIHN determined the following barriers:

- Lack of knowledge among providers to recommend diabetes screening for members with schizophrenia and bipolar disorder.
- Physicians' belief that diabetes prevalence is low in their practice.
- Lack of follow through by enrollees/members to have labs drawn when ordered.

Performance Measure Validation (PMV)

No barriers identified at this time.

Compliance Review

To address the areas requiring improvement, DWIHN will prioritize areas of low performance. The strategy will

	NCQA Standards	Owner	Co-owners	Tracking T...	Update	Task	System Updates	Current Completi...
					include data trends and root cause analyses with actionable and measurable goals, benchmarks, and interventions, addressing development and implementation of mechanisms for sustaining and spreading improvement in health outcomes, member satisfaction, and other focus areas. In addition, DWIHN will take proactive steps to ensure a successful PIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers timely. *03/01/2021*			
→ **FY21 Meet the External Quality Review (EQR) Standards : 100%**	Quality of Clinical Care Safety of Clinical Care	April Siebert | Director of Quality Improvement	-	Child Goal Average	**Tania Greason: Performance Measure Validation (PMV)** HSAG validated a set of performance indicators that were developed and selected by MDHHS for validation. The reporting cycle and measurement period were specified for each indicator by MDHHS. The performance indicators are calculated by the PIHPs for specific populations for the first quarter of state fiscal year (SFY) 2021, which began October 1, 2020, and ended December 31, 2020. All performance indicators were reported as "Reportable", with **no corrective action plan required**. **Performance Measure Validation (Compliance)** DWIHN demonstrated compliance in 50 of 65 elements, with an overall compliance score of 77 percent, indicating that some program areas had the necessary policies,	No activity recorded	**86%** **85.67 / 100%** 14% behind

procedures, and initiatives in place to carry out many required functions of the contract, while other areas demonstrated opportunities for improvement to operationalize the elements required by federal and State regulations.

Performance Measure Validation (PIP)

DWIHN submitted the Design, Implementation, and Outcomes stages of the PIP for this year's validation. Overall, 80 percent of all applicable evaluation elements received a score of Met.

Challenges: During the PMV session of the virtual review, it was identified that DWIHN MH-WIN system was capturing little to no detail from providers in regard to any follow-up conducted by the providers for members that no showed or cancelled as it related to Indicator #1. In addition, DWIHN did not capture any explanation as to why a disposition, assessment, or service request might have fallen out of compliance due to an extended amount of time. Supporting documentation provided by Detroit Wayne from August 2019 acknowledged the issues within an on-site meeting agenda and noted discussions on how to address the issue.

During the opening session of the virtual review, DWIHN noted that for Indicator #2a, the PIHP reporting percentages were the

					lowest amongst regions. There has been a low turnout of new persons receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service. While HSAG noted that a workplan has been implemented by DWIHN, which includes current reporting being sent to the providers to review the status of the indicator and missing gaps of information that needs to be populated by the provider, HSAG recommends for Detroit Wayne to conduct an additional root cause analysis of why members are not receiving follow-up services within 14 days of a completed assessment. *12/23/2021*		Current Completi...
→ **FY22 Meet the External Quality Review (EQR) Standards : 100%**	Quality of Clinical Care Safety of Clinical Care	April Siebert | Director of Quality Improvement	Tania Greason	Child Goal Average		No activity recorded	**94%** **94.33 / 100%** 6% behind
Ensure the ability to share/access health information across systems to coordinate care	Quality of Clinical Care		-	Child Goal Average	**Nasr Doss:** Vital Data has been selected as vendor of choice to produce HEDIS measures, same vendor will also work with us in an integrated care platform to be used with MHP in pilot projects. Currently we are working diligently with the vendor to build up the system and data exchange specs. **Challenges:** *No value* *09/30/2020*	No activity recorded	**100%** **100 / 100** -

Goal	NCQA Standards	Owner	Co-owners	Tracking T...	Update	Task	System Updates	Current Completi...
→ **Enable Interoperability using HIE to share data between care coordinating agencies, providers, health plans, hospitals to provide the provider the holistic view of the health of the individual. : 100%**	Quality of Clinical Care Quality of Service	Manny Singla | CNO/CIO	-	Manual Slider	**Nasr Doss:** Our goal is to achieve TOTAL HIE (Health Information Exchange) platform with our major providers (CRSPS) by the new fiscal year 2021. **Challenges:** *No value* *09/30/2020*		**Allison Smith** on 01/12/2022: Progress: 95% ▶ **100%**	**100%** **100 / 100%** -
Implement Holistic Care Model : 100%	Quality of Clinical Care		-	Child Goal Average	**Allison Smith:** DWIHN was approved for inclusion in the Michigan BHH Pilot (Estimate January 2022 for implementation). Certification tool for inclusion as a BHH partner has been developed and shared with potential providers and review will occur in Oct/Nov. **Challenges:** *No value* *09/02/2021*		**Allison Smith** on 11/06/2019: Marked goal as completed	**100%** **100 / 100%** -
→ **Ensure consistent and standardized model of care : 100%**	Quality of Clinical Care	Melissa Moody | Chief Clinical Officer (CCO)	-	Child Goal Average	**Allison Smith:** DWIHN continues move to a holistic care model by ensuring care coordination is occurring between BH & Physical providers as we move towards the BHH and OHH models and the CCBHC model. OHH Medicaid funding begins 10/1/21. Integrated Health Care unit is working to implement a strategy to ensure better transitions in care (Kids aging-out, or levels of needed care). **Challenges:** *No value* *09/02/2021*		**Allison Smith** on 09/02/2021: Progress: 0.1% ▶ **366%**	**100%** **100 / 100%** -
→ **Obtain leadership buy-in for the Behavior Health Home Model**	Quality of Clinical Care Quality of Service	Chief Network Officer (Unappointed)	-	Manual Slider			**Allison Smith** on 10/07/2019: Progress: 0% ▶▶ **100%**	**100%** **100 / 100** -
Improve population health outcomes	Quality of Clinical Care		-	Child Goal Average			No activity recorded	**90%** **90 / 100** 10% behind

Goal	NCQA Standards	Owner	Co-owners	Tracking T...	Update	Task	System Updates	Current Completi...
Manage performance improvement outcomes : 100%	Quality of Clinical Care	April Siebert | Director of Quality Improvement	-	Manual Slider	**Tania Greason:** NCQA Upload for the Effectiveness of the QI Program (QI 11). Performance Improvement Projects submitted include: • Phone Abandonment • Habilitation Supports Waiver • PHQ-A • PHQ-9 **Challenges:** No barriers identified at this time. *03/01/2021*		NEW **Allison Smith** on 08/04/2022: Progress: 0% ▶ **80%**	**80%** **80 / 100%** 20% behind
Impleme MED DROP Program (genoa healthca : 100	Quality of Clinical Care Quality of Service	Sherry Scott | Manager of Clinical Practice Improvement	Shama Faheem Ebony Reynolds	Task Completion	**Sherry Scott:** DWIHN implemented ACT step down model with the hopes of decreasing hospital recidivism and identifying members who no longer met medical necessity for the ACT program. However, since implementing the ACT Step down model, DWIHN has since went from fee for service to PMPM model for ACT as well as putting hard stops in place which stops any other billing that was outside of the H0039 bundled cpt code. Once those things were put in place there was a decrease in how much DWIHN paid out in ACT services. Also, DWIHN found that ACT members whom were stepping down from ACT did not want to participate in the Med drop/ ACT step down program and some ACT members did not meet medical necessity for the ACT program. With that being said DWIHN expanded the med drop/ ACT step down program to members who do not meet medical necessity for ACT but needed more intensive services then the traditional case management services. **6 cases were closed in December:** CCS- closed 12/30/21- the client would not attend a med review, so	**Establish Electronic Health Record (EHR) access to NEIH for Genoa** 1. **MH-WIN access for the following individuals: _Diane Cranston ,and two Coordinators that will need to be hired.** 2. **Provider 3 NEIH EHR: Diane Cranston ,and two Coordinators that will need to be hired.**	Due: 10/01/2020 Sherry Scott ☑	**Sherry Scott** on 02/01/2021: ✓ Completed Task **TEST MH WIN LBS Staff enter Genoa's MedDrop Referral Form & concurrently enter Auth in MH WIN**	**100%** **100 / 100** -

NCQA Standards	Owner	Co-owners	Tracking T...	Update	Task	System Updates	Current Completi...
				no medications could be prescribed. CNS- closed 12/7/21- dropped out- She did not want to do anymore. Thought was managing meds just fine. Was not what she expected after the fact. CNS- closed 12/1/21- dropped out- this was the client who has having the issues with PCP not allowing meds to move over to Genoa. He did not want to continue to fight about this. CNS- closed 12/17/21- the client did not attend scheduled med reviews, so medication drops did not start. This was an orientation only. DCI = closed 12/10/21- dropped out- changed his mind. He was very organized and really did not need our help. LBS- closed 12/16/21- moved out of county **Challenges:** COVID 19 became a barrier with initially implementing the program. Since implementing the ACT Step Down/ Med drop program, members were apprehensive about someone coming to their home and being in close proximity due to COVID concerns. Another barrier was that some members were not interested in participating in the ACT Step Down/ Med drop program. Another challenge is hiring and keeping staff. Since COVID 19, there were a number of staff who had reside. All of our network providers has a staffing issue	**Confirm with DWIHN IT and with NEIH S IT that users have access.** **Due to COVID 19 NEIH will implement STEP DOWN and Med DROP first quarter FY 20.** **Assign 50 CCS Members to ACT Step Down and MedDrop in MH WIN** 1. **Add 50 members from CCS to ACT Step Down for Program Alignment in MH WIN** 2. **Add 50 members from CCS to MedDrop for Program Alignment in MH WIN** **This is required for Sherry Scott to**	Due: 09/30/2020 Sherry Scott ☑	

NCQA Standards	Owner	Co-owners	Tracking T...	Update	Task	System Updates	Current Completi...
				which in turn providers were not able to hire enough case managers to implement the program. Due to all of these reasoning DWIHN expanded the population to members in outpatient, receive AOT orders and those that have a high hospital admission rate. *01/20/2022*	**capture the all members from CCS that will be part of this program.**		
					Establish Electronic Health Record (EHR) access to CCS for Genoa Due: 08/17/2020 Sherry Scott ☑		
					1. **MH-WIN access for the following individuals: Diane Cranston ,and two Coordinators that will need to be hired.** 2. **Provider 2 CCS EHR: _____ ,_____ , _____** 3. **This goal is extended to due COVID-19.**		
					LBS Coordinator complete all 50 member Assessmen Due: 08/15/ Sherry Scott ☑		

NCQA Standards	Owner	Co-owners	Tracking T...	Update	Task	System Updates	Current Completi...
					ts (ATR in MH WIN) **Authorization Submission needs to be available in MH WIN (IT staff Steve Jamison) before LBS can enter the assessments. Completing all LTR assessment tools are pushed back due to covid-19 and stay at home order that was implemented by the governor.**	2020	
					Identify team members need to complete annual ACT training	Due: 06/30/2020 Sherry Scott ☑	
					TEST MH WIN CCS Staff enter Genoa's MedDrop Referral Form & concurrently enter Auth in MH WIN	Due: 06/26/2020 Sherry Scott ☑	
					LBS MedDrop Intakes Begin **LBS MedDrop intakes began on 3/6/2020 but had to stop on 3/13/2020**	Due: 06/15/2020 Sherry Scott ☑	

NCQA Standards	Owner	Co-owners	Tracking T…	Update	Task	System Updates	Current Completi…
					conducting new intakes due to COVID-19. Four intakes were completed during this time. More intakes will began 6/15/2020.		
					Begin MedDrop LBS 1. **Hold Kick-Off at 3/6/2020.** 2. **Host short 15-30 minute Feedback Meeting on Monday 3/9/2020 with DWIN, Genoa and LBS teams to talk about any challenges or issues encountered for rapid process improvements if needed.**	Due: 03/09/2020 Sherry Scott ☑	
					Finalize Program Manual	Due: 02/25/ Sherry Scott ☑	

NCQA Standards	Owner	Co-owners	Tracking T…	Update	Task	System Updates	Current Completi…
					Program manual details the evidence based model of ACT Step down (Transitional ACT) to include members who need a higher level of care but does not meet ACT admission criteria. The manual also includes MedDrop program details. 2020		
					Establish SUG Service Utilization Guidelines for MedDrop and ACT Step Down in MCG Due: 02/25/2020	Melissa Mody ☑	
					Initial Authorization for 90 days (auto approved) because Sherry Scott has approved the initial member for the Pilot. The next 90 days will need to be approved by UM to better capture the success of the program.		
					Assign 50 Du	She ☑	

NCQA Standards	Owner	Co-owners	Tracking T...	Update	Task		System Updates	Current Completi...
					LBS Members to ACT Step Down and MedDrop in MH WIN 1. **Add 50 members from LBS to ACT Step Down for Program Alignment in MH WIN** 2. **Add 50 members from LBS to MedDrop for Program Alignment in MH WIN** **This is required for Sherry Scott to capture the all members from LBS that will be part of this program.**	Due: 02/25/2020	Sherry Scott	
					Enter ATR Assessment Tool in MH WIN **This tool needs to be entered into MH WIN so that the providers can enter the**	Due: 02/21/2020	Sherry Scott ☑	

NCQA Standards	Owner	Co-owners	Tracking T...	Update	Task			System Updates	Current Completi...
					assessment directly into MH WIN to allow reporting and tracking of members every 90 days.				
					TEST MH WIN LBS Staff enter Genoa's MedDrop Referral Form & concurrentl y enter Auth in MH WIN TEST MH WIN LBS Staff enter Genoa's MedDrop Referral Form & concurrentl y enter Auth in MH WIN	Du e: 02/ 14/ 202 0	-	☑	
					TEST MH WIN LBS Staff enter Genoa's MedDrop Referral Form & concurrentl y enter Auth in MH WIN	Du e: 02/ 14/ 202 0	She rry Sco tt	☑	
					Establish MH-WIN Program Assignment for ACT Step Down and MedDrop	Du e: 02/ 14/ 202 0	Jef f Whi te	☑	
					1. **Add a drop down for ACT Step Down for Progra**				

NCQA Standards	Owner	Co-owners	Tracking T...	Update	Task	System Updates	Current Completi...
					m Alignment in MH WIN 2. Add a drop down for MedDrop for Program Alignment in MH WIN		
				This is required for Sherry Scott to the align members to the Program before 2/28/2020.			
				Establish Electronic Health Record (EHR) access to LBS for Genoa	Due: 02/07/2020	Sherry Scott ☑	
					1. MH-WIN access for the following individuals: _Diane Cranston ,and two Coordinators that will need to be hired. 2. Provider 2 LBS		

NCQA Standards	Owner	Co-owners	Tracking T...	Update	Task	System Updates	Current Completi...
					EHR: _____ _____ ,_____ _____ , _____ _____		
					Confirm with DWIHN IT and with LBS IT that users have access.		
					Establish list of LBS members for Pilot Establish the list of LBS Members that will be included in the pilot. Additionally - the methodology needs to be developed and captured in the ACT Step Down Manual.	Due: 01/31/2020	Sherry Scott ☑
					Establish the billing reimbursement rate for Pilot. The billing rate was established by working with Steve Z. in finance based on current per member outpatient rates of IPO services and CLS	Due: 01/31/2020	Sherry Scott ☑

NCQA Standards	Owner	Co-owners	Tracking T...	Update	Task	System Updates	Current Completi...
					services for MedDrop. • **Steve Z in finance has established the billing reimbursement for Med Drop for H2015-PH $34 per 15 minute increment and $353 outpatient per member per month for ACT step down members**		
					Develop a Modifier for the MedDrop Program in MH WIN Sherry Scott requested a Modifier via Procedure Code Workgroup. The PH modifier was approved and in MH WIN. **H2015-PH**	Due: 01/31/2020 Jeff White ☑	
					Establish Electronic Health	Due: 01/ Sherry ☑	

NCQA Standards	Owner	Co-owners	Tracking T…	Update	Task	System Updates	Current Completi…
					Record (EHR) access to LBS for Genoa 1. **MH-WIN access for the following individuals: _Diane Cranston ,and two Coordinators that will need to be hired.** 2. **Provider 1 LBS EHR: Diane Cranston and two Coordinators to be determined before Feb 28, 2002**	13/ 2020 Scott	
					Establish the Referral Workflow (Pilot Program to Med Drop) **DWIHN tentatively agreed to the referral process during the 10/18/19 meeting: Referral workflow**	Due: 01/ 03/ 2020 Sherry ☑ Scott	

NCQA Standards	Owner	Co-owners	Tracking T...	Update	Task	System Updates	Current Completi...
					was added in the manual for external and internal referrals.		
					Meet with the 3 Pilot Providers re: Readiness and Rollout Plan	Due: 12/11/2019	Sherry Scott ☑
					Identify a fidelity assessment tool	Due: 12/10/2019	- ☑
					Develop Eligibility, ACT Discharge Criteria and Step-Down Criteria Once agreed up (Develop Eligibility, ACT Discharge Criteria and Step-Down Criteria) this must be put into the Program Manual.	Due: 12/09/2019	Sherry Scott ☑
					Provide TA in preparation for implementation at CCS Provide technical assistance for preparation for implementation at CCS	Due: 12/06/2019	- ☑
					Provide TA in	Due:	- ☑

NCQA Standards	Owner	Co-owners	Tracking T…	Update	Task			System Updates	Current Completi…
					preparation for implementation at LBS **Provide technical assistance for preparation for implementation at LBS**	12/06/2019			
					Signed Contract between DWIHN and Genoa • **Meeting November 12, 2019 to finalize details of contract**	Due: 11/29/2019	Chief Network Officer (Unappointed)	☑	
					Conduct a Readiness Assessment and select pilot provider(s) **ATR readiness scale, LBS, CCS, and NEGC**	Due: 11/15/2019	-	☑	
					Identify Process & Outcome Measurement Tools to Monitor Outcomes • **Identify Process and Outcome Measurement Tools to Monitor**	Due: 11/15/2019	Sherry Scott	☑	

NCQA Standards	Owner	Co-owners	Tracking T…	Update	Task	System Updates	Current Completi…
					Outcomes - • **The ATR will be used Quarterly.**		
					Establish the Population and Providers for Pilot Due: 11/12/2019	Sherry Scott ☑	

					• **ID population is ACT (SMI and Co-Occurring) and ready to step down to lower level of care (ACT Step-Down)**
					  • **# of _____**
					• **ID Providers for the Pilot**
					  • **Provider 1**
					  • **Provider 2**		

NCQA Standards	Owner	Co-owners	Tracking T...	Update	Task	System Updates	Current Completi...
					• Commitment and potential Contract/Scope Change (ie.is it a MOU or Scope Change?)		
					Build Consensus for Implementation throughout the organization This is an on-going activity. However, for the sake of tracking this as a task, this initial step of building the consensus can be marked as complete as of 10/25/2019.	Due: 10/25/2019 Sherry Scott ☑	
					Define Implementation Rationale & Quality Improvement Project	Due: 10/09/2019 Sherry Scott ☑	
					Review ACT Step-Down models utilized by other MI PIHP/CMHSPs	Due: 10/03/2019 Sherry Scott ☑	
					Identify the	Du	She ☑

NCQA Standards	Owner	Co-owners	Tracking T...	Update	Task			System Updates	Current Completi...
					Multidisciplinary ACT Step-Down Team Team was identified as: Identify the Multidisciplinary ACT Step-Down Team This also must be added to the Program Manual	Due: 10/02/2019	Sherry Scott		
					Present ACT Step-Down to IPLT for project approval Obtained approval at IPLT.	Due: 08/20/2019	Sherry Scott ☑		
					Review Literature for Models of ACT Step-Down Review Literature for Models of ACT Step-Down.	Due: 06/18/2019	Sherry Scott ☑		
					DWIHN provide training on Step-Down Model DWIHN to provide additional training on the Step-down Model, include competency in engagement/warm-hand-off transitions. This step is	-	Sherry Scott ☑		

	NCQA Standards	Owner	Co-owners	Tracking T…	Update	Task	System Updates	Current Completi…
						for the initial training for the 3 pilot providers. An additional Task that needs to be developed will be to have DWIHN have this training incorporated into the mandated trainings as a part of DWConncect.		

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
Customer Pillar							
Goal I (Members Experience and Quality of Service)	**Improve Members Experience with Services**						
I.1	ECHO Annual Satisfaction Surveys (Adult and Children)	Director of Customer Service	The 2022 ECHO® Survey (Children and Adult) results will be collated, reviewed, analyzed and reported by April of 2023.	The target goal is to increase each outcome reported during FY2021 for both Adults and Children. **Adults:** Improve member access to behavioral health services for the 3 reporting measures scoring < 50% which include:1) Preceived Improvement 29%; 2)Getting Treatment Quickly 46% 3). Office Wait 44%. **Children:** Improve member access to behavioral health services for the 2 reporting measures scoring < 50% which include: 1). Preceived Improvement 28% 2). Getting Treatment Quickly 46%.	Previously identified issues are to increase outcomes for the 5 reporting areas scoring <50% during FY2021 for Adults and Children. This is a continuation goal from FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 4 of FY-2024.

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
I.2	National Core Indicator Survey (NCI) for Adults	Director of Customer Service	In FY 2023 Q3 (April 1, 2023 through June 30, 2023) results of the surveys will be collated, reviewed, analyzed.	The target goal is to improve each score response rate to identify areas for system enhancement to improve areas of dissatisfaction, access to service and quality of care.	Previouly identified issue. DWIHN does not control or participate in the completion of this report. MDHHS has declined request to provide data of the actual survey. This is a continuation goal from FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY2024.
I.3	Provider and Practitioner Satisfaction Survey	Director of Strategic Operations, Director of Managed Care Operations (MCO)	In FY 2023 Q4 results of the Provider Satisfication surveys will be collated, reviewed, analyzed for comparision between FY2022 and FY2023. The 2022 Practitioner Satisfaction Survey results will be collated, reviewed, analyzed and reported by September of 2023.	The target goal is to increase the providers outcomes for the areas of Staff Availability, Timeliness of Responses, Knowledge of Staff to Answer Questions and Resolve issues and Credentialing/Impaneling from FY2022 by 10% or higher.	Previously identified issue. Provider Satisfaction survey questions were modified in FY2022, no data is avaialble for comparision until FY2023. This is a continuation goal from FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY2024.

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
I.4	Grievance/Appeals	Director of Customer Service	FY 2022-2023 (October 1, 2022 through September 30, 2023) results will be collated, reviewed, analyzed and reported by Q2 of January 2024.	The target goal is to improve outcomes by resolving grievances and appeals within the required time frame. Delivery of Service and Customer Services were consistently reported high over each of each of the the last two years. Interpersonal relations came in third with a total of 46 complaints during FY2021.	Previously identified issue. There was high number of grievances filed in the area of Delivery of Service and Customer Service in FY2021. This is a continuation goal from FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
I.5	Timeliness of Utilization Management Decisions	Director of Utilization Management	FY 2022-2023 (October 1, 2022 through September 30, 2023) Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to meet or exceed performance standards set by MDHHS/NCQA for timely UM decisions making, timeframes and notification. Threshold 90% .	No previously identified issues during FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
I.6	Practice Guidelines	Chief Medical Officer	FY 2022-2023 (October 1, 2022 through September 30, 2023). Guidelines are reviewed and dissemented throughout the provider network no less than every two years.	The target goal is to ensure guidelines are reviewed at least every two years and shared with the provider network for feedback through reports, clinical record reviews, and/or process indicators.	Previously identified issues. Lack provider feedback and participation to review practice guidelines as required. This is a continuation goal from FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
I.7	Cultural and Linguistic Needs	Director of Customer Service, Director of Managed Care Operations, Director of Quality Improvement Diversity, Equity & Inclusion Administrator	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to improve outcomes through cutural competency, language, and physical accessibility by identifiying existing racial and ethnic disparities within our provider network for all populations.	Previously Identified Issue: 31% of members reported their cultural needs were not met in FY2021 from the Member Satisfaction survey. This is a continuation goal from FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
Access Pillar							
Goal II (Quality of Service and Quality of Clinical Care)	**Improve members Access to Services, Quality of Clinical Care, and Health and**						

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
	Michigan Mission Based Performance Indicators (MMBPI)						
II.1	Indicator 1(a) and 1(b) - Percentage of pre-admission screenings for psychiatric inpatient care (Children and Adults) for whom disposition was completed within three hours.	Director of Quality Improvement	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to meet or exceed performance standard. Standard is 95% or above.	No previously identified issues during FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
II.2	Indicator 2(a) and 2(b) - Percentage of persons (Children and Adults) receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.	Director of Quality Improvement	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to achieve comparable scores within the region to the state wide average. FY22 results: Q1(52.85%), Q2 (59.23%), Q3 (37.84%) and Q4 (44.26%). Total population rate (48.30%).	Previously identified issues. This measure allows for no exceptions. MDHHS has not established a minimum threshold for this measure. This is a continuation goal from FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
II.3	Indicator 3(a) and 3(b) - Percentage of persons (Children and Adults) needed on-going service within 14 days of a non-emergent assessment with a professional.	Director of Quality Improvement	FY 2022-2023 (October 1, 2023 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to achieve comparable scores within the region to the state wide average. FY22 results: Q1(82.36%), Q2 (87.27%), Q3 (84.66%) and Q4 (88.32%). Total population rate (85.71%).	No previously identified issues during FY2022. This measure allows for no exceptions. MDHHS has not established a minimum threshold for this measure. This is a continuation goal from FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
II.4	Indicator 4a(1) and 4a(2) - Percentage of discharges from a psychiatric inpatient unit (Children and Adults) who are seen for follow up care within 7 days.	Director of Quality Improvement	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to meet or exceed performance standard. Standard is 95% or above.	No previously identified issues during FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
II.5	Indicator 4b - Percentage of discharges from a Substance Abuse Detox Unit who are seen for follow-up care within 7 days.	Director of Quality Improvement	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to meet or exceed performance standard. Standard is 95% or above.	No previously identified issues during FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
II.6	Indicator 10 (a) and 10 (b) - Percentage of readmissions (Children and Adults) to inpatient psychiatric unit within 30 days of discharge.	Director of Quality Improvement	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to meet or exceed performance standard. Standard is 15% or less. FY22 results Q2 (16.31%), Q3 (17.79%), Q4 (15.89%). Total population rate (15.43%).	Previously identified issues. Targerted goal not met with Recidivism for the adult population for three out of four quarters. This is a continuation goal from FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
II.7	Complex Case Management	Director of Integrated Health Care	FY 2022-2023 (October 1, 2022 through September 30, 2023) results will be collated, reviewed, analyzed and reported by Q2 of February 2024.	The target goals are to improve medical and behavioral health concerns and increase overall functional status by 10% in PHQ scores, provide early intervention for members appropriate for Complex Case Management to prevent recurrent crisis or hospitalizations, increase participation in the number of members who attended two out-patient behavioral health services within 60 days of starting CCM services who were open for at least 60 days and improve member satisfaction scores by 20%.	No previously identified issues during FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
II.8	Crisis Intervention Services	Director of Utilization Management, Director of Crisis Services	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to decrease number of re-hospitalization within 30 days of discharge to 15% or less for Adults. FY22 results Q2 (16.31%), Q3 (17.79%), Q4 (15.89%). Total population rate (15.43%).	Previously identified issues. Targerted goal not met with Recidivism for the adult population for three out of four quarters. This is a continuation goal from FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
Workforce Pillar							
Goal III. (Quality of Service)	**Develop and maintain a Competent Workforce through the Credentialing and Re-Credentialing Process**						

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
III.1	Maintain Competent Workforce	Director of Workforce Development, Provider Network Administrator Credentialing, Director of Quality Improvement, Director of Clinical Practices Improvement, Director of Managed Care Operations	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to ensure a competent workforce through performance reviews by evaluating job performance and competency, and maintaining and expanding a centralized training program for allied health professionals. Focusing on the development of new professionals is integral to achieving a collaborative integrated healthcare system.	No previously identified issues during FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
Finance Pillar							
Goal IV (Quality of Service)	**Maximize Efficiencies and Control Costs**						

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
IV.1	Verification of Services	Director of Quality Improvement, Corporate Compliance Officier	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed Bi-quarterly (1st & 2nd Quarter (October 1, 2022 - March 31, 2023); (3rd & 4th Quarter April 1, 2023 - September 30, 2023).	The target goal is to review 100% of randomly selected Paid Encounters/Claims to eliminate Fraud, Waste and Abuse in the provider network.	No previously identified issues during FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
Quality Pillar							
Goal V (Safety of Clinical Care)	**Improve Quality Performance, Member Safety and Member Rights system-wide**						
V.1	Provider Network Performance Monitoring - Clinically Responsible Service Provider (CRSP)	Director of Quality Improvement	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to increase the number of provider reviews from FY2022 by 15% or higher to ensure Continuous Quality Improvement.	No previously identified issues during FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V.2	Residential Treatment Providers	Director of Quality Improvement	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to increase number of Residential Treatment Provider reviews from FY2022 by 15% or higher to ensure Continuous Quality Improvement.	No previously identified issues during FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
V. 3	Long Term Supports Services (LTSS)	Director of Quality Improvement; Director of Customer Service	FY 2022-2023(October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	Target goal is to ensure the incorporation of individuals receiving LTSS into the review and analysis of the information obtained from quantitative and qualitative methods; and evaluate the effects of activities implemented to improve satisfaction.	Previously identified issues for FY2022 include no data collection or analysis for members receiving LTSS services.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
V.4	Provider Network Self Monitoring (Inter-Rater Reliability)	Director of Quality Improvement	FY 2022-2023(October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to increase Provider's participation in Self Monitoring reviews from the pervious year by 20% or higher to ensure inter rater reliability.	No previously identified issues during FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V.5	Autism Services	Director of Quality Improvement, Director of Children's Initiatives	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to increase the number of Providers reviewed from FY2022 by 15% or higher to ensure Continous Quality Improvement.	No previously identified issues during FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 FY-2024.
V.6	Critical/Sentinel/Unexpected Death and Risk Reporting	Director of Quality Improvement	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to meet MDHHS reporting requirements and monitor the safety of clinical care of members.	No previously identified issues during FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
V.7	Behavior Treatment Review	Director of Quality Improvement, Chief Medical Officer	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to meet the BTPRCs Technicial Requirements set by MDHHS through reviews of randomly selected cases. Threshold 95% or above.	No previously identified issues during FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
(Quality of Clinical Care)	**Quality Improvement Projects (QIP's)**						

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V.8a	Improving the availability of a follow up appointment with a Mental Health Professional with-in 7 days after Hospitalization for Mental Illness.	Director of Integrated Health Care Director of Quality Improvement	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is 45% or higher in improving the availability of a follow up appointment with a Mental Health Professional within 7 and 30 days after Hospitalization for Mental Illness.	Previously identified issue. Targeted goal of 45% or higher not met; rate was 29.57% for FY2022. This is a continuation goal from FY2022.		Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2023 on the reporting measure. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
V.8b	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Director of Integrated Health Care Director of Quality Improvement	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is 45% or higher. This measure analyzes the percentage of members 19 to 64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.	Previously identified Issue. Targeted goal not met for FY2022. This is a continuation goal from FY2022.		Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2023 on the reporting measure. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V.8c	Antidepressant Medication Management for People with a New Episode of Major Depression	Director of Integrated Health Care, Director of Quality Improvement	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is 51% or higher. Improve the importance of a good clinician/patient relationship in addressing the importance of disease management and member's fear of taking medication as well as the risks and benefits of taking the medication.	Previously identified issue. Targeted goal not met for FY 2022. Results was 13.36%. This is a continuation goal from FY2022.		Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2023 on the reporting measure. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
V.8d	Improving Diabetes Monitoring for People with Schizophrenia and Bipolar Disorder	Director of Integrated Health Care, Director of Quality Improvement	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is 80% or higher. This measure analyzes the percentage of patients 18-64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening during the measurement year.	Previously identified issue. Targeted goal not met for FY 2022 (64.86%). This is a continuation goal from FY2022.		Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2023 on the reporting measure. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V.8e	Coordination of Care	Director of Integrated Health Care, Director of Utilization Management, Director of Quality Improvement	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is 95% or higher for review of randomly selected cases through the performance monitoring process for compliance.	Previously identified issue. Targeted goal not met for FY 2022. This is a continuation goal from FY2022.		Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2023 on the reporting measure. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
V.8f	Case Finding for Opiate Treatment	Director of Substance Use Disorder	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated	The target goal is 79% or higher.	Previously identified issue. Targeted goal not met FY22. This is a continuation goal from FY2022.		Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2023 on the reporting measure. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
V.8g	PHQ-9 Implementation	Director of Clinical Practice Improvement	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is 95% or higher.	No previously identified issue. Targeted goal met FY22 (99.1%)		Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2023 on the reporting measure. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V.8h	PHQ-A Implementation	Director of Children's Initative	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is 100%	No previously identified issue. Targeted goal not met FY22 (99.2%).		Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2023 on the reporting measure. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
V.8i	Decreasing Wait for Autism Services	Director of Children's initiative	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is 100%	Previously identified issue. Targeted goal not met (67.5%). This is a continuation goal from FY2022.		Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2022 on the reporting measure. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.
	Advocacy Pillar						
Goal VI.	**Increase Community Inclusion and Integration**						

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
VI.1	Home and Community Based Services (HCBS)	Director of Quality Improvement	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal not met; Provider network is not fully HCBS compliant.	Previously identified issue. Targeted goal not met for FY22. This is a continuation goal from FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
Goal VII (Quality of Service)	**External Quality Reviews**						

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
VII.1	MDHHS Annual 1915 © Waiver Review	Director of Quality Improvement, Director of Managed Care Operations, Director of Customer Service, Director of Recipient Rights , Deputy Chief Financial Officer, Director of Workforce, Provider Network Administrator Credentialing, Director of Integrated Health Care, Director of Human Resources	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to achieve 95% or above in the Waiver compliance review.	No previously identified issues during FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 3 of FY-2024.

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
VII.2	NCQA Accreditation	Director of Quality Improvement, Director of Managed Care Operations, Director of Customer Service, Director of Recipient Rights , Deputy Chief Financial Officer, Director of Workforce, Provider Network Administrator	January 1, 2022-January 1, 2024. Reports and collated, reviewed and analyzed during the required look back period.	The target goal is to achieve recertification in FY2024.	No previously identified issues.		Submit quarterly reports to PCC on the recertification process. DWIHN will be revaluated for re-certification in January 2024.

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
VII.3	Health Services Advisory Group (HSAG)-Validation of Performance Projects (PIP)	Director of Quality Improvement	FY 2022-2023 (October 1, 2022 through September 30, 2023). Reports and collated, reviewed and analyzed during the required look back period.	The target goal is to verifies whether DWIHN's new PIP (reduce racial and ethnic disparity with African Americans for the percentage of discharges from a psychiatric inpatient unit that were seen for follow-up care within 7 day) used a sound methodology in the design, implementation, analysis, and reporting.	No previously identified issues during FY22.		Submit quarterly reports to PCC on performance outcomes. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 3 of FY-2024.

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
VII.3a	Health Services Advisory Group (HSAG)-Compliance Review	Director of Quality Improvement, Director of Managed Care Operations, Director of Customer Service, Director of Recipient Rights , Deputy Chief Financial Officer, Director of Workforce, Provider Network Administrator Credentialing, Director of Integrated Health Care, Director of Human Resources	FY 2022-2023 (October 1, 2022 through September 30, 2023). Reports and collated, reviewed and analyzed during the required look back period.	Previously identified issues. The target goal is to complete plans of action from (Year 1) and (Year 2) to address each deficiency identified during the Compliance Review in (Year 3) of August 2023.	Previously identified issue. Targeted goal not met in FY22; achieved an overall score 83.0%.		Submit quarterly reports to PCC on performance outcomes. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 4 of FY-2024.

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
VII.3b.	Health Services Advisory Group (HSAG) - Performance Measure Validation (PMV)	Director of Quality Improvement, IT Administrator, Claims Administrator	FY 2022-2023 (October 1, 2022 through September 30, 2023). Reports and collated, reviewed and analyzed during the required look back period.	The target goal is to achieve 95% or above.	No previously identified issues. Targeted goal met with no plan of correction during FY22.	I	Submit quarterly reports to PCC on performance outcomes. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 3 of FY-2024.

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
VII.4	Annual Needs Assessme	Director of Quality Improvement, Director of Managed Care Operations, Director of Customer Service, Director of Recipient Rights , Deputy Chief Financial Officer, Director of Workforce, Provider Network Administrator Credentialing, Director of Integrated Health Care, Director of Human Resources	FY 2022-2023 (October 1, 2022 through September 30, 2023). Reports and collated, reviewed and analyzed during the required look back period.	The target goal is to prioritize and implement planned actions as identified by our stakeholders, members and the provider network.	No previously identified issues during FY2022.		Submit quarterly reports to PCC on performance outcomes. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
End							

VP of CLINICAL OPERATIONS EXECUTIVE SUMMARY
PROGRAM COMPLIANCE COMMITTEE
February 8, 2023

COVID-19 RESPONSE PLAN:

DWIHN's Covid-19 Response Plan includes maintaining and creating an infrastructure to support a holistic care delivery system, with access to a full array of services. Planning will continue for COVID-19 to ensure access, placement and specialized programs for individuals served by DWIHN.

COVID-19 & INPATIENT PSYCHIATRIC HOSPITALIZATION-

	# of Inpatient Hospitalizations	COVID-19 Positive
November 2022	700	7
December 2022	689	5
January 2023	701	10

Inpatient Hospital Admission Authorization data as of 2/1/2023.

COVID -19 SUBSTANCE USE DISORDER- RECOVERY HOUSING/RECOVERY SUPPORT SERVICES-

These individuals must be receiving outpatient services from a licensed SUD provider in DWIHN's network via telehealth or telephone communications. The providers may provide up to 14 days for this specific recovery housing service for individuals who are exhibiting COVID-19 symptoms and/or tested for COVID-19 and positive.

Provider	# Served- January 2023
Quality Behavioral Health (QBH)	2 (December-37)
Abundant	4 (December-3)

* Significant decrease in Covid-19 positive cases reported from December to January 2023.

COVID-19 PRE-PLACEMENT HOUSING - Pre-Placement Housing provides Detroit Wayne Integrated Health (DWIHN) consumers with immediate and comprehensive housing and supportive services to individuals who meet DWIHN admission criteria and eligibility. Pre-Placement Housing provides funding to residential providers contracted to provide short-term housing for a maximum stay of 14- days, meals, transportation and supportive services that promote stable housing and increase self-sufficiency.

Provider	Services	# Beds	January 2023- # Served
Detroit Family Homes	Licensed Residential Home- Adults	4	0 (December-0)
Kinloch	Licensed Residential Home- Adults	3	0 (December-0)

RESIDENTIAL DEPARTMENT- COVID-19 Impact-

	Fiscal Year 2020	Fiscal Year 2021	Fiscal Year 2022	Fiscal Year 2023	January 2023
Total # Covid-19-Members	169	76	136	6	**0 (Dec.- 4)**
Related Deaths	*34*	7	*3*	*0*	**0 (Dec.-0)**
Total# Covid-19 Staff	71	59	58	0	**0 (Dec.-0)**
Related Deaths	*3*	*0*	*1*	*0*	**0 (Dec.-0)**

CLINICAL OPERATION UPDATES

ADULT INITIATIVES:

Evidence-Based Supported Employment (EBSE): During the reporting period, there were: (175) referrals, (128) admissions, (370) individuals obtained competitive employment with an average hourly wage of ($14.25). Of the (370) individuals who obtained competitive employment, (1) was a returning citizen. Individuals served were employed in a variety of jobs/positions. Twenty-nine (29) individuals transitioned from EBSE services to a lower level of care after successfully completing their employment goals.

Beginning the 2nd quarter of FY2023, an EBSE/IPS focused Motivational Interviewing training will be provided to EBSE/IPS employment specialists by MDHHS to enhance their job development skills and provide tools to increase member job retention as well as a training on member benefits planning for EBSE supervisors. In addition, Diversity, Inclusion and Equity principles will be examined and incorporated into EBS/IPSE staff's daily practice. MDHHS in-person/onsite EBSE/IPS provider fidelity reviews will also resume after a two-year suspension resulting from health and safety concerns resulting from the pandemic.

Outpatient Improvement Committee: This committee meets with providers to consult on cases and look at trends within organizations. As a result of these meetings with Providers, the CPI Team was requested to provide a training to Team Wellness employees on completing a clinically appropriate Biopsychosocial. In partnership with Quality, Children's Initiative, Adult Initiatives and several DWIHN departments, an on-site training took place with 35 Team Wellness employees. This training was very well received.

CHILDREN'S INITIATIVES:

Access: DWIHN created an Intellectual Developmental Disability (I/DD) Flyer explaining intellectual developmental disability and cognitive disability services, including a list of I/DD providers. Youth United is launching a logo creation contest to celebrate Youth United 20th Anniversary

Prevention: On 1/30/23 Children's Initiative Department met with Detroit Police Department's 3rd Precinct to discuss plans for the Here Me Out Campaign. Four Goals are: 1). Training police, parents, and youth about sexual assault, 2). Awareness via panel discussions and social media, 3). Enforcement to issue warrants and assist police when questioning victims, 4). Response Team to share trauma resources. Children's Initiative Department and the Crisis Department met with Homeless Resource Agency and Methodist Children Home Society to discuss DWIHN partnering to offer community mental health expertise on the Youth Homelessness Demonstration Program. For this grant the focus is to provide case management, short term therapy, crisis services, and connect long term community mental health services. On 1/24/23 Children's Initiative and Communications Department met with Institute of Trauma and Economic Justice organization to discuss collaboration to participate in organizing an annual Trauma conference in Wayne County scheduled for 3/31/23.

Crisis Services: Updated the Children Crisis Flyer to include the Intensive Crisis Stabilization contact information and the 988-contact information. The Juvenile Justice / CMH Stakeholder meeting was held this month to discuss Juvenile Justice Mental Health Court and status of youth at the new Dickerson location. The plan is for youth in detainment to transfer to the new building in July 2023. Children's Initiative also met with Oakland County CMH to discuss coordination of care for youth at Children's Village and was informed those services are funded via grant dollars or general funds. Medicaid is unable to pay for community mental health services while youth is in a jail setting.

Treatment Services: Meetings were held to discuss the expansion of SED Waiver services to address capacity challenges within the Provider network. Children's Initiative Department and Clinical Officer, Ebony Reynolds met with 3 out of 4 Wrap Around Providers to explain SED Waiver services and gain interest with providing SED Waiver services. In

addition, Children's Initiative Department analyzed current capacity and outcome included four (4) of the five (5) SED Waiver Providers had capacity to accept SED Waiver referrals; however, a few providers had challenges with capacity to provide additional clinical services such as outpatient and home-based therapy.

Children's Initiative Director participated in ongoing MDHHS workgroup for transitioning Therapeutic Foster Care Oregon (TFCO) service to a Medicaid service. DWIHN also participated in monthly Michi CANS workgroup where we discussed community mental health screening and intake processes.

School Success Initiative: Discussed updates to MHWIN for Providers submitting data for the School Success Initiative Program. There is noted progress with Providers now having access to view reports in MHWIN for referrals, risk factors, tier services, and discharges. A student from Southwest Counseling Solution was selected as recipient of the Spotlight Award. School Success Initiative Specialist, Rasha Bradford attended the quarterly School Social Justice Partnership Meeting on 1/31/23; in which, focus was on educating youth and parents on consequences for students making school threats.

Grants: New Infant and Early Childhood Specialist started at DWIHN this month to be the coordinator for the Infant Toddler Program Grant that started January 2023. The new coordinator will collaborate with MDHHS, Wayne County Courts, Children Providers, and DHHS for children that are involved in the Baby Court Program. DWIHN attended the initial Infant and Early Childhood Mental Health Consultation Expansion Grant launching collaborative meeting on 1/9/2023.

INTEGRATED HEATHCARE SERVICES:

Behavioral Health Home (BHH):

- ❖ Current enrollment- 446 members (December- 399, % increase)
  - Detroit Wayne is one of 5 PIHPs in the State that participates in the Behavioral Health Home model
  - Behavioral Health Home is comprised of primary care and specialty behavioral health providers, thereby bridging two distinct delivery systems for care integration
  - Utilizes a multi-disciplinary team-based care comprised of behavioral health professionals, primary care providers, nurse care managers, and peer support specialists/community health workers
  - Michigan's BHH utilizes a monthly case rate per beneficiary served
  - Added Community Living Services as a BHH provider & currently in the process of adding Psygenics as well. This will result in a total of seven (7) Health Home partners for DWIHN. DWIHN has also opened this up to our CRSP Network in an effort to provide these integrated services to more members.

Opioid Health Home (OHH):

- ❖ Current enrollment- 355 members (December- 344)
  - Michigan's OHH is comprised of primary care and specialty behavioral health providers, thereby bridging the historically two distinct delivery systems for optimal care integration
  - Michigan's OHH is predicated on multi-disciplinary team-based care comprised of behavioral health professionals, addiction specialists, primary care providers, nurse care managers, and peer recovery coaches/community health workers
  - Michigan's OHH utilizes a monthly case rate per beneficiary served
  - Michigan's OHH affords a provider pay-for-performance mechanism whereby additional monies can be attained through improvements in key metrics

Certified Community Behavioral Health Clinic- State Demonstration (CCBHC):

- Current enrollment- 3,434 members (Dec.- 3,383)
  - A CCBHC site provides a coordinated, integrated, comprehensive services for all individuals diagnosed with a mental illness or substance use disorder. It focuses on increased access to care, 24/7/365 crisis response, and formal coordination with health care.
  - This State demonstration model launched on 10/1/2021 and The Guidance Center is the designated provider for Region 7.
  - Baseline outcome data has been established for year 1 and during year 2 outcomes will be a major focus, including outcome incentives.

CRISIS SERVICES:

Request for Service: There were 283 Requests for Service (RFS) for children this month and the diversion rate decreased from 71% to 64% as compared to December. There were 89 intensive crisis stabilization service (ICSS) cases for the month of January, a 35% increase compared to December at 89. There were 1,017 adult Requests for Service (RFS) for adults this month, which is a 12% increase from December. The diversion rate increased by 1%. The Crisis Stabilization Unit (CSU) at COPE served 198 members this month, a 12% decrease from December at 225. The Mobile Crisis Stabilization Team provided services to 84 members in December, up from 47 in December.

Mobile Outreach: The DWIHN Mobile Outreach Clinician was participated in 5 events in the month of January with 471 meaningful engagements and 2 referrals. DWIHN added new events to the calendar in continuing our partnership with Wayne Metro and Black Family Development. Our clinician added several new resource vendors to the ongoing list of community partners including Chandler Park Academy, Hope Network, Suicide Prevention Coordination from the VA, Penrickton Center for Blind Children, and Zaman.

UTILIZATION MANAGEMENT:

As of 1/31/23, the UM Team has managed a total of 814 admissions across the provider network. This includes inpatient, partial hospitalization, and crisis residential services. In the month of January, there were 701 (non-MI Health Link) admissions for inpatient treatment, reflecting a 1.7% increase from the 689 inpatient admissions during December 2022.

SMI/SED	# Admited Members	# Admissions	Avg Length Of Stay	Median Length of Stay
SMI	554	577	8.75	8
SED	83	87	8.21	8
IDD	26	29	7.69	7
SUD	4	4	4.50	2.5
		0	0.00	
N/A		0	0.00	
NON		0	0.00	
Not Assesed		0	0.00	
Total	**667**	**697**	**8.61**	**8**

Source: Power BI - Hospitalizations and Recidivism - Acute Inpatient

Inpatient: 701
MHL Inpatient: 8
Partial Hospital: 77
Crisis Residential: 28 (adults – 20 and children - 8)
Total Admissions: 814

Habilitative Waiver (HSW): There are 1,084 slots assigned to the DWIHN. As of 1/31/23 there are 1,013 filled, 71 were open, which is a utilization rate of 93.5%. The goal is to have a minimum of 95% of slots filled. DWIHN is actively working with providers on enrollments and is working on internal identification of potential enrollees. Two additional providers (NSO and WC) will begin entering their recertifications directly into the WSA which will increase efficiency and timeliness of certifications and enrollments. DWIHN has a specific team with Utilization Management that will be managing this program.

Outpatient Services (Non-Urgent, Pre-Service Authorizations):
Timeframes of Outpatient Service Authorizations are being examined for possible adjustments in accordance with the feedback being received from providers. In January there were 2,892 authorizations manually approved by the UM department. This number is reflective of non-SUD, non-ASD, non-urgent pre-service authorizations. Of these, 95.4% were approved within 14 days of request (an increase of 9.6% from December). DWIHN has identified missing elements within the Service Utilization Guidelines, which will decrease the number of manual reviews required. Currently Utilization Management manually reviews approximately 23% of authorization requests. DWIHN's goal is to not only meet the 14-day expectation, but to reduce that time frame incrementally over the next year.

SUBSTANCE USE SERVICES (SUD):

Naloxone Initiative: DWIHN continues to support access to Naloxone through training. To date, DWIHN has trained 9,232 residents of Wayne County on how to reverse an opioid overdose. In addition, we have also provided each person with a Naloxone kit. DWIHN's Naloxone Initiative program has saved 1,112 lives since its inception.

Gambling Funding Reduction: Due to current budget constraints from MDHHS, it was necessary to reduce Gambling funding for Gambling Treatment Services by 50% and 25% for Prevention Gambling Services. Treatment providers effected by the reduction include Sobriety House, Mariners Inn, and Elmhurst. In addition, LAHC, Empowerment Zone and The Youth Connection will each receive a 25% reduction (prevention services).

ASAM Level of Care: MDHHS transitioned the ASAM Level of Care application process to the Customer Relationship Module (CRM) of MiCAL. As a result, Providers must submit their application using this system once approved by the PIHP.

SUD Access: Currently working with residential treatment providers to ensure they are accepting referrals 24/7. This would include providing intake services as well. It was identified that transportation may be cited as a barrier so DWIHN is also educating providers on transportation resources available to members.

CHIEF CLINICAL OFFICER'S REPORT
Program Compliance Committee Meeting
Wednesday, February 8, 2023

CHILDREN'S INITIATIVES – Director, Cassandra Phipps

Mental Health Care: Putting Children First

Goals	Updates
ACCESS **Branding** **Outreach** **Census** **Screening** **New Opportunities**	• The **access screening for ages 0 to 6 i**n MHWIN is in the development stage. Next Steps: Plan for DWIHN Access to begin completing screening eligibility for children ages 0 to 6 by April 2023. • Clinical Specialist, Kim Hoga created an **Intellectual Developmental Disability Flyer** explaining intellectual developmental disability and cognitive disability, services, and list of IDD providers. • **Youth United is launching a logo creation contest** to celebrate Youth United 20th Anniversary
PREVENTION **Conferences** **Workshops** **Schools** **Tri-County Initiative** **Pediatric Care Prevention Activities**	• On 1/30/23 Children's Initiative Department met with **Detroit Police Department 3rd Precinct to discuss plans for the Here Me Out Campaign.** 4 Goals are: 1). Training police, parents, and youth about sexual assault, 2). Awareness via panel discussions and social media, 3). Enforcement to issue warrants and assist police when questioning victims, 4). Response Team to share trauma resources. Next steps: Assist with developing a resource list of trauma related services. Attend meet and greet on 2/15/23. • Children's Initiative Department and Crisis Department met with Homeless Resource Agency and Methodist Children Home Society to discuss DWIHN partnering to offer community mental health expertise on the **Youth Homelessness Demonstration Program.** For this grant the focus is to provide case management, short term therapy, crisis services, and connect long term community mental health services. Next Steps: Children's Initiative and Crisis Department to have ongoing meetings to assist with the implementation of the grant as a supportive partner. • On 1/24/23 Children's Initiative and Communications Department met with **Institute of Trauma and Economic Justice** organization to discuss collaboration to participate in organizing an annual Trauma conference in Wayne County scheduled for 3/31/23. Next Steps: Next meeting scheduled for 2/2/23 to confirm details • On 1/30/23 Children's Initiative Director, Cassandra Phipps presented "Accessing Community Mental Health Services" presentation to **Jerry L. White school Parent Teacher Association meeting**. Jerry L. White is a specialized school for students with severe intellectual cognitive and developmental disabilities as well as autism. Provided information on community mental health services/resources (12 attendees). Next Steps: Children's Initiative and Utilization Department to return on 3/24/23 to explain options for transitional supports for when students turn 18, guardianship, power of attorney, self-determination, and residential living options.

CRISIS INTERVENTION **Care Center** **Juvenile Justice** **Expansion of Crisis Services** **Crisis Trainings**	• Updated the **Children Crisis Flyer** to include the Intensive Crisis Stabilization contact information and the 988 contact information. Next Steps: Finalize for approval • **Juvenile Justice / CMH Stakeholder meeting** was held this month to discuss Juvenile Justice Mental Health Court and status of youth at the new Dickerson location. The plan is for youth in detainment to transfer to the new building in July 2023. Children's Initiative also met with Oakland County CMH to discuss coordination of care for youth at Children's Village and was informed those services are funded via grant dollars or general funds. Medicaid is unable to pay for community mental health services while youth is in a jail setting. Next Steps: Obtain flyer for JJ Mental Health Court. Research training Provider network on Moral Reconation Therapy (MRT) as a group evidenced based practice. Providers consider offering informed therapeutic services to youth in detainment after transition to new building.
TREATMENT **Workforce Diversity / Equity / Inclusion** **Evidenced Based Practices** **Quality Services** **Expansion of Services**	• Various meetings were held to discuss the expansion of **SED Waiver services** to address capacity challenges within the Provider network. Children's Initiative Department and Clinical Officer, Ebony Reynolds met with 3 out of 4 Wrap Around Providers to explain SED Waiver services and gain interest with providing SED Waiver services. In addition, Children's Initiative Department analyzed current capacity and outcome included 4 of the 5 SED Waiver Providers had capacity to accept SED Waiver referrals; however, a few providers had challenges with capacity to provide additional clinical services such as outpatient and home-based therapy. Clinical Coordinator, Monica Hampton completed outreach to agencies to assist with recruiting more providers to do Art Therapy, Music Therapy, and Recreational Therapy. Providers are able to subcontract with The Children's Center for Art Therapy. Next Steps: Assign SED Waiver referrals to Providers according to capacity requirements. Meet with Finance Department to discuss rate difference between regular wrap around and SED Waiver wrap around rates. Work with Credentialing Department to include additional 16hr requirement for SED Waiver Wrap Around Facilitators. Continue to recruit additional providers for Art Therapy, Music Therapy, and Recreational Therapy. Continue to expand SED Waiver Providers. • **Team Mental Health:** On 1/6/23 Children's Initiative Department collaborated with other departments to assist with facilitating a training for Team Mental Health Provider on effectively completing an Integrated Biopsychosocial Assessment. In addition, DWIHN staff were able to provide technical assistance. Next Steps: On 2/10/23 DWIHN to facilitate another training for Team Mental Health on effectively completing the Individual Plan of Service and provide technical assistance. • Children's Initiative Director, Cassandra Phipps participated in ongoing **MDHHS workgroup for transitioning Therapeutic Foster Care Oregon (TFCO) service** to a Medicaid service. Next Steps: Continue monthly workgroup meetings through April 2023. • Children's Initiative Director, Cassandra Phipps participated in **monthly MichiCANS workgroup**. Discussed community mental health screening and intake processes.

	• Children's Initiative Dept and IT Department met with MDHHS to provide update on development of new **Clinical Dashboards for home-based services**. Currently in Phase 2 of 4 of the projects. • Children's Initiative Department met with Utilization Management Department to discuss technical challenges with the **Service Utilization Guidelines.** Next Steps: Make recommendations for Children Services Utilization Guidelines by February 2023

School Success Initiative (SSI) / GOAL Line

School Success Initiative: Discussed updates to MHWIN for Providers submitting data for the School Success Initiative Program. There is noted progress with Providers now having access to view reports in MHWIN for referrals, risk factors, tier services, and discharges. A student from Southwest Counseling Solution was selected as recipient of the Spotlight Award. School Success Initiative Specialist, Rasha Bradford attended the quarterly School Social Justice Partnership Meeting on 1/31/23; in which, focus was on educating youth and parents on consequences for students making school threats.

Goal Line: Community Education Commission (CEC) submitted a formal name change in the sam.gov website. Rescheduled for Children's Initiative Dept to attend the GOAL Line program at the Northwest Activity Center for February 2023.

Grants

- **New Infant and Early Childhood Specialist** started at DWIHN this month to be the coordinator for the Infant Toddler Program Grant that started January 2023. The new coordinator will collaborate with MDHHS, Wayne County Courts, Children Providers, and DHHS for children that are involved in the Baby Court Program.
- Attended the initial **Infant and Early Childhood Mental Health Consultation Expansion Grant launching collaborative meeting** on 1/9/2023.
- All **FY 2024 MDHHS Grants** are due to MDHHS by Feb 2023

Board Actions

- **BA 23-54: Infant and Early Childhood Mental Health Expansion Grant** was approved at Full Board on 1/18/23
- Children's Initiative to present board presentation of children services at Full Board on 2/15/23

AUTISM SPECTRUM DISORDER (ASD) – Clinical Officer, Ebony Reynolds

Please See Attached Report

CRISIS SERVICES – Director, Daniel West

CHILDREN'S CRISIS SERVICES January 2023

Month	RFS	Unique consumer	Inpatient admits	% Admitted	# Diverted	% Diverted	Crisis Stab Cases
December	235	208	58	25%	167	71%	89
January	283	258	90	32%	180	64%	139

- Requests for Service (RFS) for children decreased by 16% this month and the diversion rate decreased from 71% to 64% as compared to December.
- There were 89 intensive crisis stabilization service (ICSS) cases for the month of January, a 35% increase compared to December at 89. Of the 139 cases there were 68 initial screenings.
- 38 cases were served by The Children's Center Crisis Care Center in January, a slight increase from the month of December. As of Tuesday, 1/3/2022, TCC will not have any clinicians in the Crisis Care Center. TCC will be recruiting to fill two positions. TCC will continue to see members presenting for crisis screenings by assigning Intake Clinicians to the program on a rotation basis. The TCC Case Manager will continue to triage and support admission and aftercare follow up. In order to achieve this, TCC will have to modify hours of operation to 8:00 AM – 5:00 PM. Members should present by 3:00 PM to ensure sufficient time to complete a full crisis screening.

COPE January 2023

Month	RFS	Unique consumer	Inpatient admits	% Admitted	# Diverted	% Diverted	# Inpt due to no CRU
December	890	830	613	69%	260	29%	1
January	1,017	931	685	67%	306	30%	13

- There was a 12% increase in the number of requests for service for adults in January compared to December, and the diversion rate increased slightly in January.
- The Crisis Stabilization Unit (CSU) at COPE served 198 members this month, a 12% decrease from December at 225.
- The Mobile Crisis Stabilization Team provided services to 84 members in December, up from 47 in December.

CRISIS RESIDENTIAL/HEGIRA January 2023

- The number of available beds is 9.

Referral Source	Total Referrals	Accepted Referrals	Denials
ACT	0	0	Level of Care change - 10
COPE	36	16	Not medically stable due to SUD – 3
DWIHN Res.	7	1	Not medically stable due to physical health – 1
Step Down (Inpatient)	15	5	Violent/aggressive behavior: 3 Member refusal: 5
Total	58	22	No follow-up from SW/Hospital 3 Pending: 5

PROTOCALL December 2023

Month/Year	# Incoming Calls	# Calls Answered	% answer w/in 30 secs	Avg. Speed of answer	Abandonment rate
November	662	639	87.2%	20s	1.5%
December	725	707	87.4%	21s	1.7%

January data not available at the time of this report

Protocall saw a 9% decrease on call volume in December, and a 10% increase in the number of calls answered. The percentage of calls answered within 30 seconds has remained relatively constant, while the abandonment increased slightly. While Protocall saw a noticeable increase in the call-volume and call-length in December for the DWIHN account, they were able to manage that increase in volume relatively well, with a slight increase to the overall service level in December, and only a 1 second gain in average speed of answer. With roughly 8 months of more favorable performance (compared to last year) they are hopeful to be on the tail end of the service level concerns, with the awareness that challenges can occur at any moment.

MOBILE OUTREACH SERVICES, January 2023

Category	
Number of mobile events attended	5
Number of meaningful engagements	471
Number of screenings in the system	0
Number of follow-up calls made	6
Number of referrals made as a result of follow up	2
Benefit Assistance Referral	1
Bill Payment Referral	1
Complex Case Management referral	1
Connection to Access Center	4
Housing Referral	0

MOBILE OUTREACH SUMMARY, January 2023

Our DWIHN Mobile Outreach Clinician was able to add new events to the calendar in continuing our partnership with Wayne Metro and Black Family Development. We had a great event at Kevin's Song with a good turnout, as well as a beneficial event at Chandler Park Academy. Our clinician added several new resource vendors to the ongoing list of community partners including Chandler Park Academy, Hope Network, Suicide Prevention Coordination from the VA, Penrickton Center for Blind Children, and Zaman.

The Community Law Enforcement, Team Wellness CSU, and Hospital Liaison Report are not available at this time and will be updated next month.

CUSTOMER SERVICE – Director, Michele Vasconcellos

Administration/Call Center Operations/ Family Support Subsidy/Medical Records

- **Call Center Operation**: A total of 1,705 calls were offered to the Customer Service Department's Welcome/Reception Switchboard and Call Center Operations during the month of January. The Welcome /Reception Switchboard handled 1034 calls with an ABD rate of 2.8%. The Customer Service Call Center processed 671 calls with an ABD rate of 7.8 %. The ABD compliance standard is <5%

In January, the service level for Front Desk was 100%, and Call Center Operations was 90.9%, meeting the answering goal standard of within 30 seconds. The goal is 80%. There was a slight increase in the call volume and an increased ABD rate for the Customer Service Dept. Discrepancies in phone system ABD reporting are being addressed with IT.

Hired a new Customer Service Welcome Center /Switchboard operator.

- **Family Support Subsidy Activity**: Handled 579 calls for January. Applications rec'd 117. Applications Submitted to State 86.
- **Provider Closures:** Continued to initiate "Choice" letters for mailing to members as a result of provider closures or discontinuance of services.
- **Medical Records:** Processed 14 requests for Member Medical records.
- **Customer Service Orientations** Conducted Customer Service Orientations for new hires of the Access Center and Customer Service.
- **Disenrollment:** Prepared and reported on Bi-Monthly Disenrollment Update for Authorization meetings. A total of 1241 Non CRSP assignments are being addressed by Customer Service.

Customer Service Performance Monitoring/ Grievance & Appeals

- Facilitated Grievance and Appeals Case Reviews to ensure compliance with HSAG requirements.
- Participated as an evaluator for SUD Prevention Reviews.
- Conducted technical Appeals trainings with CRSP providers.
- Collaborated with MCO to address provider LBS and their grievance non-compliance.
- Processed EOBs for 4th Quarter mailings to members.
- Completed for submission the MDHHS Grievance and Appeals OIG report.
- Completed and submitted the Customer Service Member Grievance annual report to Quality for inclusion in the QAPIP Annual Report.
- Completed ICO AmeriHealth Customer Service Audit.
- Attended Quarterly Statewide Customer Service PIHP Meeting. The the focus was on HSGA final reviews, New Mediation process and Customer Service substantiated vs non- substantiated grievances.
- Interviewed and hired a CS Performance Monitor to replace vacancy.
- Developed CRSP Customer Service Performance Monitoring Audit schedule for 2023. Notification letters were forwarded to providers and audits will begin in February.
- Updated the Provider Performance Monthly Data Report to include NCQA and HSAG compliance recommendations for future reviews.

NCQA/HSAG

- Continued to collaborate with departments to address HSAG Plans of Corrections and their status updates.
- Provided applicable HSAG recommended changes to the Medicaid Grievance and Appeals forms for submission to PCE for implementation.

Member Engagement & Experience

- Launched ECHO® Adult and Children Phone Survey after nearly 12,000 combined initial surveys were sent to random participant list. Calls commenced 1/9/2023
- Received 100 contact registrations from Peers/after several attempts to collect data from peers over several months. A new link was created to identify certify peers to ensure they are receiving information related to the new CEU requirement made effective by the State as of January 1, 2023.
- Continued CV related meetings to address new efficiencies in reporting to DWIHN CEO.
- Submitted Job description for Member Experience Coordinator.
- Submitted Draft LTSS PIP for discussion with Quality.
- Participated in Bridging Gap Programming with Community Health Workers
- Initiated recommendations for re-structuring the intent of the Ambassador Program
- Provided analysis of current Clubhouse program and grant application and monitoring.
- Continue to work on unit goals and efficiencies.
- Analyzed and developed ME Overview Report.
- Worked on following proposed outreach activities for 2023 i.e. DD Month, CV retreat, and Guardianship Forum.
- Prepared and submitted Winter Edition of the Member's PPOV.

INNOVATION AND COMMUNITY ENGAGEMENT (ICE) – Director, Andrea Smith

Justice Initiatives

Project – WC Jail – IST

For the month of January, there were 132 releases from jail. Of those releases, 46 were linked back with the provider for follow-up with their member; 14 were not in MHWIN because the mental health designation from jail mental health may not meet DWIHN criteria; 5 were sent directly to another correctional facility (i.e. prison or another county jail); and 67 were not assigned to a provider within the MHWIN system.

The first quarter review was held with Naphcare and Wayne County. The projected date of the new jail is the end of summer 2023. DWIHN requested a tour with Wayne County to view and determine the set-up and structure for the mental health unit(s).

In the first quarter, Naphcare screened 611 incoming persons to the jail. There were 198 new admissions: 58 were on the mental health unit and 206 were on the mental health outpatient units. Wayne County reported that Naphcare' s Jail Director has resigned.

Specialty Courts

The first quarter review was held with Downriver Veterans Court. There are currently 17 program participants.

There were 62 AOT orders processed by clinical staff. Of these, 12 orders were not in the MHWIN system. There were 3 returning citizens for the month of January.

The 36th District Mental Health Court has 19 participants on the court docket. The current providers for the program are AWBS and Hegira.

DPD/DWIHN Partnership

The D.H.O.T. team had 45 encounters, including 4 persons who were linked with mental health services; 2 were linked to the housing navigator; and 5 were taken to shelters.

A Behavioral Health Specialist (BHS) continues to be embedded at DPD's Communication Center to assist with any calls that need mental health support and resources. There were 6 individuals referred for follow-up, and individuals received various mental health resources and supports.

In the month of January, DPD co-responders had an approximate total of 196 encounters, and 86 individuals were connected to a service. Individuals were provided with various resources for assistance with mental health, substance use, and homelessness.
The Director participated in a presentation to the Detroit Board of Police Commissioners highlighting the services and programs offered by DWIHN.

Jail Navigator

The Mental Health Jail Navigator referrals remain consistent, as 10 individuals were referred and interviewed, and did not meet the criteria and/or were released prior to placement. Currently, 8 individuals are monitored and receiving treatment services from Team Wellness Center and/or Detroit Rescue Mission Ministries.

Justice Involved Initiative	Number of Encounters/Screened	Connected to a service/resources/supports
Co-Response Teams	196	86
Mental Health Jail Navigator	10	8
Communications Behavioral Health Specialist	6	6

Workforce Development

During the month of January, staff continued to monitor DWIHN staff compliance with required training. Weekly notifications are sent to staff in the form of reminders to the org administrators and supervisors.

AV staff viewed various options for equipment that will improve the quality of output for Board meetings and other meetings that need to be streamed or in hybrid format.

Mental Health First Aid and QPR were offered to the network and interest continues to grow from community members and laypersons.

The CIT for Executives course was held with 18 individuals in attendance from chiefs and government officials.

The 40-hour CIT course was held with 21 individuals in attendance representing Southgate PD, Wayne PD, Detroit PD, Detroit Public Schools Police and the Detroit VA.

INTEGRATED HEALTH – Director, Vicky Politowski

Please See Attached Report

MANAGED CARE OPERATIONS – Interim Director, Sharon Matthews

MCO DEVELOPMENT MISSION:

There are 20 staff members in MCO all are committed to serving and reaching out to our 400+ providers monthly and quarterly to ensure providers know we are here to assist in answering any questions and directing them to the appropriate department for assistance. Questions come in daily through email or calls surrounding adding sites, authorization questions, claims questions as well as possible closing sites, in which we assist in answering.

FY 22-23 Contracts:

The FY23 contracts were sent out as of 10/4/22, with 99% received back signed by providers approximately over 400 contracts were sent out to our provider network for signature, 5 contracts were sent back due to provider signing with initials or with mark/line in the singing area.

MI Health Link contracts were sent out for execution. that were approved under MHL MHL Pre-Contracting documents are still being collected. MHL hospital and ambulance company contracts are forwarded to the provider for signature as Pre-Contracting documents are submitted and approved by Legal.

Given DWIHN's growth mode, as well as some providers experiencing staffing problems causing service delays at times, there is a need to add new providers to the DWIHN network during the course of FY 22/23. Note that MCO has developed a structured On Boarding process that evaluates prospective providers as well as facilitates and tracks the on boarding of new providers.

Internal /External-Training Meetings Held:

a. Met with 12 CRSP providers regarding the performance indicators most providers continue to experience staff shortages in the intake department for new intakes as well as ongoing services they provide. DWIHN is evaluating incentives built around this indicator to see if this could assist with other challenges providers are having.
b. Access Committee Meeting held this month focused on the review of provider requests to become contracted DWIHN providers. This meeting is typically held to discuss network adequacy and provider gaps in services. The decision was made to open the DWIHN network and to solicit RFPs for specified services. 2 new residential providers were added to the network in January.
c. Attended an external meeting with HAND and The Youth Homeless Project. DWIHN has been asked to partner with The Youth Homeless Project in providing services to homeless youth. DWIHN is seeking and entertaining opportunities to expand its role in providing services to the homeless.

PIHP Email Resolutions and Phone Provider Hotline:

For the months of December and January 27 new provider requests and received/answered 65 mails, from providers with concerns related to claims billing, credentialing issues, Provider change notifications, Procedure Code changes, Single Case agreements, and changes with the FY 2022 State Code/Modifier changes.

New Providers/ Merger/Closures Changes to the Network /Provider Challenges:

2 new providers have completed our credentialing process. Board Action 23-07 was revised and approved by DWIHN Board for the addition of 2 new residential providers. Contracts have been routed to the providers for execution.

Providers continue to struggle with staff shortages to maintain staff in homes as well as staff in general among all of our providers resulting from the continued resulting from the impact the of COV-19 pandemic.

DWIHN continues to meet with providers to find solutions that will assist during these unprecedent times. Qualified providers received retention payments to pay to staff as an incentive for staff to maintain employment.

The network continues to drop in access to care as they struggle with meeting the performance indicators 2A, # and 4A, one of the major concerns is the staff shortage which is still affecting access to services are well access to care.

The network has had several home consolidations for licensed and unlicensed settings, which has been a result of the members personal health or staff challenges providers experienced resulting in mergers or closures. For the 1st Quarter of FY 22-23 we received 15 notifications. 10 were received in December and January

Provider Closure/Mergers FY 22-23					
Description	1st Qtr.	2nd Qtr.	3rd Qtr.	4th Qtr.	YTD Totals
Licensed-Residential Homes	4				4
Unlicensed /Private Home Services (SIL's)	9				9
Clubhouse services	0				0
Outpatient-services, SUD services	2				2
Provider Organization Merger(s)	0				0
Total	15				15

Housing Resource and Street Outreach to the Homeless:

HUD is announcing they will be funding 2.8 Billion to help people experiencing homelessness. Although the number in Michigan for 2022 decreased about 17% there is still much work to do to keep the homeless from experiencing homelessness and solutions to get them in more permanent housing. According the Housing Urban Development (HUD) Annual Homeless Assessment Report, ***the funding opportunity reflects the Biden-Harris Administration's continued commitment to equity and evidence-based solutions to address homelessness. It also reinforces the Administration's commitment to boost housing supply and lower costs by supporting local engagement to increase the supply of affordable (Home/Press Room/Press Release / HUD No. 22-140)*** As the report found that the number of sheltered people in families with children declined considerably between 2021 and 2022, while the number of sheltered individuals remained relatively flat. As we partner with our providers to assist in the fight against homelessness and reaching individuals on street to -date we continue to see improvement one month at time.

Quarterly Goals still in progress:

Quarterly goals set for FY 2023.

- **The Risk Matrix**- The Risk Matric is a web-based software system that our providers can use to coordinate care, manage operations, view cost of services paid and better serve our members. The matrix allows DWHIN to be able to monitor the provider's performance and gain a base line of care services for our members. We are able to track and monitor cost and related services that will assist in finding improvement opportunities in our current care model. Each department is viewing the data for accuracy as this is a new system in place. Interdepartmental meetings are held to share and discuss data.
- **Network Adequacy form/procedure**. This internal process will assist in structing our network in a way where we can view our provider services at a glance for better monitoring over our network through this procedure. Evaluated the network in the first quarter of the FY 2022, notified gaps and analyzed for interventions. Network Adequacy assists MCO in targeting needed services and providers.
- **Online Directory- Provider/Practitioner.** We are working with internal depts (Customer Service/Credentialing unit) to enhance our online contracted provider and practitioner directory to include the type of services along with the disability designations served by the provider or practitioner making the directory more user friendly and informative for the members as well as internal use. Updates are made consistently to ensure complete and accurate information with in the Provider Directory. Ages served and payment options have been added to the search option.
- **Provider Orientation Meetings** – Provider Meeting Orientations are scheduled twice a year. The Provider Meeting Orientation will be recorded so that providers can access the Provider Orientation upon demand.
- **Quarterly Provider Network Managers "One on One' Provider Meetings** - have on going meeting with 362 providers out of 362 since the start of the meetings in January 2022. This is a 100% completion rate. Next meetings will start Jan 2023.
- **DWC Trainings** – all MCO staff are in 100% compliance with the DWC Training Schedule as required by DWIHN

Regulatory and Accreditation Compliance:

- DWIHN is in the NCQA 24 month look back period. MCO is evaluating its operations to ensure compliance with NCQA standards assigned to MCO as well as working with the DWIHN NCQA consultant, Diana Hallified to prepare evidence of compliance.
- HSAG-MCO works collaborative with Quality to response to information requests as well as comply with HSAG standards
- ICO Audits – works collaborative with Integrated Health to response to information requests as well as comply with DWHIN's 5 ICO' standards

Annual Provider/Practitioner Survey:

The Provider/Practitioner survey is a way for DWIHN to retrieve feedback from providers and practitioners on how well DWIHN does as a manager of care, this survey also helps us identify any gaps in process or procedures as well as reveal any areas for improvements. The Provider and survey was released by Strategic Planning in September – October 2022. The Practitioners survey is scheduled for release in February by Strategic Planning. MCO will conduct the analysis upon receipt of the survey results. Results will be reviewed internally as well as with the providers at an upcoming Provider Meetings. The analysis will be included in the Annual Availability and Accessibility Report.

Provider Meetings Upcoming/Held:

a. CRSP meeting scheduled for Februay3, 2023
b. Residential and Outpatient Provider meetings were held on January27, 2023
c. 1st quarter 9 Provider Capacity Meetings are scheduled with BH CRSP Provider every 45 days to discuss the provider's indicator numbers as well as capacity status.

RESIDENTIAL SERVICES – Director, Shirley Hirsch
Please See Attached Report

SUBSTANCE USE DISORDER – Director, Judy Davis
Please See Attached Report

UTILIZATION MANAGEMENT – Director, Leigh Wayna
Please See Attached Report

Autism Spectrum Disorder Benefit

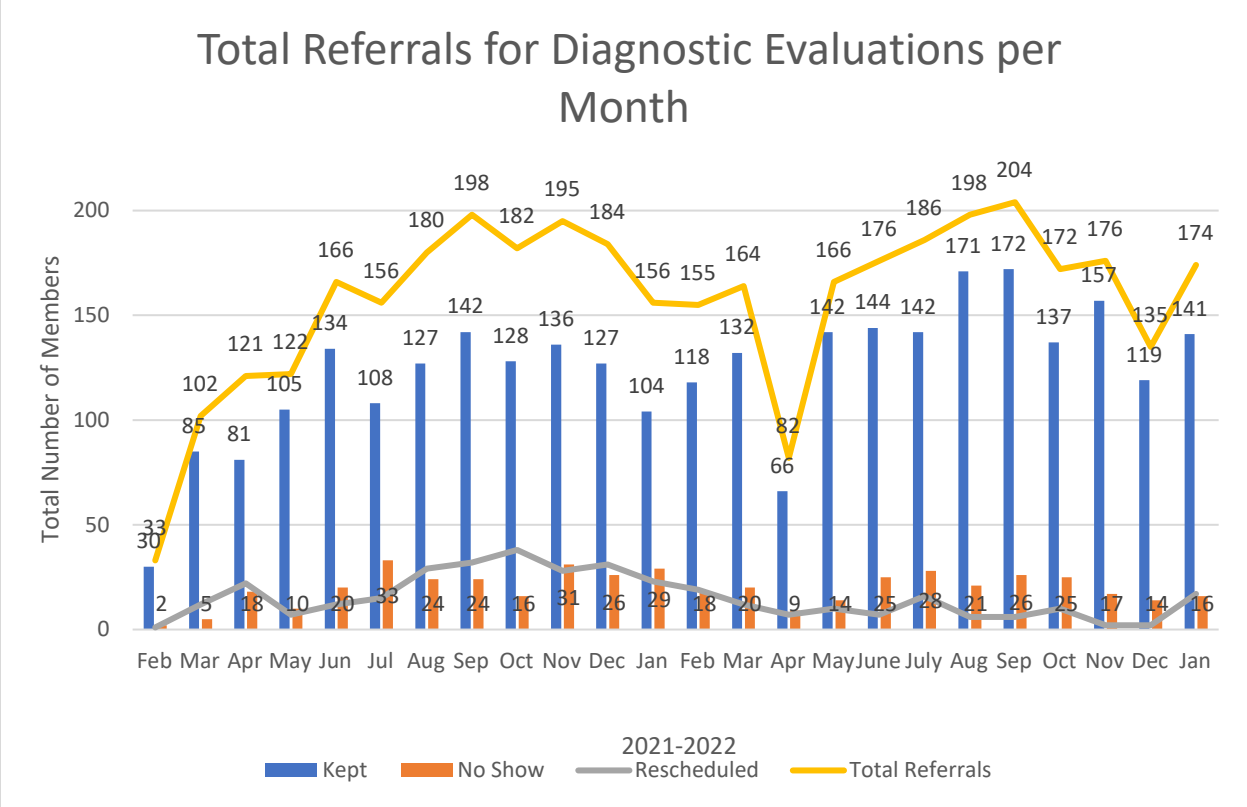
January 2023 Monthly Report

Enrolled in ASD Benefit

Total open cases for the month of January are 2,728 members which is an increase of 49 members from December to January.

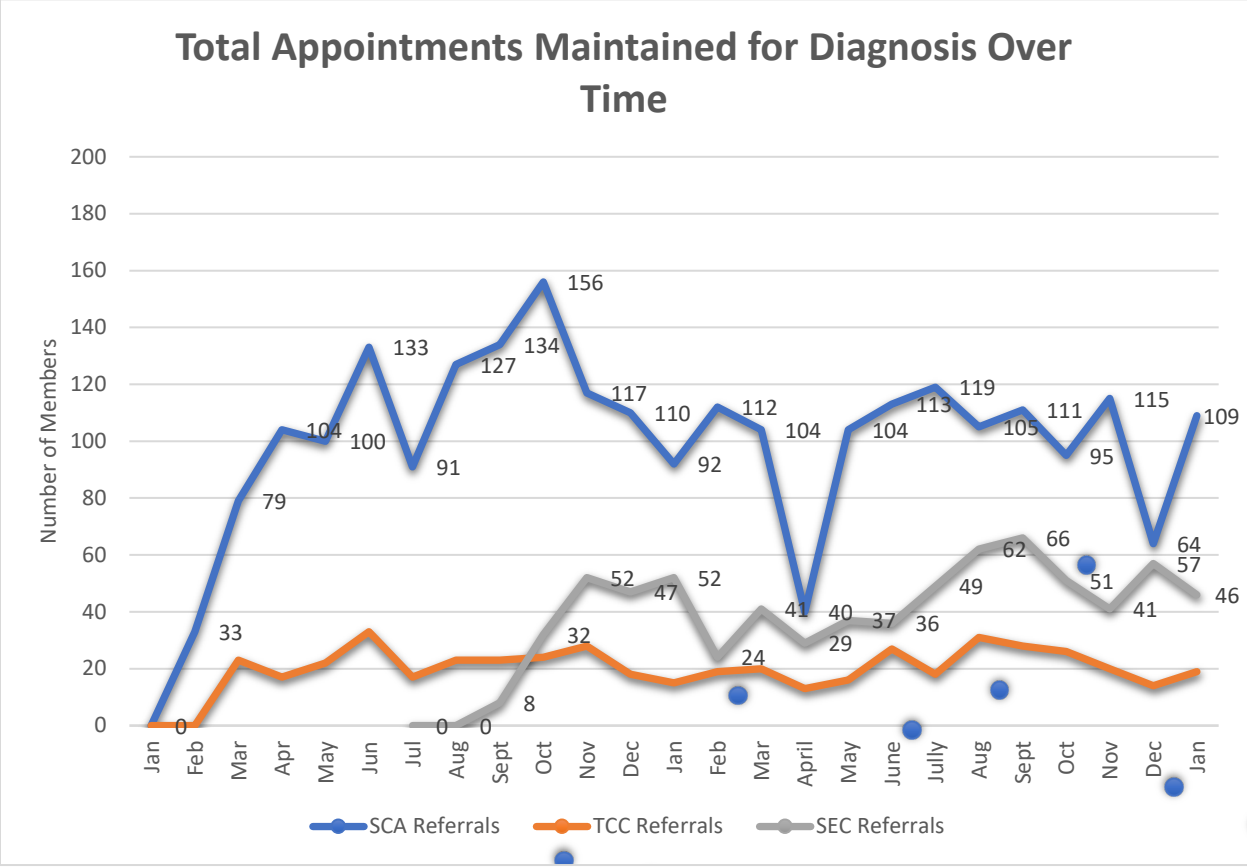
Summary of Initial Diagnostic Evaluations

Independent Evaluator data displayed below includes Social Care Administrator (SCA), The Children's Center (TCC), and Sprout Evaluation Center (SEC) for totals referral for ASD diagnosis per month. Total referrals scheduled by the Access Call Center was 174 and of those scheduled 141 appointments were kept resulting in 14 members not eligible (non-spectrum) for the Autism Benefit and 127 diagnosed with autism spectrum disorder (ASD).



Individual Data Points for Diagnostic Evaluators:

The below graph represents all three Diagnostic Evaluator's total appointments kept across January 2021 to January 2023. The average diagnostic evaluation appointments kept across three months for Social Care Administration was 79 appointments, for The Children's Center 15 appointments, and Sprout Evaluation Center reports 45 appointments.



Provider Updates

- MetroEHS hosted Dr. a 2-day workshop on practical functional assessment, skill-based treatment processes, procedures for maximizing the safety, televisibility, and shared rapport of the process were emphasized. Additionally, effective and parent-validated treatment process were taught along with minimizing risks and expanding the practitioner's scope of practice.
- In the effort to meet the increase in service requests for ABA therapy, DWIHN posted a Request for Qualifications (RFQ) for Outpatient Mental Health Providers to provide Applied Behavior Analysis (ABA) services. Award will only be issued to the list of qualified vendors that result from the RFQ.
- A virtual pre-response meeting occurred on Monday, February 13, 2023 at 4:00 p.m which resulted in clarifications, modifications or amendments to the RFQ.

Integrated Health Care Department

Monthly Report

January 1, 2023

Collaboration with Community Partners

During the month of January IHC hosted a lunch and learn for all CRSP providers to educate on QIP and HEDIS Platform in the IHC Department.

Quality Improvement Plans

The IHC department manages five Quality Improvement Plans (QIPs) that are in alignment with NCQA requirements. The focus of the QIPs includes the following: 7 and 30 day Follow Up After Hospitalization for Mental Illness (FUH), Adherence to Antipsychotic Medication (AMM), Diabetes Screening for members prescribed atypical antipsychotic medications (SSD), and Hepatitis C treatment. The current HEDIS certified platform displays individual CRSP provider data to allow early intervention and opportunity to improve outcomes. The HEDIS certified platform will include measures for Opioid Health Home and Behavior Health Home. DWIHN and Vital Data continue to work on the HEDIS platforms that show the data for these QIP for providers.

During the month of January, the HEDIS scorecard was reviewed at the CRSP monthly meeting and in individual meetings with **5** CRSP, FUH data was also shared. IHC created an educational presentation on HEDIS measures and definitions for CRSP medical directors.

Scores from HEDIS Scorecard as of October 2022 due to claims lag.

Measure	Measure Name	Eligible	Total Com	Non Comp	HP Goal	Year to Date
AMM	Antidepressant Medication Management Acute phase	1974	496	1478	77.32	25.13
AMM	Antidepressant Medication Management Continuation Phase	1974	41	1933	63.41	2.08
FUH	Follow-Up After Hospitalization for Mental Illness Adults	5728	2634	3094	58	45.98
FUH	Follow-Up After Hospitalization for Mental Illness Children	512	321	191	70	62.7
SAA	Adherence to Antipsychotic Medications for Individuals With Schizo	5235	2862	2373	85.09	54.67
SSD	Diabetes Screening for People With Schizophrenia or Bipolar Disorc	8117	5210	2907	86.36	64.19

Population Health Management and Data Analytics Tool

All Medicaid Health Plans and ICO's were added to the HEDIS Scorecard. DWIHN can now pull data on these individually by CRSP provider.

Integrated Health Pilot Projects

DWIHN has identified 3 Health Plans for Integrated HealthCare Pilot Projects.

Health Plan 1:

Health Plan 1 and DWIHN met on December 12 with Health Plan 1 to train on the new shared platform. Health Plan 1 agreed that the shared platform will be helpful with care management.

The platform will be used to find members who need more services and follow up. Health Plan 1 has created a statement of work and it was approved by the legal department and signed by the CEO. DWIHN is waiting for the return of the SOW. DWIHN and IHC meet monthly for care coordination. January meeting was canceled due to a conflict Health Plan 1 had.

Health Plan 2:
Care Coordination with Health Plan 2 was initiated in September 2020, these meetings occur monthly. Health Plan 2 had **8** members identified of having gaps in care with partial compliance. Intervention were outreach to members and CRSP, 3 of the members gaps were closed due to assistance with post reschedule where member kept appointments.
Health Plan 2 has decided that the shared platform has a benefit and IHC Director, DWIHN IT and Health Plan 2 have reviewed the platform in January. The platform will be used in February care coordination meeting to obtain more members to coordinate.

Health Plan 3's
DWIHN staff are working with Health Plan 3 on a new project of monitoring individuals who utilized the emergency room department or inpatient psychiatric unit and how to perform data sharing.
There are 4 CRSP's in the pilot: Neighborhood Services Organization, Lincoln Behavioral, Hegira and Guidance Center. This started on June 16, 2022

DWIHN IT and PCE are developing a database so that the number of members can be tracked. Baseline data is complete and will be tracked monthly.

MI Health Link Demonstration

IHC department under the MI Health Link Program received total of **439** request for level II in the month of December 2022 from the following ICO organizations below: Pending = not processed yet, Voided = Member was unable to reach, referred in error, or declined assessment, or declined BH services, Active= Level II was sent to ICO.

ICO	Active	Pending	Voided	Totally by ICO
Aetna	10	15	11	36
Amerihealth	0	0	0	0
HAP	4	7	8	19
Meridian	5	6	9	19
Molina	60	114	193	369
TOTAL	**74**	**142**	**221**	**439**

Voided referrals reasons are as follows:

	Member Declined Assessment	Member Declined Services	Member not available before deadline	Referrals in error	Unable to reach
Aetna	0	7	0	0	7
Amerihealth	0	0	0	0	0
HAP	0	3	0	0	5
Meridian	2	3	0	0	8
Molina	32	45	11	31	85
Total	**34**	**45**	**11**	**31**	**102**

Comparison Data for Voided Referrals:

	Number of Voided Referrals	Member Declined Assessment	Member Declined Services	Member not available before deadline	Referrals in error	Unable to reach
January 2022	180	3	120	5	7	45
February 2022	177	2	81	8	25	61
March 2022	153	3	93	3	7	47
April 2022	241	3	48	2	6	28
May 2022	105	3	57	4	11	33
June 2022	66	1	801	16	2	66
July 2022	138	1	71	8	12	46
August 2022	219	7	91	10	18	93
September 2022	162	2	38	12	8	102
October 2022	201	0	77	28	19	77
November 2022	193	0	80	14	9	90

December 2022	165	0	63	6	12	84
January 2023	**223**	**34**	**45**	**11**	**31**	**102**

*Increase in number of Member declined servcies, process and interventions to be reviewed.

ICO Meridian is still unable to receive level II responses through the Care Bridge, referrals are logged in MH WIN and manually processed by sending to Meridian through secure email. documents have not been received to share internally with DWIHN.

ICO Aetna had a system issue where 60 referral responses are delayed in sending to ICO due to system issue dates from 11/3/22 thru January. This was resolved during the beginning of this reporting period however prior to end of reporting period system issue with 18 referrals unable to send at this time.

There were **25** LOCUS assessments completed for the MI Health Link Demonstration received from Network Providers who service Nursing Home Facilities for Mild-Moderate population.

Care Coordination Activities for the ICO enrollees **22** individuals who have been identified to have a gap in services. **5** cases where members attended outpatient appointments due to connecting with IHC Care Coordination team. This is a combined effort between IHC staff and the ICOs.

ICO Plan Name	**Number of members w/Gaps in care**	**Type of Gap:** **A.) Non/Partial Compliance** **B.) Assisting Plan to connect for HRA/Physical Health Care** **C.) FUH post follow up**	**What Were Interventions:** **A.) Coordinate and Outreach to BHCRSP.** **B.) Coordinate w/ICO for transportation.** **C.) Outreach to members**	**Number of cases to refer to Complex Case Management**	**Total Number of Successful Outcomes**
HAP	**6**	**A,C** **B=4**	**A, C**	**0**	**2**
AET	**6**	**A, C**	**A**	**0**	**2**
Amerihealth	**1**	**A, B, C**	**A, C**	**0**	**Still IP**

Meridian	**2**	**A, C**	**A, C**	**0**	**1**
Molina	**7**	**A, C**	**A**	**0**	**0**

Special Care Coordination Project

Plan Name	Number of members w/Gaps in care	Type of Gap: A.) Non/Partial Compliance B.) Assisting Plan to connect for HRA/Physical Health Care C.) FUH post follow up	What Were Interventions: A.) Coordinate and Outreach to BHCRSP. B.) Coordinate w/ICO for transportation. C.) Outreach to members	Number of cases to refer to Complex Case Management	Total Number of Successful Outcomes
BCC	**10**	**A, B**	**A, B**	**0**	**3**
Priority	**3**	**A, B**	**A**	**1**	**2**

Data Share with Medicaid Health Plans

In accordance with MDHHS Performance Metric to Implement Joint Care Management, between the PIHP and Medicaid Health Plans, IHC staff performs Data Sharing with each of the 8 Medicaid Health Plans (MHP) serving Wayne County. Mutually served individuals who meet risk stratification criteria, which includes multiple hospitalizations and ED visits for both physical and behavioral health, and multiple chronic physical health conditions are identified for Case Conference. Data Sharing was completed for **58** individuals in January. Joint Care Plans between DWIHN and the Medicaid Health Plans were developed and/or updated, and outreach completed to members and providers to address gaps in care.

MHP Plan Name	Number of members w/Gaps in care	Type of Gap: A. Non/Partial Compliance B. Assisting Plan to connect for HRA/Physical Health Care C. FUH post follow up	What Were Interventions: A. Coordinate and Outreach to BHCRSP. B. Coordinate w/ICO for transportation. C. Outreach to members	Number of cases to refer to Complex Case Managem ent	Total Number of Successful Outcomes
AET	5	A,B,C	A,C	2	0
BCC	8	A,C	A,B,C	0	3
HAP	5	A,B,C	A,C	0	0
McLaren	5	A,B,C	A,C	1	0
Meridian	8	A,B,C	A,C	0	3
Molina	6	A,B,C	A,C	0	1
Priority	16	A,B,C	A,B,C,D	1	9
United	7	A,bBC	A,C	0	2

In January, **525** members admitted and discharged of the cases.**5** currently have and encounter for HEDIS. **25** cases were contacted from IHC department of those, **12** cases where members attended outpatient appointments due to connecting with IHC Care Coordination team.

Medicaid Health Plan (total)	Kept follow up apt
Priority	5
BCC	8
Aetna	2
HAP	1
McLaren	1
Meridian	3
Molina	1
UHC	1

FUA:

There was a total **63** FUA members presented at an ED for the month of January of those cases. **44** cases were fee for service Medicaid no plan attached of the cases **15** were open to DWIHN and **2** kept the appointment.

Medicaid Health Plan (total)	How many open DWIHN	How many made aftercare appt.	How many were sent to health plan	How many did the health plan indicate will attempt to be reach	How many were attempted to reach	How many appr kept
Priority	0	0	0	0	0	0
BCC	2	4	5	0	3	0
Aetna	1	2	0	0	0	0
HAP	0	0	2	0	0	0
McLaren	0	0	1	0	1	0
Meridian	2	2	0	0	0	0
Molina	6	0	3	0	5	0

UHC	**2**	**0**	**1**	**0**	**1**	**0**
Fee for Service	**15**	**3**	**n/a**	**n/a**	**3**	**2**
Total	**28**	**11**	**12**	**0**	**13**	**2**

Audits

- ICO Molina has placed DWIHN on POC for timeliness of referral responses, provider directory, credentialing, and UM member & provider notification of authorization decision. POC is due Feb 1, 2023.
- Access Dept was trained by IHC for new hires and importance of program. IHC also met with Access team to update MHWIN system for MHL demo during this reporting period.
- ICO Meridian has requested policies and procedures for review awaiting determination.
- ICO Aetna requested additional policies and procedures for review for 2021/2022 desk audit.
- ICO Amerihealth has requested policies and procedures for review awaiting determination.
- IHC met with ICO HAP, Aetna and Amerihealth regarding marketing materials for 2023 then in turn worked with Customer Services and Utilization Management to update and submit to ICOs templates awaiting finalization from IT Vendor. During this reporting period DWIHN has templates available for review to ICOs.
- There were 3 closures that were reported to ICOs to insure compliance with program for members residing in residential settings with ICO Aetna, ICO Meridian, and ICO Molina.
- During this reporting period encounter reports were shared with the department for oversight or correction, still being reviewed to determine barriers to reporting.
- ICO Meridian has requested cost settling meeting for this reporting month for the CY2019, 2020, 2021, and 2022. IHC and Finance will review data internally along with verifying contract language to determine if cost settling is appropriate at this time as contract indicated completion in CY2019. Finance will reevaluate rates for services to determine if current with todays standards of Medicare service fees. DWIHN has not resolved cost settlements but has confirmed CEO address for Quality Withhold notifications that will be sent to DWIHN before the end of this reporting period for CY2020, CY 2021. No update for this currently. ICO Meridian has requested annual delegation audit and information is being gathered from respective departments. ICO

Meridian was submitted via secure email documents for this audit awaiting results. No updates during this reporting period.

- ICO Aetna has requested financial meeting with DWIHN to discuss cost settlement.
- IHC department has identified 6 ICO Members impacted by the High Scrutiny Waiver Program. ICOs have been notified that members will be requested to move from current location according to the list provided by DWIHN Quality Department and will be updated upon new location by next reporting period. Aetna (1), Amerihealth (1), HAP (1), Meridian (1), Molina (2). IHC has continued to follow these cases members have not been transitioned during this reporting period. No update provided at this time on members transitions.
- ICOs are requesting monthly reporting of HAB Waiver share members, IHC is working with IT to improve metrics on Power BI so that ICO can obtain data independently of manual monthly reporting, project will be completed next reporting period. During this reporting period ICO HAP requested a list be sent of current HAB Waiver members

Complex Case Management

Complex Case Management Services require the individual to agree to receive services, have Physical and Behavioral Health concerns and experiencing gaps in care. The enrollee must also agree to receive services for a minimum of 60 days.

For the month of January 2022, there are currently **9** active cases, **6** new case opened, **6** case closures, and no pending cases. Six **(6)** cases were closed due to meeting treatment goals.

Care Coordination services were provided to **21** additional members in January who either declined or did not meet eligibility for CCM services.

Follow up after hospitalization was competed with **65** consumers to help identify needs and 47 individuals who had hospital recidivism. Out of these members, **24** were reached and coordinated of care was competed and **3** were engaged in CCM.

Complex Case Management staff have been working to identify additional referral opportunities. IHC completed **34** presentations for DWIHN CRSPs and at Provider Meetings: CLS, Team Wellness, Lincoln Behavioral Services, Development Center, Guidance Center, Wayne Center, Social Security Administration, Michigan Guardian Services, Roderick Bingham Guardian, Beginning Step, Havenwyck, St. Mary's Hospital, Henry Ford Kingswood, Henry Ford Wyandotte, Pontiac General, Samaritan, Beaumont Taylor, Hawthorne.

EMS Friendly Faces:

DWIHN had **0** on the EMS lists for January 2023.

Omnibus Budget Reconciliation Act/Pre-Admission Screen Annual Resident Review (OBRA/PASRR) Services:

DWIHN contracts with Neighborhood services Organization (NSO) to perform the OBRA screening.

The DWIHN Clinical Specialist OBRA/PASRR continued to monitor the MDHHS OBRA/PASARR assessment que on an ongoing basis to review assessments that have been submitted by the OBRA/PASARR provider, Neighborhood Services Organization (NSO), to MDHHS. The Clinical Specialist also participated in the monthly meetings with NSO and quarterly meeting with MDHHS during the quarter. In April 2022 NSO was taken off the plan of correction and DWIHN has received the letter from the State of Michigan and has placed it in Cobblestone.

Congruence rate between OAS recommendations and MDHHS determinations for the month of December 98% 2022.

21/87 (24%) pended in **December 2022**. Reasons include: Psychosocial Issue 4, Nursing Issue 2, Spelling and Grammar 2,

Clerical 4, 3877/3878 or No SPMI Letters 1, Coordinator 4, Other 1, Too Old 6, and Dx Formulation Issue 1

20/105 (19%) pended in **November 2022**. Reasons include: Psychosocial Issue 5, Nursing Issue 1, Diagnostic Issue 2, Spelling and Grammar 4, 3877/3878 or No SPMI Letters 2, Coordinator 4, and Other 2.

11/91 (12%) pended in **October 2022**. Reasons include: Psychosocial Issue 2, Nursing Issue 1, Spelling and Grammar 3, Recommendations 1, Coordinator 2, Other 1, and Presenting Problem 1.

13/84 (15%) pended in **September 2022**. Reasons include: Psychosocial Issue 1, Nursing Issue 2, Spelling and Grammar 1, 3877/3878 or No SPMI Letters 2, Coordinator 5, Other 1, and Dx Formulation 1

8/87 (9%) pended in **August 2022.** Reasons include: Dx Issue 1, Spelling and Grammar 1, Coordinator 3, Dx Formulation 1, and Presenting Problem 2.

12/73 (16%) pended in **July 2022**. Reasons include: Psychosocial Issue 1, Nursing Issue 1, Spelling and Grammar 1, Clerical 1, 3877/3878 Issue or No SPMI 1, and Coordinator 7.

3/87 (3%) pended in **June 2022**. Reasons include: Psychosocial Issue 2, and 3877/3878 Issue or No SPMI 1.

12/86 (14%) pended in **May 2022**. Reasons include: Psychosocial Issue 5, 3877/3878 Issue or No SPMI 2, Coordinator Issue 3, Other 1, and Presenting Problem 1

11/72 (15%) pended in **April 2022**. Reasons include: Psychosocial Issue 1, Dx Issue 2, Recommendation 2, Coordinator Issue 6.

5/85 (6%) pended in **March 2022**. Reasons include: Nursing Issue 1, Dx Issue 2, and Coordinator Issue 2.

13/66 (20%) pended in **February of 2022**. Reasons include: psychosocial issue 4, Nursing Issue 1, 3877 or No SPMI Letter 3, returned twice 1, Coordinator Issue 3, and other issue

8/67 (12%) pended in **January of 2022**. Reasons include: psychosocial issue **2**, Dx Issue **2**, spelling and grammar **2**, returned twice **1**, and presenting problem **1**.

14/72 (19%) pended in **December of 2021**. Reasons include: psychosocial issue **2**, nursing issue **2**, spelling and grammar **1**, 3877/78 or no SPMI letters **1,** Coordinator **5**, other **2**, presenting problem **1**.

9/59 (15%) pended in **November of 2021**. Reasons include: psychosocial issue **2**, nursing issue **2**, spelling and grammar **1**, 3877/78 or no SPMI letters **1,** Coordinator **2**, other **1**.

Detroit Wayne
Integrated Health Network
Residential Services Department

Department Monthly Report: **January 2023**

DWIHN Members Serviced in Residential Settings	**2,875**
Licensed Settings	2,052
Unlicensed Settings	823

Residential Referrals	**214**
Inpatient Hospitals	93
CRSP	82
ED	15
Nursing Home/SNF	8
Foster Care for Age-Outs (DHHS)	4
Self-directed -into- Residential Services	4
Crisis Residential Unit (Oakdale House)	4
Residnetial Assessment reviews in Specialized Settings	3
OTHER [Wayne County Jail]	1

Unit Metrics

RECEIPT NOTIFICATION: Timeliness to complete emailed receipt notification to referring agents on same day or next business day if received after 2 PM. **214**

- Completed same day 116
- Next business day | After management review for assignment 98

RCS FIRST CONTACT (after case assignment): Timeliness to complete First Contact to referring agent. The measure is within 24 hours or by next business day. **214**

- Completed within 1-2 days 132
- 3-5 days 64
- 6 or more days 18

ASSESSMENT DATE: Timeliness is to complete the Residential Assessment within 1-3 business days after First Contact. **214**

- No assessments need (Brokering Only, Cancelled/Redirected after assigned) 97
- Completed within 1-5 days 26
- 6-10 days 11
- 11 or more days 7
- Assessments appointments scheduled after 1/31/23 73

Metric Barrier Trends

- Cancellation/rescinded/redirected requests by the referring agent after case assignment date or after First Contact [i.e., nursing home needed, SUD services or program, returning to family home refusing specialized services.].
- CRSP response time from First Contact to confirm requested appointment with the referring agent, member, guardian and/or current residential provider to assure member's availability to attend.
- Members inpatient or in the ED may not be clinically stable enough to speak with RCS complete needed assessment.

Service Authorizations

Authorizations Processed	**754**
Approved within 14 Days	638
Approved after 14 Days	116

- Interim IPOS Completed by DWIHN Auth Team 30
- Requests Submitted Residential Care Specialists 179
- Requests Processed Through MHWIN Queues 570

State Hospitals

	Walter Reuther	**Caro**	**Kalamazoo**	**Forensic Psychiatry**
# of Carry Overs (prior to 1/1/23)	***10***	***0***	***1***	***0***
New Referrals Received	**6**	**0**	**1**	**2**
# Members Placed	5	0	1	1
Pending Discharges (awaiting community placement)	11	0	1	1
Average Length of Stay (days)	**64.0 days**	**0**	**112.0 days**	**21.0 days**
Prospective Discharge Locations:				
MCTP Program	1	0	0	0
Out-of-County	3	0	0	0
Community	7	0	1	1

Placement Barriers

- Age of patient (younger)
- Bed Availability requests NGRI committee requests (outside Detroit/Wayne County)
- Noted behaviors (history of aggression, property destruction, etc.)

Residential Facility Closures

Carried Over prior to 1/1/2023	***2***
TOTAL # of Closure Notifications: January 2023	**6**
Requests ON-HOLD (2) / ON-GOING (5)	7
Completion of Facility Closures	1
Members Relocated under Alternate DWIHN Providers	**44**
NOTIFICATION TYPE MCO Notifications | Sanctions	1
APS Complaint	2
CRSP Notifications | Recipient Rights Complaint	1
Provider Notifications	2

Member Discharges Notifications

30-DAY DISCHARGES carried over prior to 1/1/23	**6**
Notifications Received: January 2023	**7**
30-Day Discharges **COMPLETED within 30-days**	6
Rescinded 30-Day Discharges	***0***
Discharges in Progress	**7**

Average timeliness of 30-day discharge closure: **19.1 days**

EMERGENT DISCHARGES carried over prior to 1/1/23	**3**
Notifications Received: January 2023	**11**
Emergency Discharges **COMPLETED**	8
Rescinded Emergency Discharges	***0***
Discharges in Progress	**6**

Average timeliness of emergent discharge closure: **9.3 days**

COVID-19

# of COVID-19 Positive Cases: 1/1/23 – 1/31/22		**0**
AMI IDD	0 0	
Related Death Cases: 1/1/23 – 1/31/22*		**0**
AMI IDD	0 0	
DCW Staff COVID-19 Positive cases		**0**

No reported deaths since February 2022

COVID-19 Vaccination & Boosters*

Licensed Facilities		**TOTALS**
AMI IDD	424 225	**649**

- # of Members NO LONGER in the Facility (since initial vaccine reporting) 96
- Initially REFUSED Vaccine; Changed Mind 29
- Member is NEW ADMISSION into DWIHN and/or Facility 17

Unlicensed Facilities		**TOTALS**
AMI IDD	48 45	**93**

- # of Members NO LONGER in the Facility (since initial vaccine reporting) 57
- Initially REFUSED Vaccine; Changed Mind 24
- Member is NEW ADMISSION into DWIHN and/or Facility 11

No changes since 2022 year-end reporting submission

Residential Sponsored Meetings and Trainings

	Meeting Date	# of Meetings	# of Attendees
CRSP/Residential Provider Meetings	Quarterly	2	99

- Remaining residential department meetings & trainings to resume February 2023.

Department Goals

Staffing

- (2) Residential Care Specialists transferred to new positions under UM effective 1/10/23.
- Managerment continue to interview for remaining positions for (2) Residential Care Specialists.
- Continue to assess department staffing needs based on increased number specialized referral and emergent placement requests

Members' Services

- Overview of specific MDHHS (direct) specialized placement referrals identifying staffing and specialized residential facility needs.
- Identify number of increased number of requests for first-time IDD member CRSP requests entering specialized placements from family homes.
- Develop specific programs as they pertain to increased placement requests of DHHS age-out foster kids and LGBTQI+ communities.
- Work with identified CRSP to develop programming to meet increase service needs of the DHHS foster care and LGBTQI+ communities.
- Implementation of quarterly meetings with guardianship corporations to begin dialogue addressing needs and concerns as they relate to DWIHN members.

Facilities

- Review current specialized residential facilities to develop service gap analysis of over- and under-utilized facilities.
- Overview and reinstatement of DWIHN pre-placement facilities and providers with quarterly meetings to review policies and procedures.

DETROIT WAYNE INTEGRATED HEALTH NETWORK

Substance Use Disorders Report

www.dwihn.org

1-800-241-4949

Date: January 23, 2023 **Prepared by:** Judy Davis (SUD Director)

Project/Activity/Event	Status	Follow-up
NEW GRANT FUNDS SUD FY 22/23	The MDHHS awarded the SUD Department an additional $350.000.00 from the American Rescue Plan Act Grant. The funding will provide, treatment, and recovery support continuum services, including various evidence-based services and supports for individuals, families, for the youth communities.	Meeting with providers one on one to provide technical assistance and guidelines
MDHHS Site Review	SUD is scheduled for site review with the MDHHSS for 1115 Waiver/SABG. Region 5: December 12/21/22 @ 2:00 Region 6: February 2/14/23 @ 2:00 Region 7: April 4/19/23@ 2:00 Region 9 : June 6/21/23 @ 2:00 Region 10: August 8/8/23 @ 2:00 Salvation Army: September 9/20/23 @ 2:00	Documents are due 30 days prior to the site review date.
MDHHS	Boilerplate language from the FY 23 budget included the following: **Sec. 965.** **From the funds appropriated in part 1, the department and the PIHPs shall increase the comparison rates and any associated reimbursement rates of the bundled rate H0020 for the administration and services of methadone to $19.00.** DWIHN has been informed that we must implement the increase with the Opioid Treatment Programs. This increase will mean the current rate of 7.50 for methadone medication will increase to $19.00. This will significantly increase our Block Grant expenditures for FY 23	DWIHN is working to comply with this boilerplate requirement.

2 TREATMENT UPDATES

Naloxone Initiative	DWIHN continues to support access to Naloxone through training. To date, we have trained **9,232** residents of Wayne County on how to reverse an opioid overdose. In addition, we have also provided each person with a Naloxone kit. DWIHN's Naloxone Initiative program has saved **1,112** lives since its inception. Again, the saved lives are underreported, especially during the COVID pandemic. The logs are coming in slowly from law enforcement and the community. DWIHN only reports those saves that we have documentation to support this initiative. DWIHN expanded access to Naloxone through the Barbershop Talk Tour Initiative to Hair Salons. This permits the life-saving medication to include more people who might encounter someone experiencing an overdose. In addition, it allows family and friends of opioid users to have more knowledge of opioid overdose and the ability to respond appropriately after receiving training in naloxone administration. Training includes topics on Men's Health Issues, Male Responsibilities, Substance Use Disorder, Mental Health, Police Brutality, and Naloxone training. During October, presentations were conducted at 6 locations in Wayne County. Training totaled 28 men and 5 women.	Ongoing
Providers Meeting	The bi-monthly SUD Provider Meetings will continue to be held virtually from 930am -1100 am on the fourth Wednesday of every other month in 2022. These meetings allow DWIHN to share updates, provide training, and an opportunity to network with colleagues in the field. We encourage participation from administrative, clinical, and staff members. Our next meeting will take place on Monday, November 21, 2022.	Next SUD Treatment Provider Meeting will be held in January
PA 2 Funding	A two-bill package designed to extend the capture of liquor tax revenue that counties use for substance abuse programs passed during the last days of the legislative session this week and will soon mean a $25 million boost to counties	TBD
COVID19	**COVID Cases** As the pandemic continues into year three, providers should have mechanisms in place to safely accommodate clients who test positive for COVID-19. No individual should be removed from necessary treatment due to a positive COVID-19 test unless there is an alternative placement coordinated with another provider prior to discharge. All DWIHN-contracted SUD providers must have policies/procedures in place regarding mitigating the spread of COVID-19, including the process for how a positive test for COVID-19 is safely navigated, according to CDC guidelines.	Ongoing

	In October, we provided services to individuals for quarantine compare to the previous month (61). Quarantine Sites: Quality Behavioral Health and Abundant Community Recovery Services. We are looking to add additional Quarantine Site with SHAR due to the significant increase of COVID cases in treatment	
Gambling Funding Reduction	Due to current budget constraints from MDHHS, it was necessary to reduce Gambling funding for Treatment services by 50% and 25% for Prevention Gambling Services. Providers effected by the reduction include Sobriety House, Mariners Inn, and Elmhurst for Treatment. In addition, LAHC, Empowerment Zone and The Youth Connection will each receive a 25% reduction	*Submitted recommendation to MDHHS on 1/19/23*
RFQ	The Evaluation Team has completed its evaluation of all submitted proposals received in response to Treatment SUD RFQ No. 2022-010 the Final Evaluation recommendation as a result of that evaluation are as follow. DWIHN received 15 responses and 9 of the proposal qualified for SUD Treatment services: All Well-Being Services, Arab Community Center for Economic and Social Services, Black Family Development, Inc, Carefirst Community Health Services, Growth Works, Inc. Lakeridge Village, Sacred Heart Rehabilitation Center, Inc., Sobriety House, Inc. and Team Wellness Center	*Ongoing*
	DWIHN issued an RFQ on October 26, 2022 for Substance Use Disorder (SUD) prevention services. The Qualified list will be valid for 5 years, and only approved, qualified providers who meet the qualifications will be placed on the eligible list. This list does not guarantee a Contract with DWIHN to provide SUD Prevention services. The initial response was due November 29, 2022. The RFQs for Treatment is under the Procurement Administrators' direction and are in the scoring phase	
ASAM Level of Care	MDHHS transitioned the ASAM Level of Care application process to the Customer Relationship Module (CRM) of MiCAL. As a result, Providers must submit their application using this system once approved by the PIHP. All provider agency providing a level of care will need to submit through the CRM by January 31, 2023.	Every 2 years

4 TREATMENT UPDATES

New Hire	DWIHN hired a New Complex Case Manager, Davon Jones and the new Administrator Assistant will begin on January 23, 2023. MDHHS will allocating additional funds for Pregnant and Post -Partum Grant Coordinator	
Conferences	2023 Rx Drug Abuse and Heroin Summit April 10-13, 2023 Atlanta, GA	Please see attached information

DWIHN UTILIZATION MANAGEMENT MONTHLY REPORT
January 2023

Executive Summary

- **Autism:** There were approximately 273 authorization requests manually approved during the month of December. There were an additional 130 authorizations completed via the auto-approval process for a total of 403 approvals for the month of January. There are currently 2,745 cases open in the benefit.
- **Habilitation Supports Waiver:** There are 1,084 slots assigned to the DWIHN. As of 12/31/22 1,011 filled, 72 were open, for a utilization rate of 93.4%.
- **County of Financial Responsibility:** In the month of December, there were two (2) adult review requests & one (1) child review request. This total does not include committee-reviewed cases deemed non-COFR that were redirected to DWIHN Residential and/or identified as single-case agreements/contract updates.
- **Denials and Appeals:** For the month of December, there were two (2) denials and zero (0) appeals reported. There were also twenty-two (22) inpatient service authorization administrative denials and thirteen (13) administrative appeals. One (1) of the administrative appeals was upheld, four (4) were overturned, six (6) were partially upheld and two (2) are pending a determination.
- **General Fund:** Of the General Fund Exception authorization requests reviewed during January 2023, there were 316 approvals, including 5 for the Guidance Center. There were 9 Administrative Denials. There were 285 Advance Notices for timeline and SUG corrections and for Administrative Denials.
- **MI Health Link:** The reporting format of MI Health Link authorizations reflects the total number of authorizations requests and the amount of each authorization type for the 5 ICOs. There were 52 MI Health Link authorizations received and processed as of 1/31/23. The number of MI Health Link admissions to inpatient, partial and CRU are also included in the Provider Network data.
- **Provider Network/Outpatient Services:** A total of 814 admissions including Inpatient, MI Health Link, Partial Hospital and Crisis Residential were managed by the UM Department. Timeframes of Outpatient Service Authorizations are being examined for possible adjustments in accordance with the feedback being received from providers regarding the ways the approval time frames impact the service delivery to our members. Currently, the PowerBI Dashboard indicates that in December there were 1,799 authorizations manually approved by the UM department. This number is reflective of non-SUD, non-ASD, non-urgent pre-service authorizations. Of these 1,799 authorizations, 1,522 (or 85%) were approved within 14 days of request; 244 (or 13.9%) were approved within 21 days of request; 33 (or 1.8%) were approved within 28 days; and none were approved beyond 28 days.
- **State Facilities:** There was one adult state hospital admission for the month and 76 NGRI consumers are currently managed in the community. 3 consumers remain on the wait list. There were no new children's state hospital admissions; there is one (1) youth in the admission pool (wait list).

- **SUD:** The Power Bi dashboard indicates SUD UM staff approved 1,289 authorizations as of 12/31/2022. Of these 1,289 authorizations, 748 (or 58%) were approved within 3 days of request; 456 (or 35.4%) were approved within 4 - 11 days; 54 (or 4.2%) were approved within 12-14 days; and 31 (or 2.4%) were approved outside of 14 days.
- **Administrative Denials**: During the month of November the SUD team issued 12 administrative denials compared to 9 the previous month.

General Report

Utilization Management Committee

The monthly UMC Meeting was held in December and minutes are available for review.

Autism Spectrum Disorder (ASD) Benefit

There were approximately 273 authorization requests manually approved during the month of December. There were an additional 130 authorizations completed via the auto-approval process for a total of 403 approvals for the month of January. There are currently 2,745 cases open in the benefit.

ASD Authorization Approvals for Current Fiscal Year to Date*

	Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	Aug	Sept
Manual Approvals	374	332	348	241								
Auto Approvals	174	128	172	130								
Total Approvals	547	460	520	403								

*Numbers are approximate as they are pulled for this report prior to when all data for the month is available.

ASD Open Cases and Referral Numbers Per WSA*

Fiscal Year to Date												
	Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	Aug	Sept
Open Cases	2550	2628	2666	2745								
Referrals	134	110	96	Pending Update from the WSA								

*Numbers are approximate as they are pulled for this report prior to when all data for the month is available.

Habilitation Supports Waiver

There are 1,084 slots assigned to the DWIHN. As of 1/31/23 1,013 filled, 71 were open, for a utilization rate of 93.5%.

Monthly HSW Utilization	November 2022
Allocated	1,084
Used	1,011
Available	72
Percent Used	93.5%

Quality and Timeliness are the primary issues. Currently the overall quality of the IPOS' greatly impacts timeliness (reviewing, returning certs, corrections needed). "Training" has been the primary action taken to address audit citations for the past two years. However, unless quality is addressed in a different manner, repeat citations are likely to continue. It should also be noted, HSW Coordinator only monitors one habilitative goal and does not make recommendations or review IPOS in its entirety. To address timeliness; a clear timeline which includes follow up has been established, 2 additional CRSPs (NSO and WC) will begin entering their recertifications directly into the WSA, tasks for backlog/recertification/future enrollees divided. Additional staff will be hired and ongoing discussion regarding quality will be pursued in the upcoming month.

Serious Emotional Disturbance Waiver (SEDW)

# of youth expected to be served in the SEDW for FY 22-23	65
# of active youth served in the SEDW, thus far for FY 22-23	58
# of youth currently active in the SEDW for the month of January	57
# of referrals received in January	9
# of youth approved/renewed for the SEDW in January	0
# of referrals currently awaiting approval at MDHHS	0
# of referrals currently at SEDW Contract Provider	6
# of youth terminated from the SEDW in January	1
# of youth transferred to another County, pursuing the SEDW	2
# of youth coming from another county, receiving the SEDW	0
# of youth moving from one SEDW provider in Wayne County to another SEDW provider in Wayne County	0

County of Financial Responsibility (COFR)

Due to staffing transitions, limited updates are available for reporting.

	Adult COFR Case Reviews Requests	Children COFR Case Reviews Requests	Resolved	Open*
December 2022	3	1	0	n/a

*This is a running total. Recommendations forwarded to Administration and pending determination

Note: Not all new cases referred are reviewed within the month they are received. All new cases are added to COFR Master List with date referral is received. Cases are reviewed by priority of the committee.

This total does not reflect committee-reviewed cases deemed non-COFR that were redirected to DWIHN Residential and/or identified as single-case agreements/contract updates.

General Fund

Consumers requesting General Fund Exception are:

- Without health care benefits at the time of the start of behavioral health services
- Returning for services without health care benefits after an absence
- Actively receiving services and experiencing a lapse in insurance benefits

The following chart shows the FY 2022-2023 number of approved authorization requests, the number of Guidance Center CCBHC approvals and the number of Advance Notices for corrections to requests and Administrative Denials issued.

General Fund Fiscal Year 2022-2023 to Date													
	Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	Aug	Sept	**FY To Date TOTAL**
Approvals	**332**	**327**	**260**	**316**									**1,235**
The Guidance Center	**12**	**12**	**11**	**5**									**40**
Advance Notices	**257**	**266**	**203**	**285**									**1,011**
Administrative Denials	9	10	9	9									**37**

Denials and Appeals

Medical Necessity Denials

For the month of December, there were twenty-two (22) authorization requests sent to the physician for a peer review. Of the twenty-two (22) peer reviews sent to the physician, two (2) reviews were denied due to not meeting medical necessity criteria for continued inpatient hospitalization stay days. The remaining twenty (20) authorization requests that were sent to the physician for a peer review were approved for additional continued inpatient days. There were no medical necessity appeals reported for the month of December.

	Oct 22	**Nov. 22**	**Dec. 22**	**Jan. 23**	**Feb. 23**	**Mar 23**	**Apr 23**	**May 23**	**Jun. 23**	**Jul. 232**	**Aug. 23**	**Sept 23**
Denial	3	2	2	0	0	0	0	0	0	0	0	0
Appeal	0	0	0	0	0	0	0	0	0	0	0	0

Service Authorization Administrative Denials

During the month of December, there were a combined total of sixty-five (65) administrative denials between the inpatient, outpatient and SUD services. There were also thirteen (13) administrative appeals. One (1) of the administrative appeals was upheld, four (4) were overturned, six (6) were partially upheld and two (2) are pending a determination. The chart below is shows the number of denials and appeals for each service.

	Inpatient	Outpatient	SUD
Denial	22	2	43
Overturn	4	0	0
Upheld	1	0	0
Partial Denial	6	0	0

Timeliness of UM Decision Making: Quarter 1 (October-December 2022) Threshold 90%

***Note: COPE, measures were not available at the time of the report. **Source: Power BI*

Autism Program

	Urgent Concurrent	Urgent Preservice	Non-Urgent Preservice	Post Service
Numerator	N/A	N/A	1060	N/A
Denominator	N/A	N/A	1065	N/A
Total	N/A	N/A	99.5%	N/A

MI Health Link Program

	Urgent Concurrent	Urgent Preservice	Non-Urgent Preservice	Post Service
Numerator	2	N/A	30	12
Denominator	2	N/A	34	12
Total	100%	N/A	88.2%	100%

Substance Use Disorder

	Urgent Concurrent	Urgent Preservice	Non-Urgent Preservice	Post Service
Numerator	1053	N/A	3071	N/A
Denominator	1097	N/A	3464	N/A
Total	95.9%	N/A	88.7%	N/A

COPE (NOTE: data not available at time or report)

	Urgent Concurrent	Urgent Preservice	Non-Urgent Preservice	Post Service
Numerator	N/A	N/A	N/A	N/A
Denominator	N/A	N/A	N/A	N/A
Total	N/A	N/A	N/A	N/A

State Hospital Liaison Activity Report

Hospital	Caro Center		Kalamazoo		Walter Reuther	
Census	Total	1	Total	3	Total	75
	NGRI	0	NGRI	1	NGRI	22
	Non-NGRI	1	Non-NGRI	2	Non-NGRI	53
Wait List	0		0		3	
Admissions	Total	0	Total	0	Total	1
	NGRI	0	NGRI	0	NGRI	0
	Non-NGRI	0	Non-NGRI	0	Non-NGRI	1
ALS Status	0		0		76	

- No referrals for state hospital admission were received this month; three total referrals are on the wait list. All referrals are pending for Walter Reuther. All referred members are being treated in a community hospital inpatient setting and are continuously being reviewed for discharge.
- Liaison staff continue to provide NGRI training to DWIHN and CMH partners to support provider staff, maintain and meet target deadlines, and facilitate skill development. 96 individual liaison/training contacts were made this month.
- This month 5 NGRI members were released to the community for aftercare and follow-up.
- One referral for the MDHHS DCPP program was received this month, 2 members (1 voluntary and 1 NGRI) are awaiting discharge via the DCPP.

Children's State Hospitalization

As of 1/31/23, there are three (3) youth admissions being funded by DWIHN, with no new admissions this month. Two (2) of the funded members are discharge ready and awaiting MDHHS placement, with the longest since 8/2022. No additional discharges. One (1) youth was added to the admission pool this month.

As noted in previous reports, MDHHS State Hospitals Administration partnered with Hope Network to create the Michigan Community Transition Program (MCTP), which is used as a step down from state hospitalization; the State Hospitals Administration fully funds this program. Like state hospitalizations, DWIHN (or its CRSP designee) participates in monthly meetings to monitor treatment updates. Currently, there are currently three (3) DWIHN members in that program.

MI Health Link

Monthly ICO Authorization Report – January 2023

Report Filters			
Date Range Selected:	1/1/2023	thru	1/31/2023
ICO's Selected:	AETNA BETTER HEALTH OF MICHIGAN; AMERIHEALTH MICHIGAN, INC.; FIDELIS SECURECARE OF MICHIGAN; HAP MIDWEST HEALTH PLAN, INC.; MOLINA HEALTHCARE OF MICHIGAN INC		

	Preservice Authorizations		Urgent Authorizations		Expedited Authorizations (Currently No DWIHN Authorizations labeled as Expedited)		Post Service Authorizations	
Total # of Auth's Received for the Month	Total Amount Preservice Auth's Received	Total Preservices processed ≤14 days	Total Amount Urgent Auth's Received	Total Urgent processed ≤24 hrs	Total Amount Expedited Auth's Received	Total Expedited processed ≤72 hrs	Total Amount Postservice Auth's Received	Total Post Service processed ≤14 days
52	2	1	20	20	0	0	30	30

***The number of MI Health Link admissions to inpatient, partial and CRU are included in the Provider Network data.*

The data for January 2023 delineates the total number of authorizations requests and the amount of each authorization type for the 5 ICOs. The table(s) account for the total number of authorizations by ICO, the type of authorization and the amount of time taken to process the request. Additionally, the data only includes those authorizations that required manual review and approval by UM Clinical Specialists. It does not include those authorizations that were auto approved because the request fell within the UM Service Utilization Guidelines.

There were 52 MI Health Link authorizations received compared to 49 authorizations during the month of November, a 6.12% increase. By ICO, there were 13 authorizations for Aetna, 6 for AmeriHealth, 0 for Michigan Complete Health (Fidelis), 5 for HAP Midwest and 28 for Molina. Of the 52 of MI Health Link authorization requests, 51 (98.1%) were processed within the appropriate timeframes.

At the time of this report, UM notes that technical errors with populating authorizations are now fixed. UM Clinical Specialists continue to encounter fewer errors with initial MI Health Link authorizations, though the issue is not eliminated.

Of note, this technical error likely affects the validity of the MI Health Link and Provider Network monthly reports, as many members may be incorrectly reported (and initially authorized) under the DWIHN CMH affiliate.

Provider Network

As of 1/31/23, the UM Team has managed a total of 814 admissions across the provider network (including MI Health Link members). This data includes inpatient, partial hospitalization, and crisis residential services. In the month of January, there were 701 (non-MI Health Link) admissions for inpatient treatment, reflecting a 1.7% increase from the 689 inpatient admissions during December 2022.

SMI/SED	# Admited Members	# Admissions	Avg Length Of Stay	Median Length of Stay
SMI	554	577	8.75	8
SED	83	87	8.21	8
IDD	26	29	7.69	7
SUD	4	4	4.50	2.5
		0	0.00	
N/A		0	0.00	
NON		0	0.00	
Not Assesed		0	0.00	
Total	**667**	**697**	**8.61**	**8**

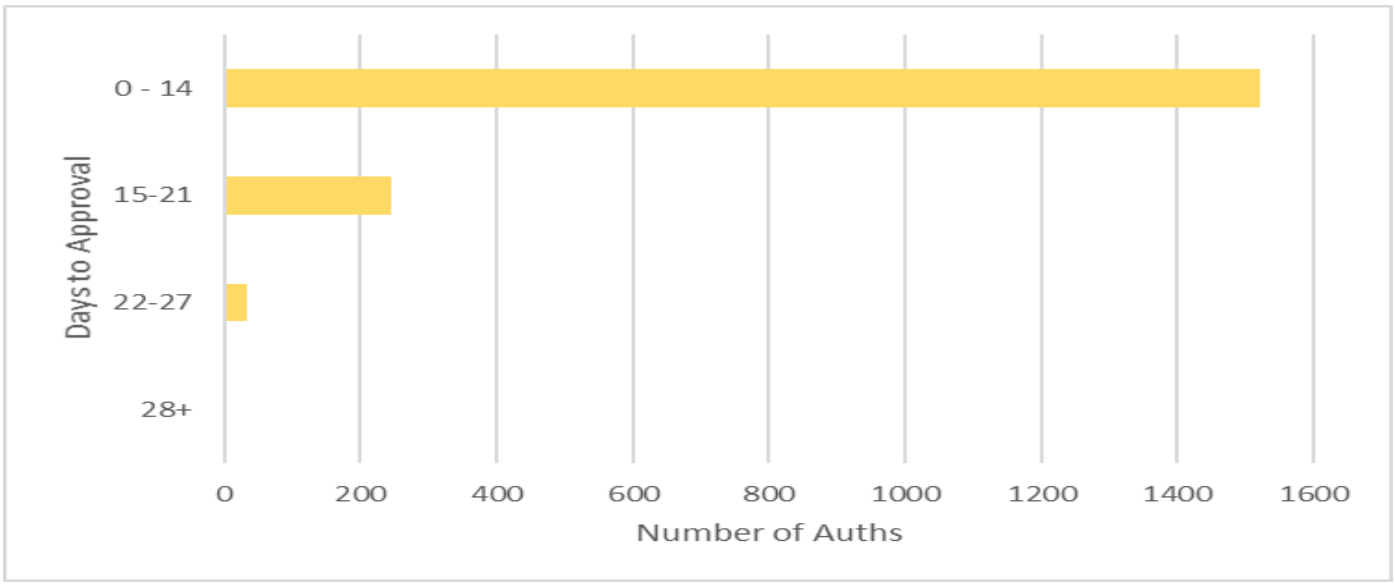
The data outlined below reflects the number of admissions as of 1/31/2023:

- Inpatient: 701
- MHL Inpatient: 8
- Partial Hospital: 77
- Crisis Residential: 28 (adults – 20 and children - 8)
- Total Admissions: 814

The UM and Crisis Services teams continue their work with increasing education & utilization of other step down and diversion resources. UM Higher Levels of Care staff are involved with peripheral monitoring of pilot program with Team Wellness, which involves coordination between their hospital liaison and identified facilities (Detroit Receiving Hospital Crisis Center and StoneCrest Center). Other pilot programs will be implemented soon, including UM Higher Levels of Care staff assisting with aftercare scheduling.

Outpatient Services (Non-Urgent, Pre-Service Authorizations)

Timeframes of Outpatient Service Authorizations are being examined for possible adjustments in accordance with the feedback being received from providers regarding the ways the approval time frames impact the service delivery to our members. Currently, the PowerBI Dashboard indicates that in December there were 1,799 authorizations manually approved by the UM department. This number is reflective of non-SUD, non-ASD, non-urgent pre-service authorizations. Of these 1,799 authorizations, 1,522 (or 85%) were approved within 14 days of request; 244 (or 13.9%) were approved within 21 days of request; 33 (or 1.8%) were approved within 28 days; and none were approved beyond 28 days.



****Data Source: Power-BI****

Substance Use Disorder

SUD Authorizations

The Power Bi dashboard indicates SUD UM staff approved 1,289 authorizations as of 12/31/2022. Of these 1,289 authorizations, 748 (or 58%) were approved within 3 days of request; 456 (or 35.4%) were approved within 4 - 11 days; 54 (or 4.2%) were approved within 12-14 days; and 31 (or 2.4%) were approved outside of 14 days.

Medical Necessity Denials

There were no SUD medical necessity denials for the month of December. (S*ource Sharepoint Master UM Data Tracking Log – SUD)*

SUD Bulletins Issued by PCWG

Two bulletins were issued by the Procedure Code Workgroup that pertain to SUD. #22-005 addresses atypical medications in SUD Residential in August. They are posted on the website. There are follow up questions primarily from Hegira that are being addressed by the PCWG. This needs to be reviewed to ensure follow-up. We are still awaiting a rate for Q9991 and Q9992 from finance. These are new codes from MDHHS re: Buprenorphine injections. **The SUD UM Guidelines as well as the SUD rate sheet need to be updated when established.**

SUD Timeliness Dashboard

For the month of December, there was a total of 1289 authorizations approved. There were 349 urgent authorizations approved. Out of the 349, 316 (90.5%) were authorized within 72 hours. There were 940 non-urgent authorizations and 912 (97%) were approved within 14 days.

SUD Provider Training PowerPoint

Feedback on current powerpoint which was updated by Jennifer Miller was not received from any of the SUD staff. Reviewers discussed the training should be limited to one hour which will allow for questions. It appears as if zoom may be the preferred training platform. New leadership may have to move this forward. Minimally the powerpoint may be shared at the next SUD Provider meeting.

MCG

MCG Has been updated to the 26th edition.

IRR

IRR testing continues with new hires. IRR annual case studies have been distributed for all staff eligible and required to receive annual case studies.

DETROIT WAYNE INTEGRATED HEALTH NETWORK

QAPIP Annual Evaluation

Fiscal Year 2022

QAPIP Annual Evaluation

- The QAPIP Evaluation is an annual document that assess results, improvements and outcomes that has occurred throughout the year with respect to the QAPIP Work Plan for FY 2022.
- The QAPIP Evaluation is aligned with the six (6) pillars that are identified in DWIHN's Strategic Plan.
  - Customer, Access, Quality, Advocacy, Finance and Workforce Development,
- The evaluation is intended to address the performance monitoring of our system, timeliness, accessibility, quality and safety of clinical care, member satisfaction and performance improvement projects.
- Not all the performance improvement measures will be covered in the PowerPoint presentation.
- Once approved by the full Board copies of the QAPIP Evaluation and Work Plan will be available on DWIHN website for stakeholders and members to review.

QAPIP Annual Evaluation

The goal of the **Customer Pillar** is to focus on DWIHN's commitment to providing an Excellent Member Experience and Services to Members. Several departments contribute to the makeup of this Pillar.

- There are six (6) objectives under the Customer Pillar. 3 of the 6 objectives were Not Met.
- ECHO Survey - *Goal Not Met (pg. 4)*
  - The results of the survey not available until late April.
- National Core Indicator Survey - *Goal Not Met (pg. 6)*
  - The results of the survey not available until September.
- Practitioner Survey - *Goal Not Met (pg. 11)*
  - The practioners survey was not administered during FY2022 and will be sent out in Q2 (January-March) of FY2023.
  - The results of the survey not available until later this year.

QAPIP Annual Evaluation

The goal of the **Access Pillar** is to monitor access to service using the Michigan Mission Based Performance Indicators (MMBPI) data. There are five (5) indicators that have been established by MDHHS that are the responsibility of the PIHP to collect data and submit on a quarterly basis.

- There are (6) objectives under the Access Pillar. 1 of the 6 objectives was Not Met.
  - PI#10 (Recidivism or Readmission within 30 days) did not meet Q2 (16.31%), Q3 17.79%, Q4 15.89% for Adults (pg. 19).

    The standard is 15% or less. This remains an opportunity for ongoing improvement. We will continue with the efforts to work with the screening agencies to identify and discuss clinical ramification for those members considered recidivistic in efforts to address recidivism rates.

QAPIP Annual Evaluation

DWIHN met the standards for PI#1 (Children & Adults), PI#4a (Adult), 4b (SUD) and PI#10 (Children) during FY22. DWIHN provided access to treatment/services for 95% or more members receiving a pre-admission screening for psychiatric inpatient care within 3 hours of a request for service. DWIHN demonstrated an 6.75% performance rate for Children who were re-admitted within 30 days of being discharged from a psychiatric hospitalization. This was a significant improvement in performance from the previous reporting period (pgs. 16-18).

Performance Indicators	Population	1st Quarter 21/22	2nd Quarter 21/22	3rd Quarter 21/22	4th Quarter 21/22
Indicator 1: Percentage who Received a Prescreen within 3 Hours of Request (95% Standard)	Children	97.78%	98.14%	98.91%	98.80%
	Adults	97.14%	98.81%	97.83%	97.69%
	Total	97.29%	98.65%	98.06%	97.89%
Indicator 4a & 4b: Percentage who had a Follow-Up within 7 Days of Discharge from a Psychiatric Unit/SUD Detox Unit (95% Standard)	Children	98.15%	93.75%	86.44%	100.00%
	Adults	94.80%	95.94%	96.81%	97.90%
	Total	95.09%	95.71%	95.83%	98.10%
	SUD	100%	99.37%	99.81%	98.97%
Indicator 10: Percentage who had a Re-Admission to Psychiatric Unit within 30 Days (<15% Standard)	Children	5.06%	7.69%	6.76%	6.80%
	Adults	14.93%	16.31%	17.79%	15.85%
	Total	14.05%	15.63%	16.86%	15.15%

QAPIP Annual Evaluation

- The goal of the **Quality Pillar** is to monitor clinical performance of provider services and programs to ensure system wide compliance with State, Federal regulations and the safety and wellness of the people we serve.
- There are (6) objectives under the quality pillar. All 6 objectives were Met (pgs.41-45).
- The goals were to increase performance monitoring by 25% or greater with CRSP, Residential, B3 Services, Autism, Waiver Programs, SUD and Inpatient Hospital Settings (Goal Met)
- The goal was to increase the providers self-monitoring reviews by 10% (Goal Met)
- MDHHS reporting requirements for CE/SE (Goal Met)
- The Behavior Treatment reporting requirements (Goal Met)

Year End Monitoring Data FY 2022

Provider Monitoring Reviews
Total Number Reviews Conducted = 166
CRSP, SUD, Autism, B3, Waivers and Inpatient Hospital Settings

Staff Record Reviews
Total Number of Staff Records Audited = 114
Overall Score = 96%

Provider Self-Monitoring
22 CRSP
1st Q Case Records
Overall Score = 93%

Provider Self-Monitoring
25 CRSP
2nd Q Case Records
Overall Score = 92%

Provider Self-Monitoring
24 CRSP
3rd Q Case Records
Overall Score = 90%

Provider Self-Monitoring
14 CRSP
4th Q Case Records
Overall Score = 92%

Provider Network Trainings
Total Number Hosted = 6
Attendees = 800+

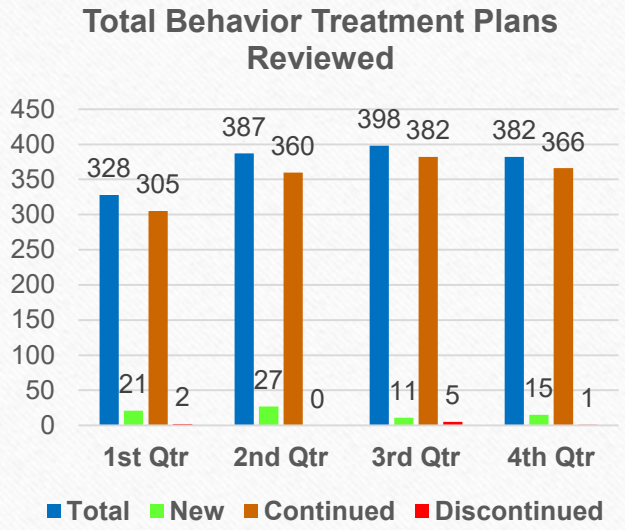
Critical/Sentinel, Unexpected Deaths and Risk Reporting

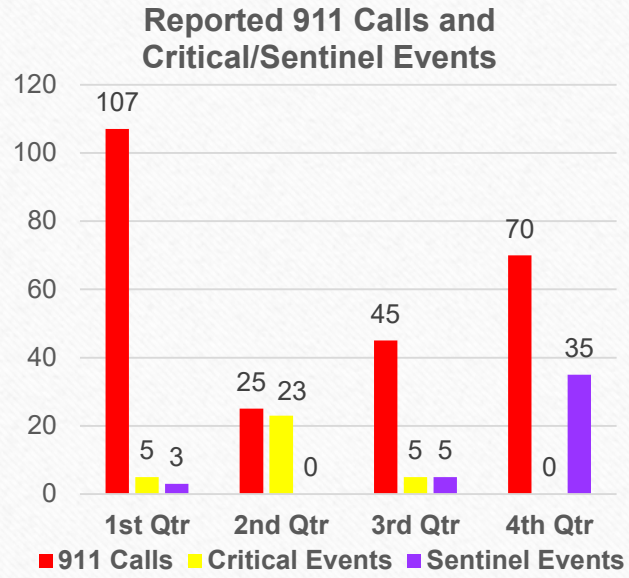
In FY2022, the Quality Performance Improvement Team processed 1,915 Critical/Sentinel Events, which is a decrease of (39.3%) from FY2021. This decrease is attributed ongoing training with the Provider Network on correct and accurate reporting. Of those incidents, the SERC reviewed and analyzed over eight-hundred and thirty (830) critical incidents. Critical Incidents include arrests, deaths, emergency medical treatment due to injuries or medication errors, and hospitalizations due to injuries or medication errors (pgs. 46-50).

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

Behavior Treatment Review

In FY22, through DWIHN's BTPRC provider network there were 1,495 member cases on Behavior Treatment Plans which is an increase of 334 (28.76%) from the previous year. The data below depicts all the use of intrusive and restrictive techniques, 911 calls/critical events and use of medication per Individual receiving the intervention. The charts below illustrate the BTAC Summary of Data Analysis FY22. During FY 2021-20222, DWIHN BTAC staff provided three system-wide trainings on Technical Requirements of Behavior Treatment Plan Review Committee (BTPRC) Processes with a total of 1,215 staff trained within our provider network (pgs. 50-52)





QAPIP Annual Evaluation

Performance Improvement Projects

- There are (9) PIPs. 8 of the 9 PIP's did not meet the Target goal (pgs. 54-79)
  - *Improving the availability of a follow up appointment with a Mental Health Professional after Hospitalization for Mental Illness - Adult*
    - *(7 Day Follow-Up: Goal Not Met – 28.33%, Goal 45% or higher).*
    - *(30 Day Follow-Up: Goal Not Met – 46.67%, Goal 58% or higher).*
  - *Adherence to Antipsychotic Medications for Individuals with Schizophrenia (Goal Not Met – 46.92%, Goal 68.00% or higher)*
  - *Antidepressant Medication Management for People with a New Episode of Major Depression (Goal not Met – 13.36%, Goal 46.42%)*
  - *Improving Diabetes Monitoring for People with Schizophrenia and Bipolar Disorder (Goal not Met – 64.86%; Goal 78.01%)*
  - *Coordination of Care (Goal Not Met – 68.86%, Goal 95% or higher)*
  - *Case Finding for Opiate Treatment (Goal not Met – 60%, Goal 79% or higher)*
  - ***PHQ-9 Implementation (Goal Met – 99.1%, Goal at 95%)***
  - *PHQ-A Implementation (Goal Not Met – 99.2%, Goal 100%)*
  - *Decreasing Wait for Autism Services (Goal Not Met – 67.5%, Goal 100%)*

QAPIP Annual Evaluation

- The goal of the **Workforce Pillar** is to continue to focus on maintaining and expanding a centralized training program for health professionals.
- There was (1) objective under the workforce pillar. Goal was met (pg. 80).
  - DWIHN met the objective by continuous quality monitoring of our workforce through credentialing and through Provider trainings on Detroit Wayne Connect, a continuing education platform for stakeholders of the behavioral health workforce.

QAPIP Annual Evaluation

The goal of the **Finance Pillar** is to ensure financial stewardship and provide monitoring and oversight of claims/encounters submitted within the Provider Network. DWIHN verifies the delivery of services billed through our Medicaid Claims Process.

- There was (1) objective under the finance pillar. Goal was met (pg. 83).
  - In FY2022, a total of 3,598 claims were randomly selected for verification. Of those claims, 3,524 were reviewed and validated for 98.03%, which is a 35.75% increase from the previous fiscal year 2021 (1260). 3,210 of the claims reviewed were compliant, having received scores of at least 95%, and 215 of the claims reviewed had scores ≤ 95%, of which 124 required a Plan of Correction during FY2022 (pg. 45).

QAPIP Annual Evaluation

The goal of the **Advocacy Pillar** is to promote full integration in the community.

- There was (1) objective under the advocacy pillar. Goal not met (pg. 84).
  - Ensure full compliance in the network with the Home and Community Based Setting requirements.

QAPIP Annual Evaluation

HSAG conducted three (3) mandatory External Quality Reviews (EQR) as required to ensure compliance with regulatory requirements (pgs. 87-91).

- Performance Improvement Project
  - Goal met/outcome (100%) Target goal (80%)
- Performance Measurement Validation
  - Goal met received (100%) with no POC required.
- Compliance Review
  - Goal partially met received a score of 83% with a corrective action plan.

QAPIP Annual Evaluation

- Overall, most activities planned in the Work Plan FY22 2021-2022 is at approximately (70%) completion goal.

- The activities that were Not Met, Partially Met or opportunities for Continuous Quality Improvement will be continued during FY2022-2023.

Quality Assurance Performance Improvement Plan (QAPIP)

FY 2021-2022 Work Plan Evaluation

Prepared by April L. Siebert, Director of Quality Improvement – asiebert.dwihn.org.

Approved:

Approved by the Quality Improvement Steering Committee (QISC)	1/31/2023
Approved by Program Compliance Committee (PCC)	
Approved by Full Board of Directors	

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Executive Summary

The Detroit Wayne Integrated Health Network (DWIHN) is the Pre-Paid Inpatient Health Plan (PIHP) and Community Mental Health Service Provider (CMHSP) for Detroit and Wayne County. DWIHN is the largest community mental health service provider in the State of Michigan. The Quality Assurance Performance Improvement Plan (QAPIP) Evaluation is an annual document that assesses the results, Improvements, and outcomes DWIHN has made with respect to the Annual Work Plan for FY2022.

Description of Service Area

Wayne County is the most populous county in the State of Michigan. Wayne County is comprised of 34 cities and 9 townships covering roughly 673 miles. The municipality of Detroit had a 2021 estimated population of 632,464 which is a noted decrease of 37,567 from the previous fiscal year (670,031). Member populations receiving services through DWIHN are commonly referenced throughout this evaluation using the following abbreviations:

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

Demographics

DWIHN provided services to an unduplicated count of 75,873 members during FY2022, which is an increase of 2,465 (3.35%). Of those served 47,526 (62.64%) received services through Medicaid funding, 18,893 (24.90%) received services through Healthy Michigan Plan funding, 7,025 (9.26%) received services through General Fund, 6,057 (7.98%) through SUD Block Grant, 6,084 (8.02%) through MI Health Link, 1,393 (1.84%) through State Disability Assistance (SDA) and 1,035 (1.36%) through Habilitation Supports Waiver. The percent of adults who reported having an SMI in FY22 was 44,349 (58.45%), demonstrating an increase of (2.64%) from the previous year. Followed by 11,222 (14.79%) (SED), 12,952 (17.07%) (IDD), 1,343 (4.92%) (SUD), 1,925 (2.54%) (MI), 2,387 (Co-Occurring, and 303 (0.40%) unreported, which is a substantial decrease of unreported disability designation from the previous year. Of those served 41,633 (54.87%) were of African American descent. The Caucasian count was 23,428 (30.88%). The remaining (14.25%) were identified as other, two or more races, unreported, Asian, American Indian, Native Hawaiian, and Alaskan.

The largest group of individuals served are in the age group of 22-50 years-old 33,662 (44.37%). Followed by the age group of 0-17 years-old,16,923 (22.30%), and the age group of 51-64 years-old, 15,424 (20.33%). The growth of persons served 65 and over continues to increase by (6.31%) from the previous year. *Data was extracted for this report on January 9, 2023.

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

Customer Pillar

Member Experience with Services

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

Quantitative Analysis and Trending of Measures

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

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

Evaluation of Effectiveness

During FY21, DWIHN scored well on several measures, notably parents/guardians reporting receiving information on patient rights (95%), confidence in the privacy of their information (93%), and completely discussing the goals of their child's treatment (93%). However, there were four measures with scores of less than (50%): Perceived improvement (25%); Getting treatment quickly (42%); Counseling and treatment (49%); and Amount helped (49%). There was variation in the overall rating during FY2020 compared to FY2021, "Perceived improvement" (28% compared to 29%); How Well Clinicians Communicate" (73% compared to 68%); and rating of counseling and treatment (54% compared to 51%). DWIHN will complete an analysis on the comparison of data for FY2021 and FY2022 once the final report is available in June of 2023.

Identified Barriers

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

Opportunities for Improvement

DWIHN will continue to focus on access to care for behavioral health services based on the 2021 survey results and will incorporate the 2022 survey results once available. Each intervention is designed to address an identified barrier in the treatment related factors:

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

National Core Indicators (NCI) Survey

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

Quantitative Analysis and Trending of Measures

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

Identified Barriers

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

Opportunities for Improvement

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

Long-Term Services and Supports (LTSS)

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

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

Opportunities for Improvement

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

Member Grievance and Appeals

DWIHN's Customer Service completes an analysis of member experience trends and occurrences through a review of Grievance data. DWIHN uses this data and other initiatives to determine priority actions and improvements to better engage members and stakeholders. Analyzing the data helps to forecast the direction and future of DWIHN's public behavioral health system by enhancing and developing policy, initiating process improvement plans, and funding new programs and services to enhance our system of care. It also serves as a source to identify opportunities for improvement in the quality and delivery of behavioral health services within the DWIHN system.

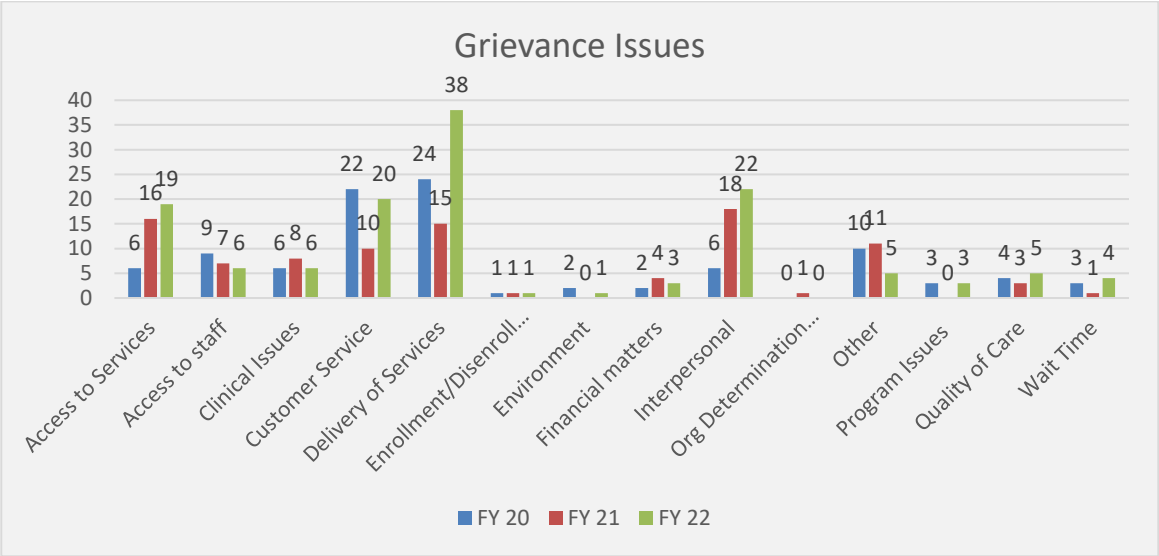
DWIHN's goal is to educate members as well as providers on the importance of promoting expressions of member dissatisfaction as a means of identifying continuous quality improvements in our delivery of behavioral health care services. It promotes members' access to medically necessary, high-quality,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

Quantitative Analysis and Trending of Measures

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

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

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



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

All MI Health Link grievances were resolved within the 30-calendar day timeframe. Of the 205 grievances reported over the last three fiscal years, 94% were resolved within the Customer Service unit at either the Service Provider or DWIHN**.** Those grievances were usually coordinated with other departments for resolution. There were 13 grievances received during the same time frames that were determined not to be in DWIHN jurisdiction and therefore referred to outside entities for further assistance and follow-up which accounts for 6%.

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

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

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

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

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

Provider and Practitioner Satisfaction Survey

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

Quantitative Analysis and Trending of Measures

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

Evaluation of Effectiveness

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

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

Causal Analysis of Provider Survey Results

Staff Availability

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

Timeliness of Response

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

Ease of Reach

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

Knowledge of Staff to Answer Questions and Resolve Issues

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

MI Health Link

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

Credentialing

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

Identified Barriers

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

Opportunities for Improvement

Based upon the Provider Survey results DWHIN will:

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

Cultural and Linguistic Needs

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

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

Evaluation of Effectiveness

Diversity, Equity, and Inclusion

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

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

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

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

Identified Barriers

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

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

Opportunities for Improvement

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

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

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

Practice Guidelines

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

Evaluation of Effectiveness

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

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

Identified Barriers

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

Opportunities for Improvement

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

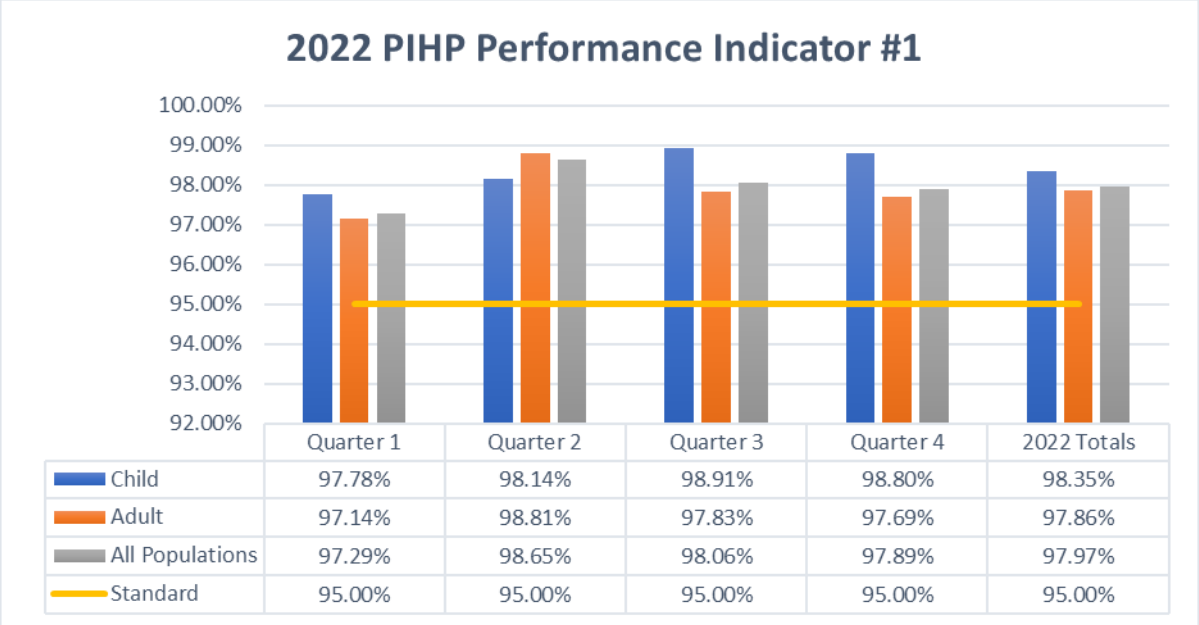
Access Pillar

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

Mission Michigan Based Performance Indictors (MMBPI)

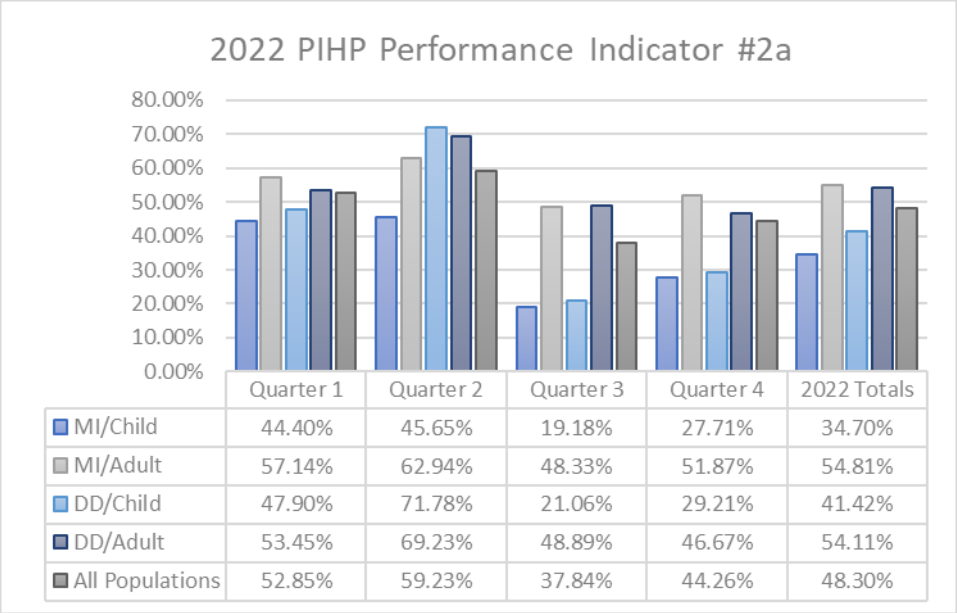
Qualitative Analysis and Trending of Measures

The percentage of persons during 2022 receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. **Goal**: The goal is to attain and maintain performance standards as set by the MDHHS contract. Standard 95% or above. **Results:** FY2022 standard met for all populations. Total population rate (97.97%).



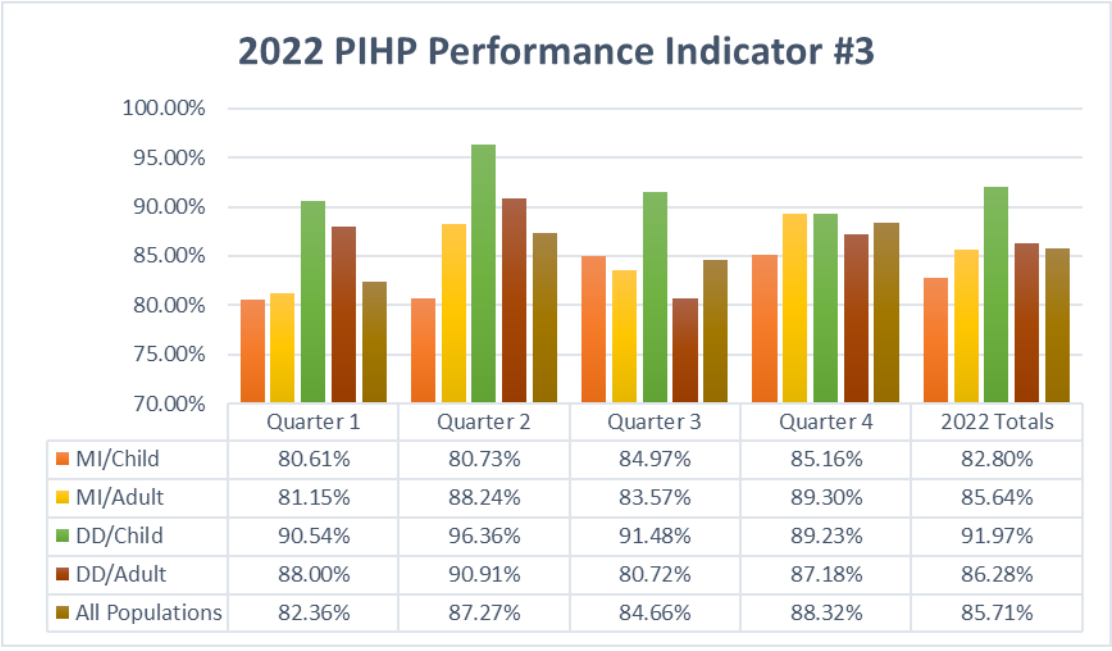
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2022 Totals
Child	97.78%	98.14%	98.91%	98.80%	98.35%
Adult	97.14%	98.81%	97.83%	97.69%	97.86%
All Populations	97.29%	98.65%	98.06%	97.89%	97.97%
Standard	95.00%	95.00%	95.00%	95.00%	95.00%

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



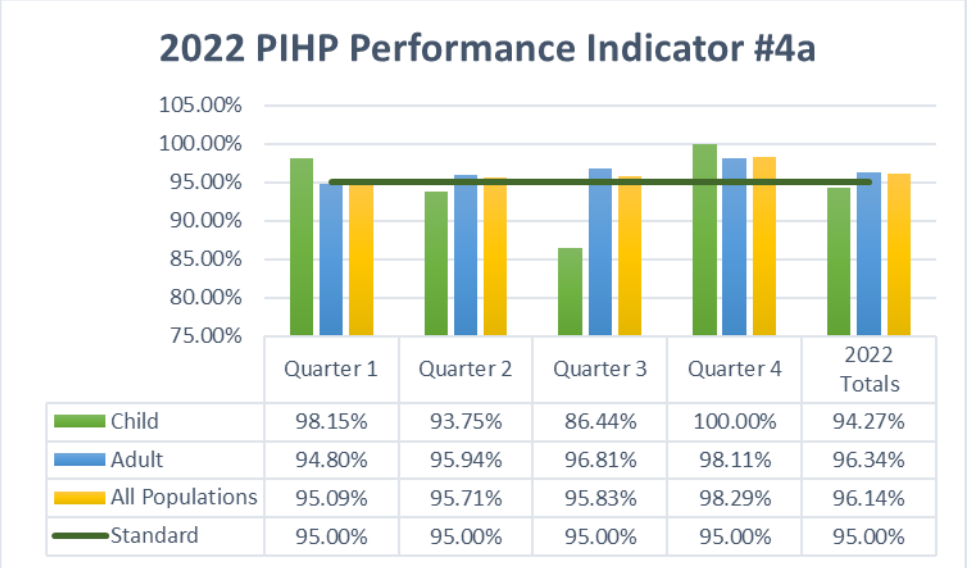
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2022 Totals
MI/Child	44.40%	45.65%	19.18%	27.71%	34.70%
MI/Adult	57.14%	62.94%	48.33%	51.87%	54.81%
DD/Child	47.90%	71.78%	21.06%	29.21%	41.42%
DD/Adult	53.45%	69.23%	48.89%	46.67%	54.11%
All Populations	52.85%	59.23%	37.84%	44.26%	48.30%

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



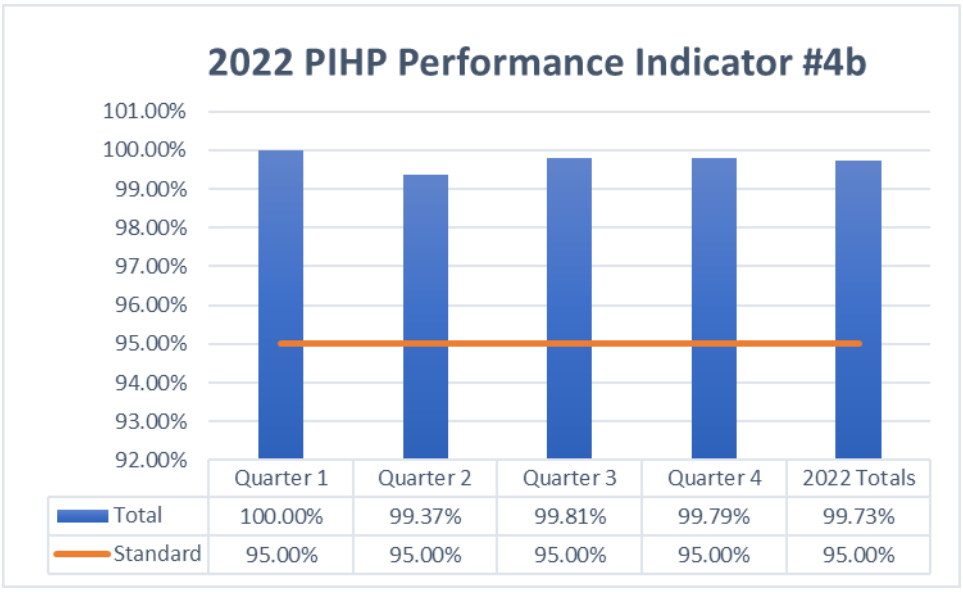
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2022 Totals
MI/Child	80.61%	80.73%	84.97%	85.16%	82.80%
MI/Adult	81.15%	88.24%	83.57%	89.30%	85.64%
DD/Child	90.54%	96.36%	91.48%	89.23%	91.97%
DD/Adult	88.00%	90.91%	80.72%	87.18%	86.28%
All Populations	82.36%	87.27%	84.66%	88.32%	85.71%

The percentage of discharges from a psychiatric inpatient unit during FY2022 who are seen for follow-up care within seven days. **Goal**: The goal is to attain and maintain performance standards as set by the MDHHS contract. Standard 95% or above. **Results**: FY22 standard was not met for the following quarters/populations Q2 Child (93.75%), Q3 Child (86.44%) and Total Child (94.27%) and Q1 Adult (94.80%). Total population rate (96.14%).



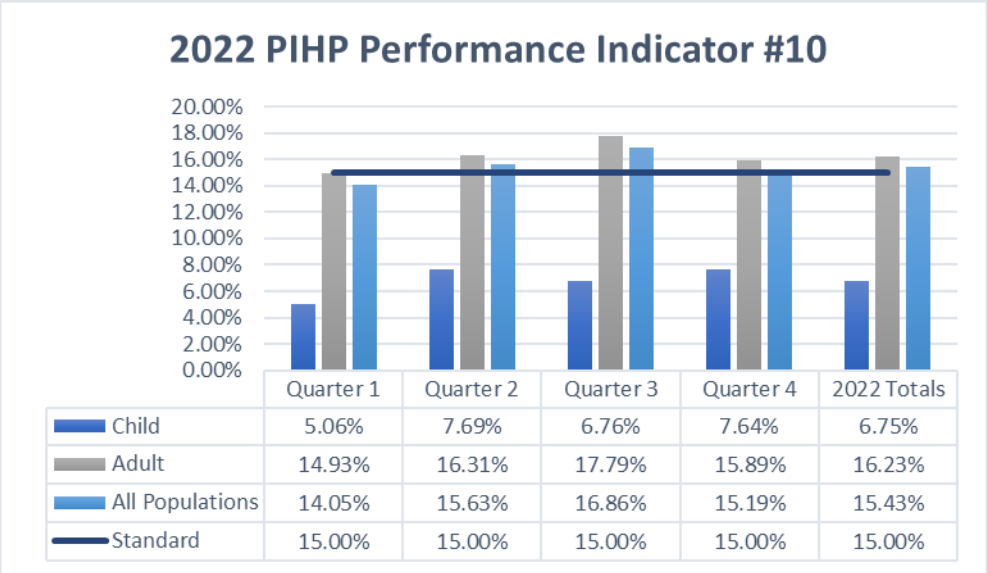
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2022 Totals
Child	98.15%	93.75%	86.44%	100.00%	94.27%
Adult	94.80%	95.94%	96.81%	98.11%	96.34%
All Populations	95.09%	95.71%	95.83%	98.29%	96.14%
Standard	95.00%	95.00%	95.00%	95.00%	95.00%

The percentage of discharges from a Substance Abuse Detox Unit who are seen for follow- up care within 7 days. **Goal**: To achieve MDHHS established benchmark of (95% or above) for four quarters during FY2022. Standard 95% or above. **Results**: FY2022 standard met for all 4 quarters. Total rate (99.73%).



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

The percentage of readmissions of children and adults during FY 2022 to an inpatient psychiatric unit within 30 calendar days of discharge from a psychiatric inpatient unit. **Goal**: The goal is to attain and maintain performance standards as set by the MDHHS contract. Standard 15% or below. **Results:** FY2022 standard met for the children population. Standard not met for the adult population for three out of four quarters Q2 (16.31%), Q3 (17.79%), Q4 (15.89%). Total population rate (15.43%).



Evaluation of Effectiveness

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

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

DWIHN met the standards for PI#1 (Children & Adults), PI#4a (Adult), 4b (SUD) and PI#10 (Children) during FY22. DWIHN provided access to treatment/services for 95% or more members receiving a pre-admission screening for psychiatric inpatient care within 3 hours of a request for service. DWIHN demonstrated an 6.75% performance rate for Children who were re-admitted within 30 days of being discharged from a psychiatric hospitalization. This was a significant improvement in performance from the previous reporting period.

For PI#4a, the percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days (Children) did not meet the 95% standard during Quarter 2 (93.75%) and Quarter 3 (86.44%). Root Cause Analysis (RCA) were requested from four CRSPs during these two quarters where the 95% MDHHS standard was not met. One CRSP reported lack of documentation to determine the outcome of the appointments. They reported that they would be increasing their monitoring efforts and implement a tool to track the data. The second CRSP reported DWIHN's Call Center incorrectly placed the members in the wrong appointment slots and members had to be reassigned. This was discussed with the Call Center and rectified. The third CRSP trained its administration on its scheduling process and restructured staff alignment to improve its reporting. The last CRSP also slightly restructured its processes and made one clinician primarily responsible for the hospital discharge appointments. An additional intervention during FY2022 was individual 30-45 Day meetings with all DWIHN's CRSPs. During each of these meetings, each providers PI#4a data was shared and discussed.

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

Data Analysis

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

Beginning Q3 of FY 2020, separate indicators were developed for PI#2a new persons receiving a completed Biopsychosocial Assessment within 14 calendar days of a non-emergency request for service, PI#2b SUD Services and indicator #3 new persons starting any medically necessary on-going covered service within 14 days of completing a non-emergent Biopsychosocial Assessment. MDHHS has not established a standard for these indicators. The indicators are for persons with mental illness, developmental disabilities, and substance use disorder. During FY2022, the total compliance rates ranged from 37.84% - 59.23% for #2a and 82.36% - 88.32% for #3.

Identified Barriers

DWIHN developed dashboards to measure and track the outcomes for evidence-based practices, which are tied to DWIHN value-based service models. These dashboards will track incentives related to outcomes on four the performance indicators (2a, 3a, 4a and 10). PI#2a continues to demonstrate low scores. Providers are reporting a staffing shortage of intake workers as well as ongoing staff for members. Appointment meetings with DWIHN's clinical team, the Access Center, Quality, and providers' executive leadership have been occurring during all FY2022. These meetings discuss each CRSPs' data. Individual barriers and challenges are discussed with each provider during these meetings.

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

Those areas that perform below the standard DWIHN has developed a workplan to address areas of deficiency to increase the reported scores. Providers are reporting a staffing shortage of intake workers and ongoing staff. Appointment meetings with DWIHN's clinical team, the Access Call Center, Quality, and providers' executive leadership have been occurring in the last month to discuss solutions. Efforts will continue to include working with DWIHN's Access Center unit, IT and PCE to review and identify barriers from scheduling the first appointment to completing the biopsychosocial assessment within 14 calendars. The 2022 overall rate of 48.30% did show a little improvement from the 44.95% rate in 2021.

Efforts to decrease hospital admissions and readmissions have continued to be a challenge. DWIHN seeks to reduce psychiatric inpatient admissions and provide safe, timely, appropriate, and high-quality treatment alternatives while still ensuring members receive the appropriate required care. DWIHN continues its efforts to expand the comprehensive continuum of crisis services, supports, and improve care delivery. Rates continue to decrease slightly from quarter to quarter. The 15.43% rate for 2022 showed continued progress from the 16.20% from 2021.

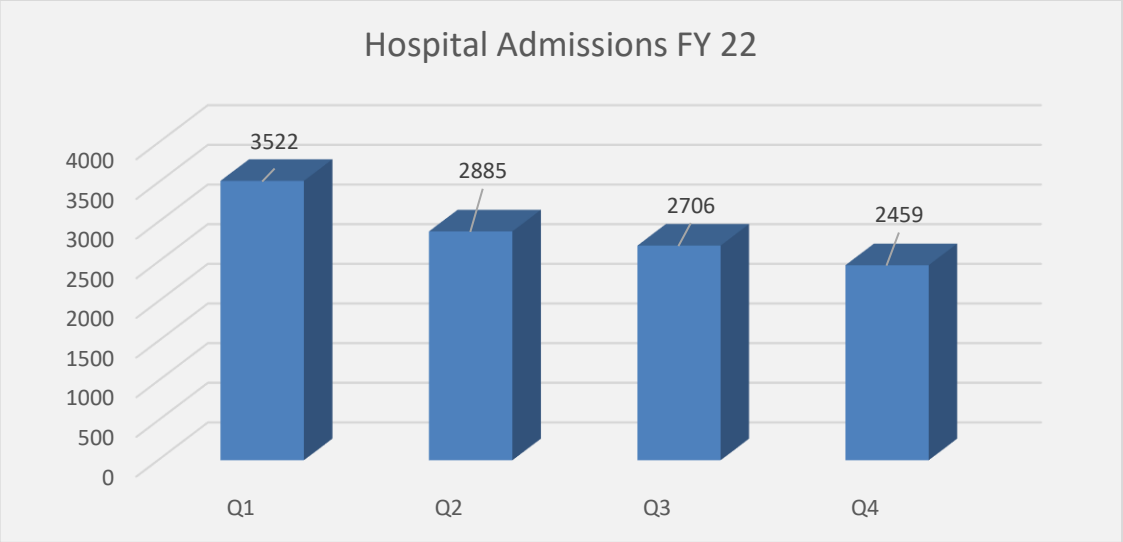
Opportunities for Improvement

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

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

Timeliness of Utilization Management

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



Quantitative Analysis and Trending of Measures

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

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

Alternative Levels of Care

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

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

Identified Barriers

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

Opportunities for Improvement

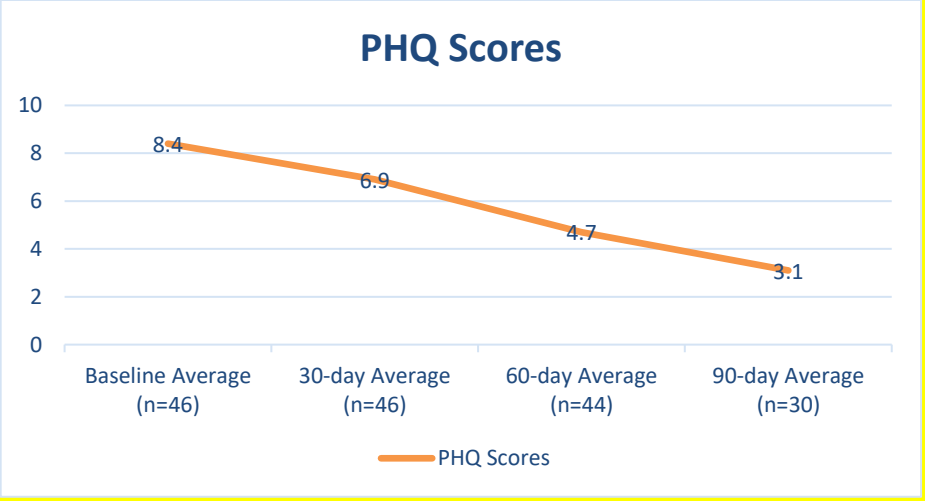
- Implementation of ongoing Authorization, Code, and Modifier training for Provider Network
- Expansion of Electronic Review Process to Crisis Residential and Partial Hospital providers
- Continued implementation of updates to current processes and procedures that reflect 42 CFR requirements including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

Complex Case Management (CCM)

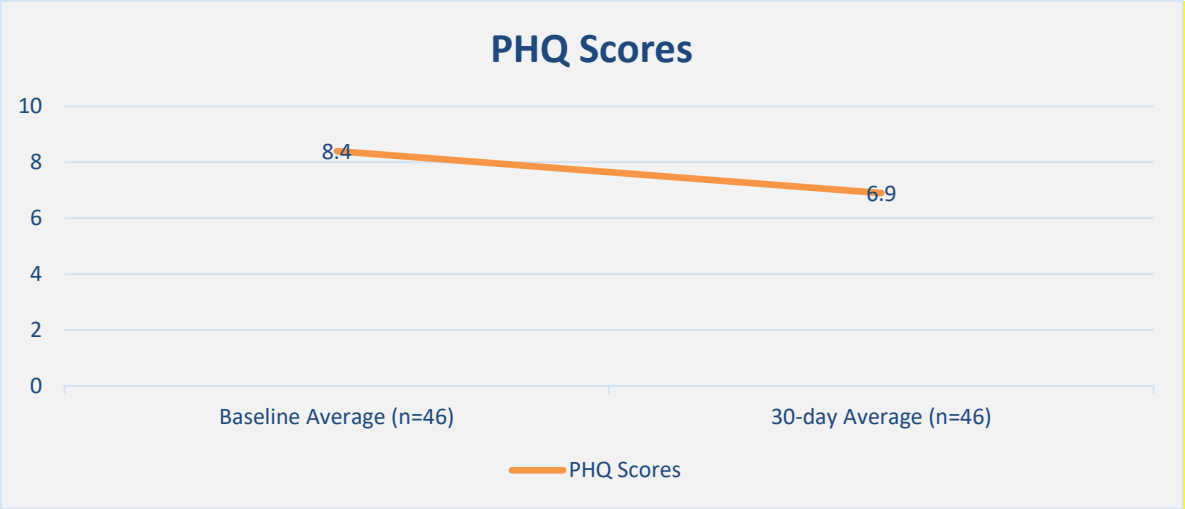
DWIHN utilizes various tools to measure effectiveness of the CCM program and ensure that outcomes are being improved for members served. DWIHN utilizes the evidenced-based assessment tools PHQ-9, PHQ-A, and WHO-DAS. These tools are embedded in the assessment that is completed upon the start of CCM services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

Qualitative Analysis and Trending of Measures

In FY2022, 74 members were enrolled in CCM services. 66 members were enrolled in CCM for at least 60 days and 65 members were enrolled in CCM for at least 90 days during FY2022. During FY2022, information was gathered to identify member rates of symptoms of depression. Depression symptoms were measured using the Patient Health Questionnaire (PHQ-9) for adults (18 and older) and Patient Health Questionnaire – Adolescent (PHQ-A) for children (under 18). The PHQ assessments are embedded in the CCM assessments for adults and children and are completed when the assessment is completed at the start of CCM services and every 30 days thereafter until CCM services end. The higher the score on the PHQ-9/PHQ-A, the greater the symptoms of depression are present. A decrease in PHQ score indicates an improvement in symptoms of depression. PHQ scores were gathered from the CCM assessments that were completed at the start of CCM services and at 30, 60 and 90 days after starting CCM services. PHQ scores were evaluated for members at closure who were open for at least 90 days in the CCM Program during FY2022. Members PHQ baseline scores ranged from 0 to 18, with an average score of 8.4. Members participating in Complex Case Management services demonstrated overall improvement in their PHQ scores, and the improvement increased the longer that the members participated in CCM services. As illustrated in the chart below, the average PHQ scores improved 18% from baseline at 30 days, 31% at 60 days and 34% at 90 days of receiving CCM services.



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



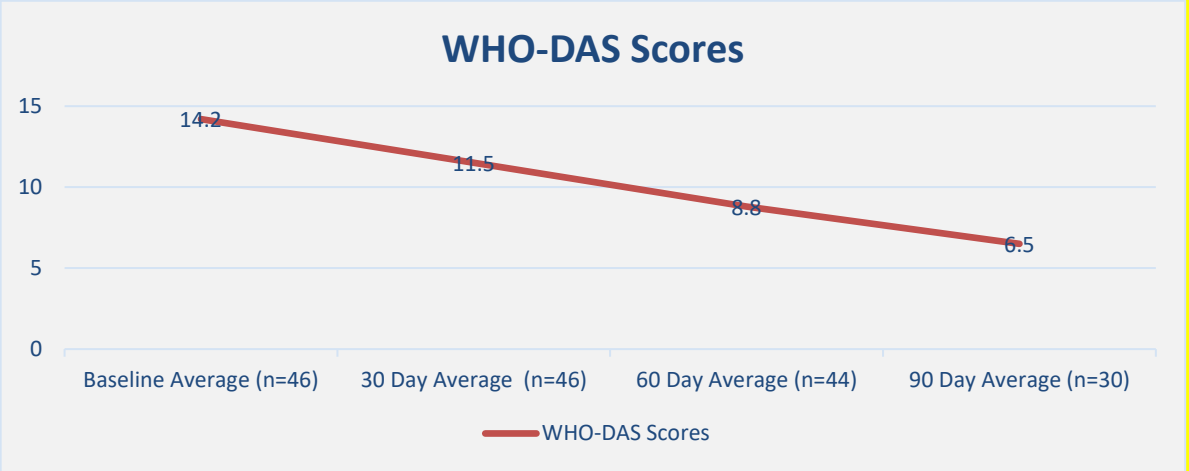
Causal Analysis

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

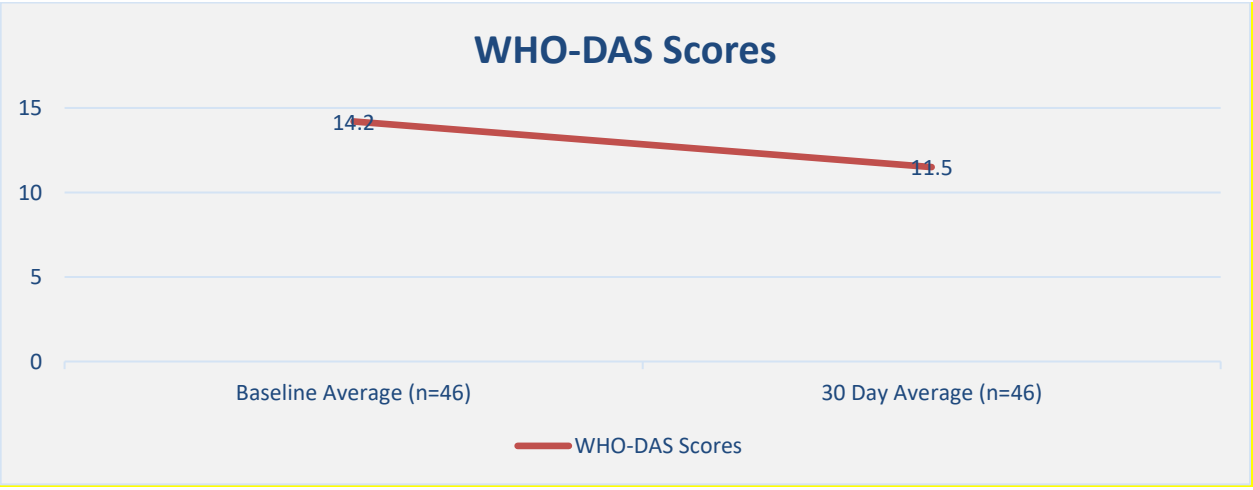
WHO DAS Scores

During Fiscal Year 2022, information was gathered to assess member quality of life using the World Health Organization's Disability Assessment Schedule (WHO-DAS). The WHO-DAS assessment is embedded in the CCM assessment and is completed when the assessment is completed at the start of CCM services and every 30 days thereafter until CCM services end. The higher the score on the WHO-DAS, the greater the level of disability. The WHO-DAS assesses six domains: cognition, mobility, self-care, getting along with others, life activities and participation. Practitioners must be trained to administer this assessment. A decrease in WHO-DAS score indicates an improvement in level of disability. WHO-DAS scores were gathered from the CCM assessments that were completed at the start of CCM services and at 30, 60 and 90 days after starting CCM services. WHO-DAS scores were evaluated at closure for members who were open for at least 90 days in the CCM Program.

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



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

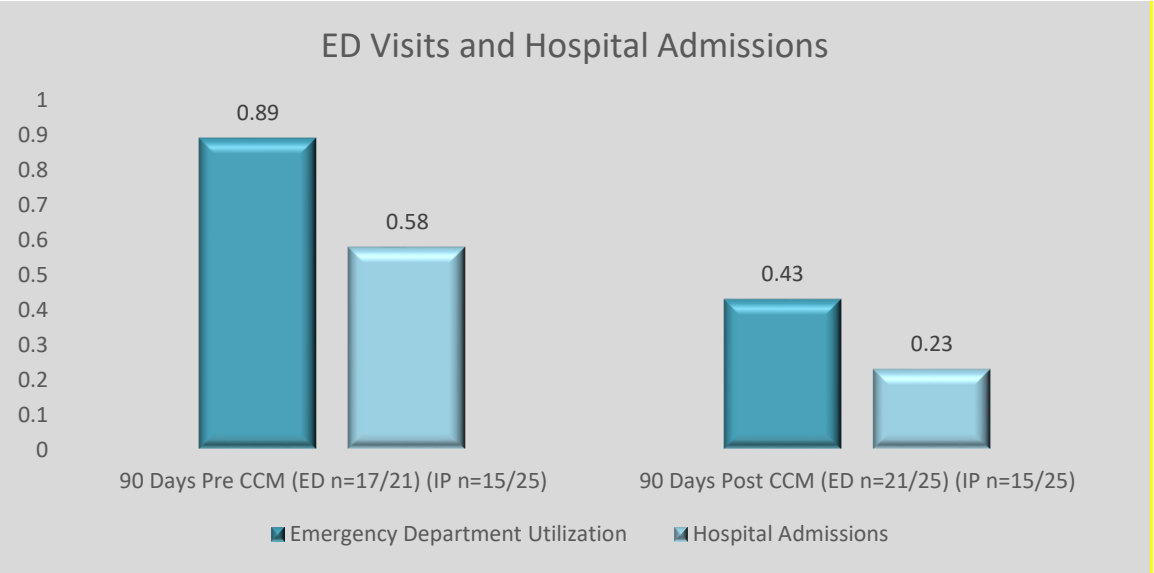


Causal Analysis

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

Emergency Department Utilization and Hospital Admissions

DWIHN analyzed member Admission, Discharge and Transfer (ADT) alerts and DWIHN claims data to measure utilization of Emergency Department and Hospital Admissions 90 days prior to participating in CCM services and 90 days after starting CCM services at closure in FY 2022. Members participating in CCM services showed an average 50% reduction in Emergency Department utilization and average 60% reduction in Hospital Admissions from 90 days prior to 90 days after starting CCM services. Members had an average of 0.89 Emergency Department visits and .58 Hospital admissions during the 90 days prior to receiving CCM services and had an average of .43 Emergency Department visits and 0.23 Hospital admissions during the 90 days after starting CCM services.



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

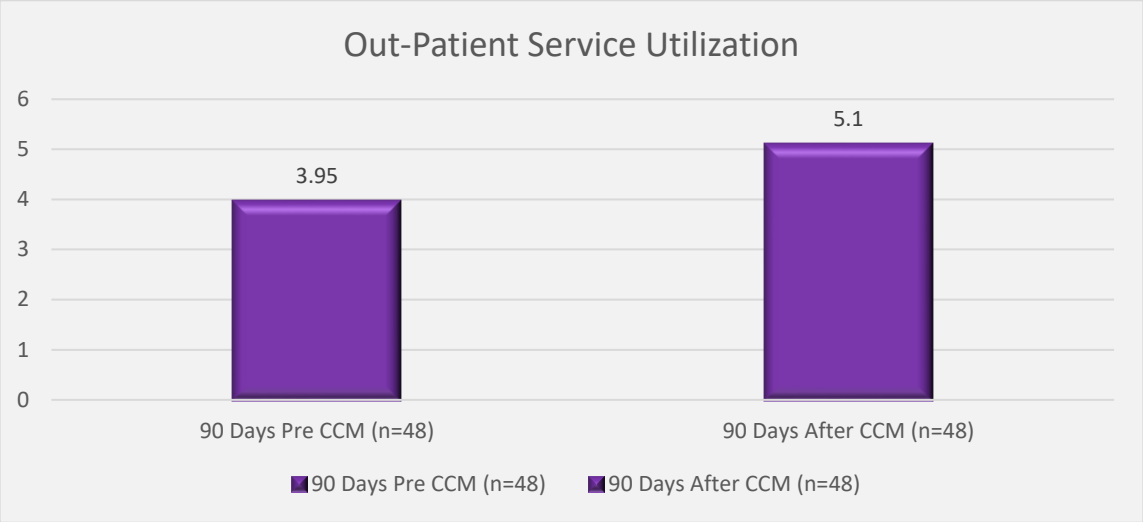
Out of 74 active cases, 19 members were not included in the denominator due to their CCM cases still being active and closing after October 2022 at the time of the review. 25 members were included in the denominator for inpatient hospitalizations. 7 members were not included in the denominator due to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

Causal Analysis

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

Utilization of Out-patient Services

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



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

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

Causal Analysis

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

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

Opportunities for Improvement

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

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

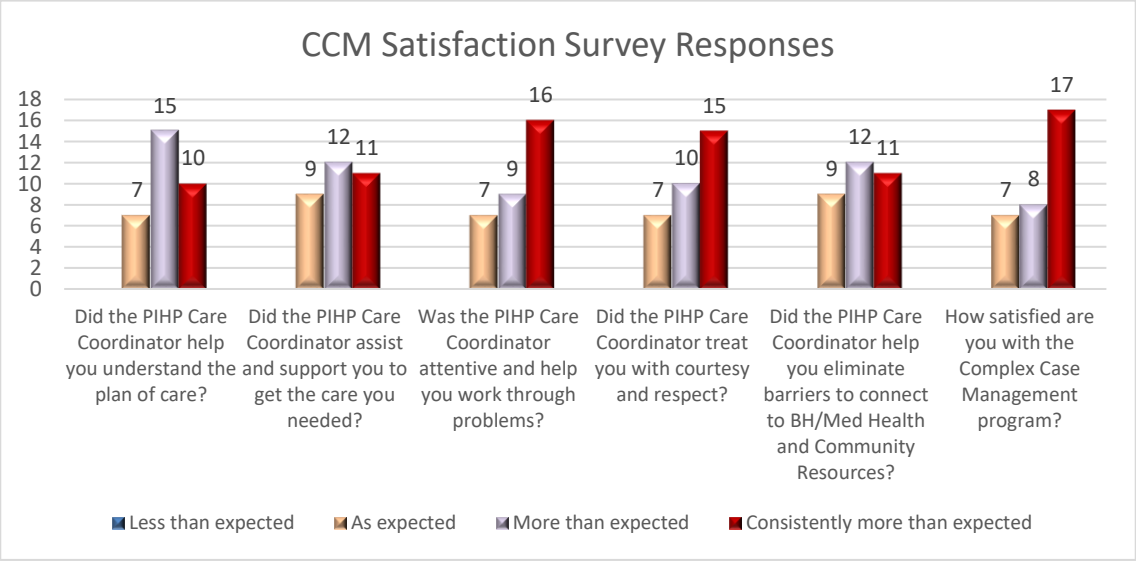
Evaluation of Effectiveness

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

Satisfaction surveys were offered to all members upon closure of Complex Case Management services. Members were informed that completion of the Survey was not mandatory, but that they were encouraged to complete the Survey to provide feedback regarding their experience receiving CCM services. Of the 74 CCM cases opened during FY2022, 58 members had Complex Case Management services closed during FY2022. 32 (55%) Satisfaction Surveys were completed and returned. The goal was to have an 80% satisfaction rate.

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

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



Causal Analysis

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

The results of the FY2022 analysis of CCM services can be compared to the results of analysis completed for FY2021 and FY2020. Comparisons can be made in the areas of PHQ scores, WHO-DAS scores, hospital admissions, behavioral health engagement, and Satisfaction Survey results. The PHQ and WHO-DAS scores were lower than PHQ and WHO-DAS scores at baseline, 30 days, and 60 days after starting CCM services in FY2022 compared to the previous fiscal years. PHQ and WHO-DAS score averages consistently declined the longer members participated in CCM services for all three fiscal years.

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

In effort to increase member sustainability and engagement in out-patient behavioral health services after they are no longer receiving CCM services, the percentage of members who engage in at least two out-patient behavioral health services within 60 days of closure of CCM services will continue to be measured. During FY22, Care Coordinators mailed out educational material to members about the benefits of attending Behavioral Health Outpatient appointments within 2-3 weeks after case closure. Care Coordinators also contacted members around 30 days post case closure for follow up to encourage outpatient appointment attendance. Care Coordinators will also contact members CRSP to speak with the assigned Case Manager or Supports Coordinator to ensure members barriers are being addressed and care team is working with member to increase outpatient visit participation.

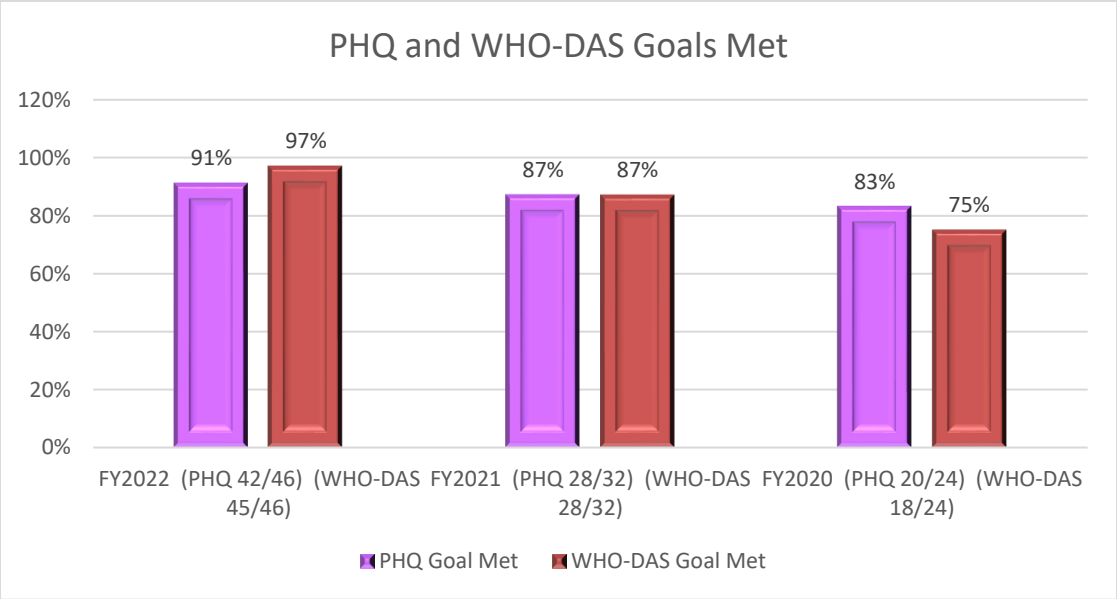
Qualitative Analysis and Trending of Measures

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

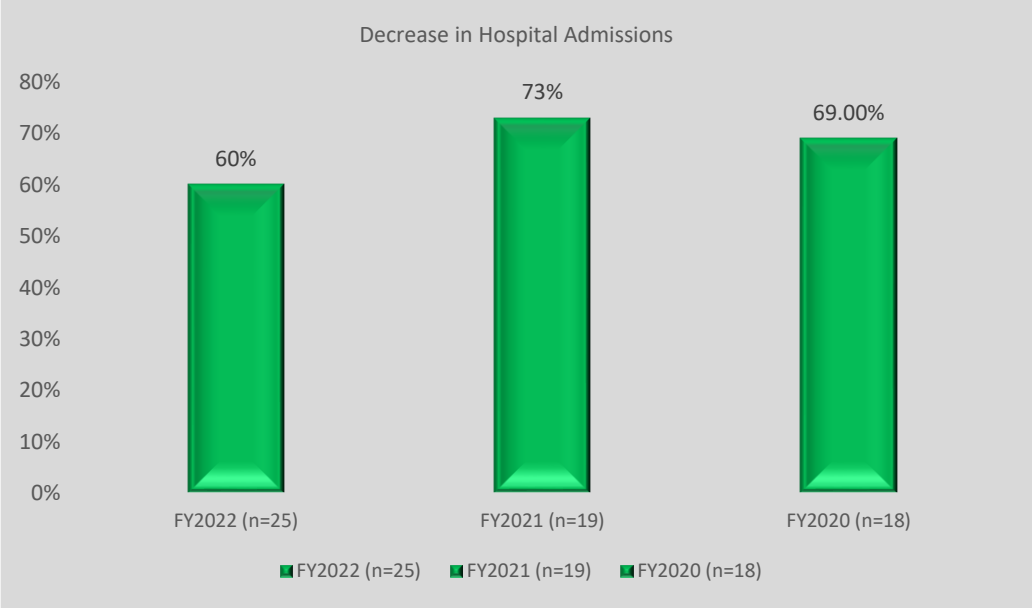
Members showed overall improvement in the areas analyzed to measure effectiveness of, and satisfaction with, the Complex Case Management program during FY2022.

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

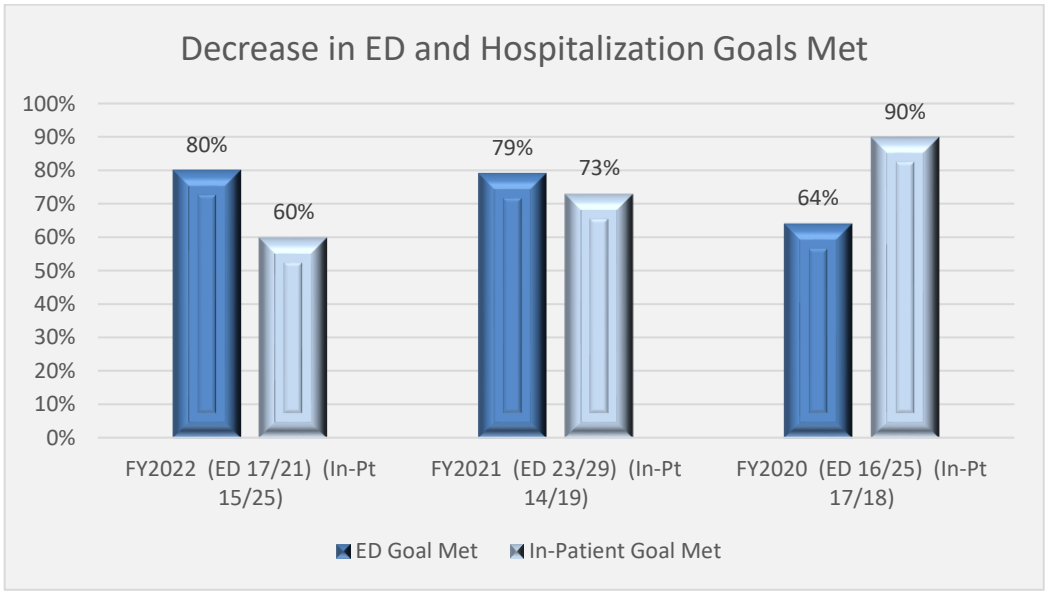
The number of members who met the goal of a 10% reduction in their PHQ and WHO-DAS scores at time of closure from CCM services increased in FY2022 compared to the previous fiscal years.



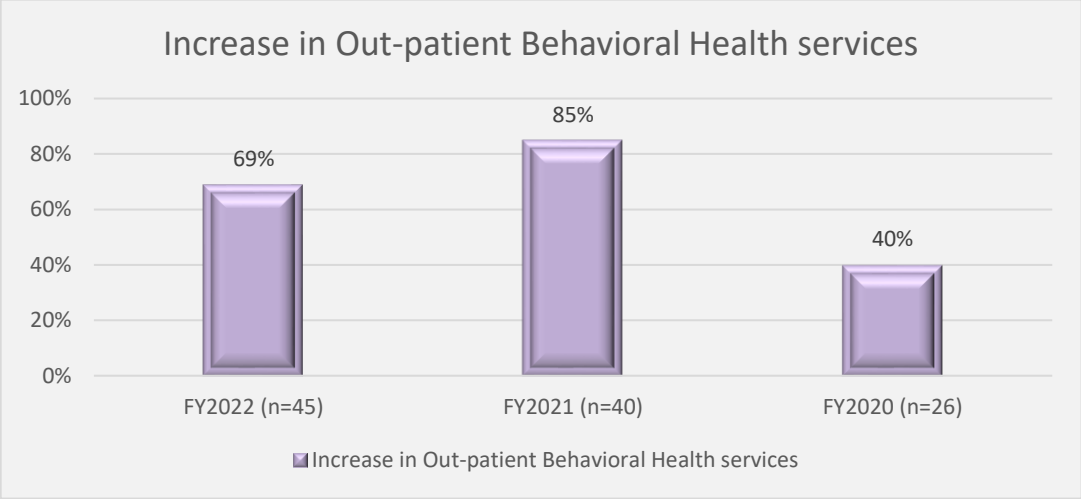
The average percentage of decreased hospital admissions from 90 days prior to starting CCM services to 90 days after starting CCM services decreased from FY2022 to the previous fiscal years, however, the percentage of decrease in hospital admissions was highest in FY2021.



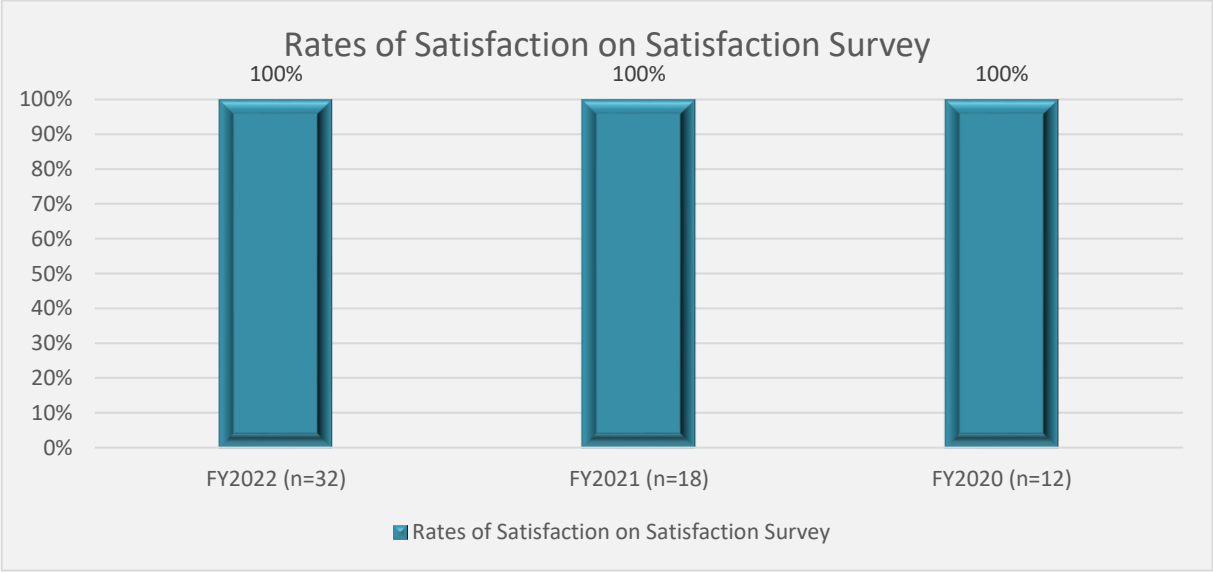
The percentage of members who met the goal of experiencing a 10% decrease in Emergency Department utilization was highest in FY2022. The goal of Emergency Department utilization increased with the passing of each fiscal year. The percentage of members who met the goal of experiencing a 10% decrease in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

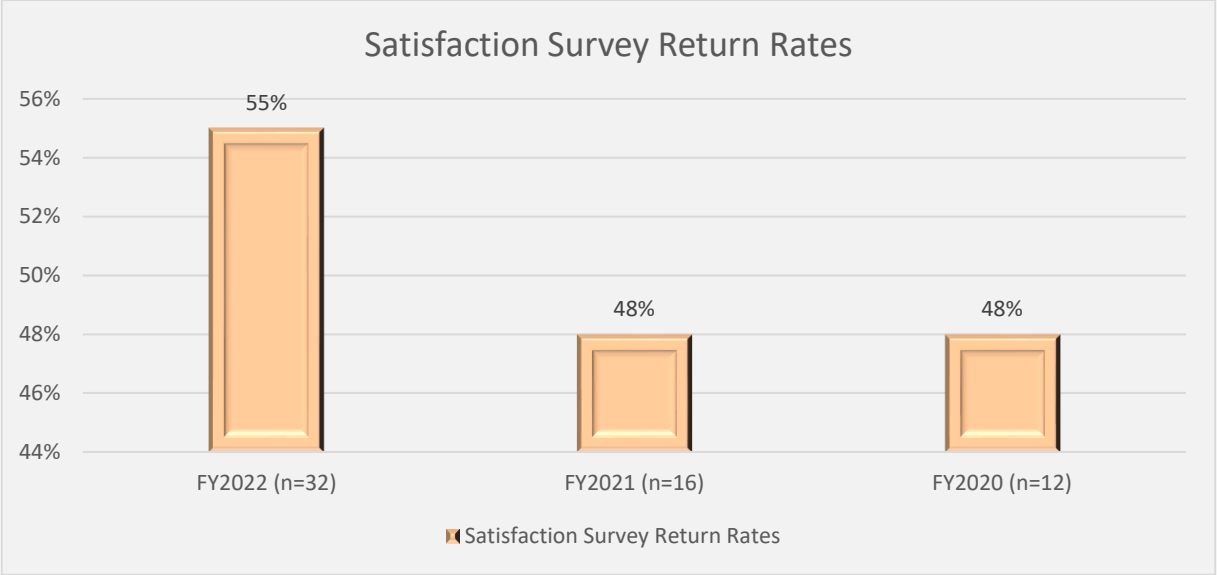


The percentage of members who experienced an increase in out-patient services from 90 days prior to starting CCM services to 90 after starting CCM services decreased from FY2022 to FY2021 but has increased from FY2020.



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





Identified Barriers

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

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

Opportunities for Improvement

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

- Improve medical and/or behavioral health concerns and increase overall functional status as well as improve overall quality of life as evidenced by an overall 10% improvement in PHQ scores and an overall 10% improvement in WHO-DAS scores at CCM closure for members enrolled for at least 90 days.
- Provide early intervention for members appropriate for Complex Case Management to prevent recurrent crisis or unnecessary hospitalizations as evidenced by an overall 10% reduction in Emergency Department (ED) utilization and an overall 10% reduction in hospital admissions from 90 days prior to receiving CCM services to 90 days after receiving CCM services for members at closure who were enrolled for at least 60 days.
- Increase participation in attending out-patient appointments as evidenced by an overall 10% increase in out-patient behavioral health services from 90 days prior to receiving CCM services to 90 days after receiving CCM services for members at closure who were enrolled for at least 60 days.
- Improve participation in the number of members who attended two out-patient behavioral health services within 60 days of starting CCM services who were open for at least 60 days and closed as of October 2022 as evidenced by an overall 10% increase in participation.
- Improve 80% or greater member satisfaction scores for members at closure who have received CCM services.
- Continue to place greater emphasis on developing, reviewing, and updating crisis plans with members to reduce utilization of Emergency Department services.
- Continue working with current care team to increase members participation in Follow up after Hospitalization appointments as well as attendance for regular outpatient appointments.
- Continue to offer a $10 Walmart Gift Card to all members who complete and return a CCM Satisfaction Survey.
- Continue to contact any members who have not returned their satisfaction survey within 30 days of the satisfaction survey being mailed to encourage them to complete by telephone.
- Continue to emphasize the importance of familiarization with crisis plans and becoming more knowledgeable of managing conditions. Care Coordinators will also emphasize the importance of member attendance and participation at outpatient behavioral health appointments.
- Continue to work with members to address barriers of attending appointments, including arranging transportation, rescheduling appointments to accommodate member schedules, and connecting members to service providers of members preference.
- Continue to contact members assigned Clinically Responsible Service Provider (CRSP) for increased coordination to improve member attendance for aftercare appointments.

Access Call Center

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

Qualitative Analysis and Trending of Measures

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

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

Opportunities for Improvement

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

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

Crisis Services

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

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

Crisis Data

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

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

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

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

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

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

Crisis Residential Services (CRU)

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

Causal Analysis

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

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

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

Opportunities for Improvement

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

Quality Pillar

Provider Network

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

Quantitative Analysis and Trending of Measures

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

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

CRSP Self-monitoring Audits

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

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

1915(c) Waiver Reviews

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

Monitoring of B3 Service Providers

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

Evaluation of Effectiveness

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

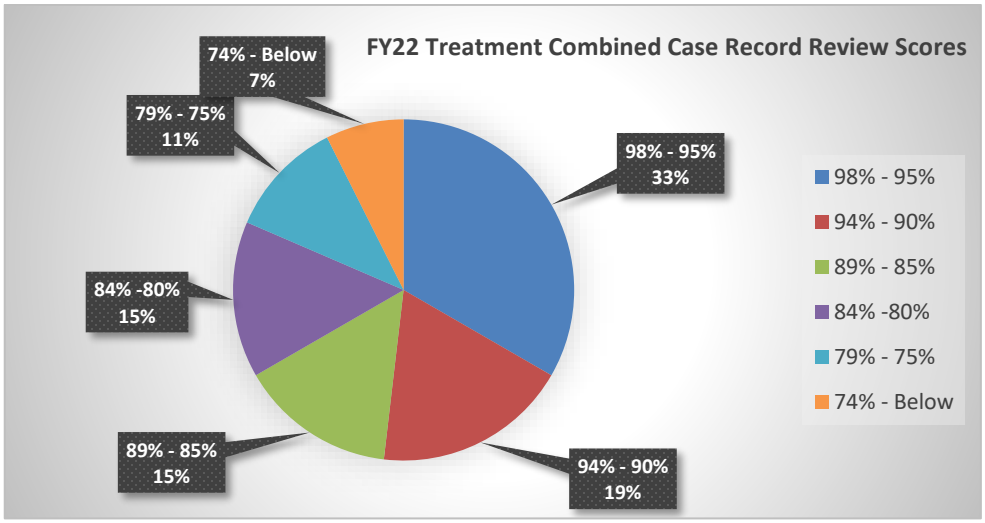
Quality improvement staff determined the eligibility of at least 1492 direct care staff that worked with the member during the time of the claims being audited, based on Medicaid's Provider Qualifications requirements. This is accomplished by verifying that the individual is at least 18 years of age;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

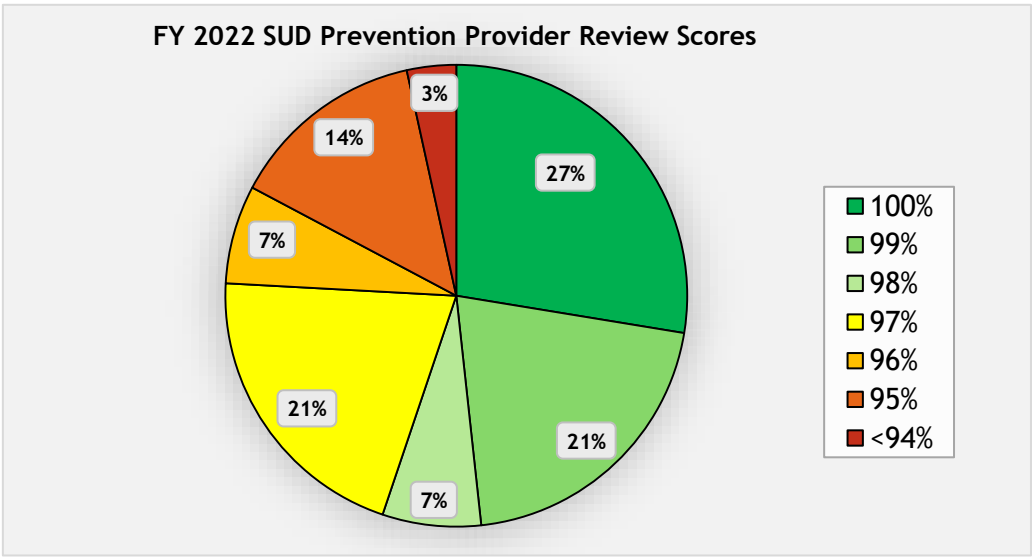
During FY 2021-20222, the DWIHN Quality Team and other units provided six system-wide trainings on Home Community Based Services (HCBS), the Habilitation Supports Waiver (HSW), Children's Waiver Program (CWP) and the Waiver for Children with Serious Emotional Disturbance (SEDW), and Individual Plan of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

Substance Abuse Disorder (SUD) Results

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

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





Naloxone Initiative

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

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

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

Opportunities for Improvement

- Continue to monitor the network to determine if additional contracts need to be executed to provide more access to services.
- Engage with providers to expand the behavioral health providers including diverse ethnic and cultural service. Further identification of these providers will provide a more personalized member experience.
- Increase monitoring of the providers corrective active plans.
- Provide technical assistance as needed.
- Ensure providers are self-monitoring through quarterly reviews.
- Monitor the information in the Autism Dashboard to provide continuous feedback to the providers.

Autism Results

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

Evaluation of Effectiveness

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

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

Opportunities for Improvement
Improved access point for referral process

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

Verification of Services

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

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

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

Opportunities for Improvement

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

Critical/Sentinel, Unexpected Deaths, and Risk Reporting

The following data represents fiscal years 2018 through 2022 system reports of Critical/Sentinel events gathered from the Clinically Responsible Service Provider (CRSP) reports into the Mental Health Wellness Information Network (MH-WIN). The reporting represents only those events entered the system; however, of important note is the underreporting throughout the system based on the monitoring and review of Quality Performance Improvement findings.

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

Quantitative Analysis and Trending of Measures

In FY2022, the Quality Performance Improvement Team processed 1,915 Critical/Sentinel Events, which is a decrease of (39.3%) from FY2021. This decrease is attributed ongoing training with the Provider Network on correct and accurate reporting. Of those incidents, the SERC reviewed and analyzed over eight-hundred and thirty (830) critical incidents. Critical Incidents include arrests, deaths, emergency medical treatment due to injuries or medication errors, and hospitalizations due to injuries or medication errors. If a CI is determined to be a Sentinel Event, DWIHN requests that a Root Cause Analysis (RCA) be conducted by the Provider. The SERC reviews and approves the RCAs. In FY2022, the highest category being reported is Deaths (492); Serious Challenging Behavior (437); the next top category is Physical Illness Requiring Hospitalization (239); and the lowest number of critical incidents is Medication Error (14).

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

5-YEAR AGGREGATE DATA

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

Evaluation of Effectiveness

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

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

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

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

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

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

- If Coordination of Care letters are signed, what then is the barrier to receiving hospital discharge documentation?
- Are providers offering services to help members to get access to care and following up with appointments after hospitalizations?
- What can we implement in MH-WIN to have easy access to this information without having to go through the provider?
- How can we integrate the member's health care to not just focus on getting services to mental health, but physical health as well?

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

Patterns, Trends, and Recommendations:

Substance Use Disorder

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

Behavioral Health

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

Identified Barriers

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- What can we implement in MH-WIN to have easy access to this information without having to go through the provider?

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

Opportunities for Improvement

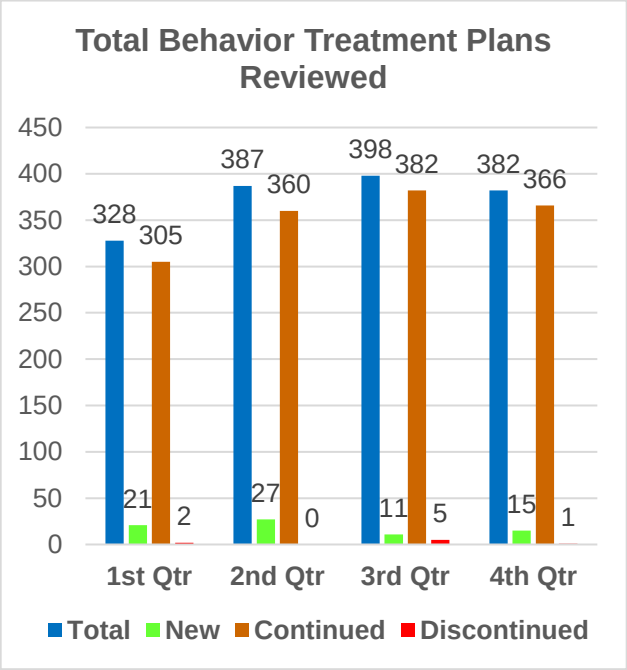
- Development of training modules for the entire network and members on "Choking Hazards" to include instructions on the Heimlich Maneuver.
- Standards and instructional manual on "Eating Guidelines" for members with plans that require guidance and support in eating meals.
- Positioning the committee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

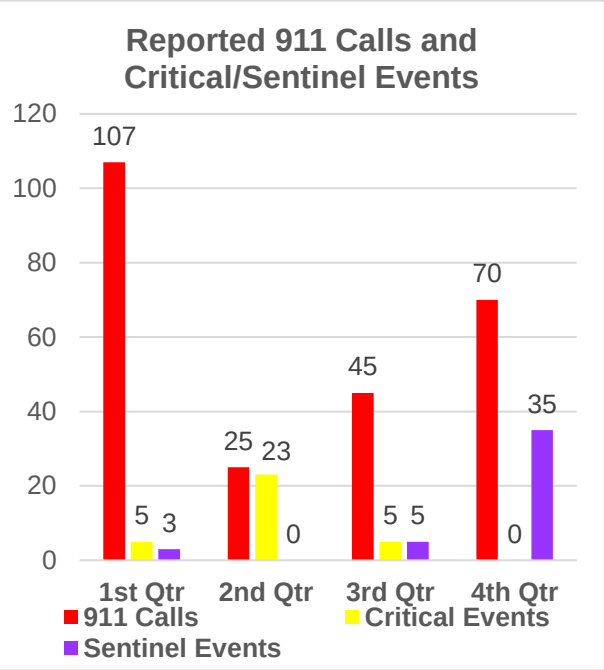
Behavioral Treatment Review

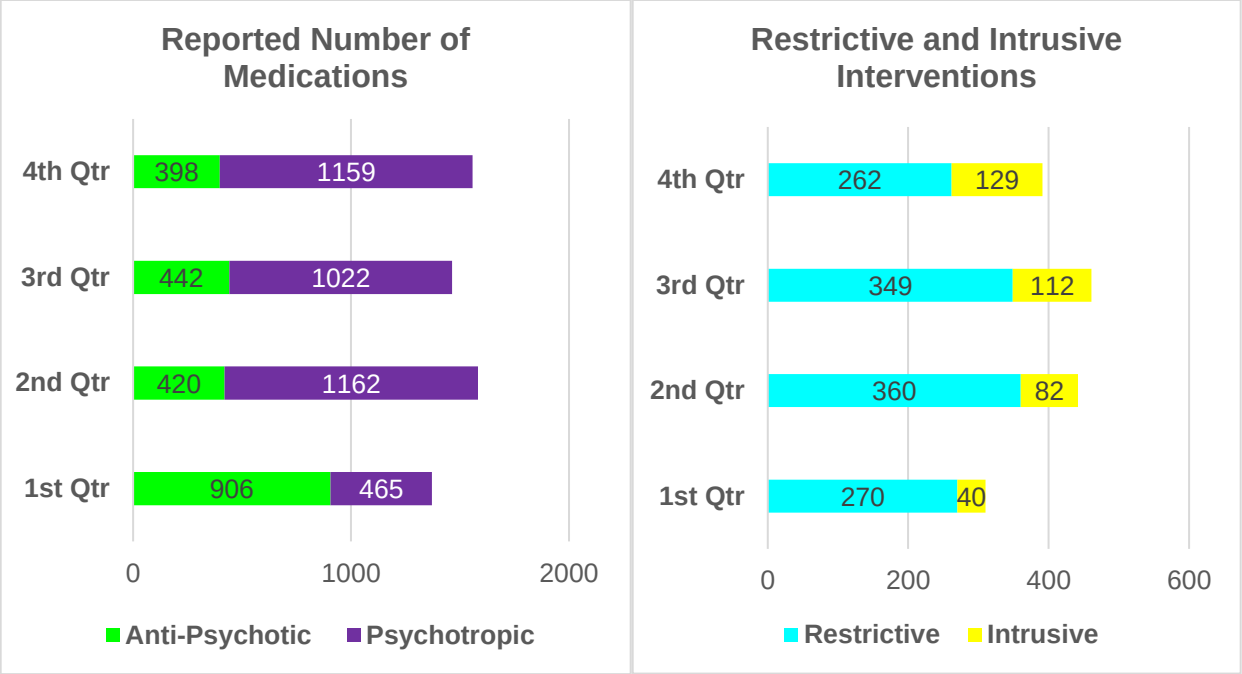
The QAPIP quarterly reviews analyses of data from the Behavior Treatment Review Committee (BTRC) where intrusive or restrictive techniques have been approved for use with members and where physical management has been used in an emergency. The data track and analyze the length of time of each intervention.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

Quantitative Analysis and Trending of Measures

In FY22, DWIHN BTPRC reviewed 1,495 members on Behavior Treatment Plans which is an increase of 334 (28.76%) from the previous year. The data below depicts all the use of intrusive and restrictive techniques, 911 calls/critical events and use of medication per Individual receiving the intervention. The charts below illustrate the BTAC Summary of Data Analysis FY22.







Evaluation of Effectiveness

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

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

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

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

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

Children's Initiatives

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

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

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

Mental Health Care: Putting Children First Initiative

Access	Prevention	Crisis Intervention	Treatment

These initiatives include:

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

Performance Improvement Projects (PIPs)

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

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

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

Quantitative Analysis and Trending of Measures

The State of Michigan specifications for this measure for 30 day is 70% for children 6-17 and 58% for adults 18-64. DWIHN has chosen to use the State of Michigan measures as a comparison goal. DWIHN 2020 rate for 30 days for ages 6-17 is 62.96%. DWIHN 2021 rate for 30 days for ages 6-17 is 66.32%. This is a 3.36 percentage point increase. DWIHN 2020 rate for 30 days for ages 18-64 is 48.74%. DWIHN 2021 rate for 30 days for ages 18-64 is 46.67%. This is a 2.07 percentage point decrease. DWIHN will continue to compare its goal to the State of Michigan goal. The State of Michigan specifications for measure for 7 days is 45% for 6 years and older. DWIHN has chosen to use the State of Michigan measures as a comparison goal. DWIHN 2020 rate for 7 days for ages 18-older is 29.14%. DWIHN 2021 rate for 7 days for ages 18-older is 28.33%. This is a 0.81 percentage point increase. DWIHN will continue to compare its goal to the State of Michigan goal of 45%. DWIHN is in the process of purchasing Quality Compass to run customer reports that will report HEDIS percentile to determine where we fall, 25th, 50th, 75th or 95th percentile.

FUH 30 Day

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

FUH 7 Day

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

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

Barriers identified by IPLT

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

Barriers Identified by Contracted Providers

- When facility called for seven-day follow-up appointment for member often there is no appointment available within the timeframe at member's preferred provider site. (Referral access)
- Develop written educational material for members regarding importance of follow-up appointments, providing oral and written information.
- Improve ability for member to get appointments within timeframes required.
- Improve access to appointments with contracted behavioral health providers/practitioners within timeframes required.
- Improve process of who and how follow-up appointments are scheduled.
- Identification of ways that member can be reminded of appointments.
- Identify a process to address transportation issues when member is not able to schedule their own transportation with Medicaid vendor or not scheduling at least 5 days in advance of appointment and reminding transportation vendor to pick up member.
- Improve members knowledge regarding importance of follow up with a behavioral health practitioner.
- Improve appointment time conflicts with other activities member has by addressing appointment availability times and exploring virtual technology(telehealth)
- Improve Member involvement in discharge planning and follow-up.
- Improve Practitioners and Providers knowledge regarding the importance to seeing a member in follow-up within 7 days of discharge.
- Providing information to members both verbally and written using simple language that is focused and using teach back method.

Causal Analysis

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

Key Interventions

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

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

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

Identified Barriers

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

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

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

Opportunities to Improvement

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

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

Goal: Improving Adherence to Antipsychotic Medications for Individuals with Schizophrenia

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

Quantitative Analysis and Trending of Measures
Michigan HSAG 2021, reports the adherence to antipsychotic medication average health plan result for 2020 was 68.17%, putting them in the 75th percentile for this measure. DWIHN result for 2020 was 79.34% which is above the 75th percentile. DWIHN's goal is to be in the 95th percentile. In 2021 DWIHN results have trended down to 46.92%. This is a 32.42 percentage point decrease.

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

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

Barriers identified by IPLT

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

Opportunities for improvement

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

Committee Participation

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

Identified Barriers

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

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

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

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

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

Performance Monitoring

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

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

Identified Barriers

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

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

Opportunities for Improvement

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

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

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

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

Quantitative Analysis and Trending of Measures

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

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

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

Evaluation of Effectiveness

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

Clinical literature search was initially used to identify barriers in January 2021 to identify interventions to address any opportunities to improve the measure, NCQA: https://www.ncqa.org/hedis/measures/diabetes-and-cardiovascular-disease-screening-and-monitoring-for-peoplewith-schizophrenia-or-bipolar-disorder.
To determine the root cause for DWIHN's current performance, the following barriers have been identified:

- Lack of knowledge/consistent practice among providers of the prevalence of diabetes in this population and the need for screening.
- Physician belief that diabetes prevalence is low in their practice.
- Lack of knowledge among providers of recommendations for screening for diabetes in members with schizophrenia and bipolar disorder.
- Lack of knowledge among providers of HEDIS measure or DWIHN's HEDIS measure results.
- Lack of knowledge by enrollee/members that they are at risk for diabetes if on atypical antipsychotic medication.
- Lack of follow-through by enrollee/members to have labs drawn when ordered.
- Lack of knowledge by enrollee/members on importance of healthy eating and exercise to help control any weight gain associated with antipsychotic medication.
- Enrollee/Members may not be linked to a primary care physician or not consistent in follow up.

Identified Barriers

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

Opportunities for Improvement

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

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

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

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

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

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

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

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

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

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

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

- Poor instruction by the clinician regarding antidepressant medication including side effects, how to take, purpose of medication.
- Medication related side effects.
- Enrollee/members forgetting to take their medication.
- Emotional concerns of enrollee/members such as fears that antidepressant medications will alter their personality.
- Lack of follow-up care
- Lack of knowledge by the enrollee/member of the importance of medication compliance
- Clients were also found to have difficulty getting to their appointments to obtain medication. Causing a delay with medication fills.
- Feedback was also elicited from contracted facilities in January 2021 and these barriers were identified: clients miss appointments, shortage of staff causing increased caseloads.
- DWIHN has a high transient population causing missed follow up appointments.
- Poor instruction by the clinician regarding antidepressant medication including side effects, how to take, purpose of medication.
- Improve members knowledge regarding importance of taking medication as prescribed.
- Identification of ways that member can be reminded of medication.
- Providing information to members both verbally and written using simple language that is focused and using teach back method.
- Identify a process to address transportation issues when member is not able to schedule their own transportation with Medicaid vendor or not scheduling at least 5 days in advance of appointment and reminding transportation vendor to pick up member.
- Improve ability for member to get appointments at a convenient time and date.
- Identify a process that address members financial status to determine client's qualifications for assistance with medication payments.

Opportunities for Improvement

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

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

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

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

Quantitative Analysis and Trending of Measures

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

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

Evaluation of Effectiveness

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

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

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

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

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

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

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

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

Identified Barriers

The noted barriers include:

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

Opportunities for Improvement

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

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

Quantitative Analysis and Trending of Measures

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

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

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

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

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

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

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

Opportunities for Improvement
To meet the member needs:

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

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

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

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

Quantitative Analysis and Trending of Measures

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

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

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

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

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

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

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

Evaluation of Effectiveness

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

Identified Barriers

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

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

Opportunities for Improvement

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

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

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

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

Quantitative Analysis and Trending of Measures

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

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

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

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

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

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

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

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

Evaluation of Effectiveness

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

Identified Barriers

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

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

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

Quantitative Analysis and Trending of Measures

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

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

DWIHN set a goal of 80% or greater for all the questions on the practitioner satisfaction survey and for questions scoring under this goal an action plan is required. Although DWIHN saw improvements in the satisfaction of communication between psychiatry and SUD providers and Supports Coordinators and Direct Care Workers, the 80% goal set by DWIHN nor the State Performance Measure goal of 95% set by the state of Michigan for the PIHP's for Continuity and Coordination of Care was met. This may be attributed to a shutdown of face-to-face services mandated except for the most critical services, to keep all persons safe from the virus. Tele-health services were provided to the persons that we served in an expedient and efficient manner. Staff were expected to provide these services from a home environment, with some limited staff continuing to provide crisis and/or medical services from the office, when it was impossible to do so via telehealth. Providers receiving evidence of requested documentation from the PCP, Natural and other Community Supports.
which is still considerably.

Evaluation of Effectiveness

DWIHN worked with the following health plans in FY2021: AmeriHealth, Aetna, Michigan Complete, Molina and HAP Midwest. The Agency Profile within I-Dashboards indicates 5,864 MI Health Link members were enrolled with DWIHN in FY2021, compared to the 5,271 members reported as enrolled last fiscal year. MI Health Link enrollees are a significantly small subset of DWIHN members (7%). There were 616 MI Health Link (MHL) members hospitalized during FY2021. During FY2020, DWIHN managed 560 community hospital admissions of MI-Health Link members. 92 MHL members were readmitted in FY2020 and in FY2021, there were 58 members who were readmitted within 30 days of discharge. The number of readmissions decreased by (47%) in FY2021. Molina saw the highest number of admissions during FY2021 at 251, (40%) of the DWIHN MHL admissions for FY2020. AmeriHealth had the lowest number with 60 members admitted, followed by MI Complete, with 62 admissions.

Identified Barriers

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

Opportunities for Improvement

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

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

Workforce Pillar

DWIHN strives to provide continuous support to the community through educational outreach and engagement while placing an emphasis on recovery and supporting resilience. Workforce Development and Retention efforts continue to focus on maintaining and expanding a centralized training program for health professionals. Focusing on the development of new professionals is integral to achieving a collaborative integrated healthcare system. The Health Resources and Service Administration have recognized the innovative university and community partnership model nationally and regionally.

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

Quantitative Analysis and Trending of Measures

During the past fiscal year, the country has grappled with challenges of workforce retention which causes a burden on the ability to develop a workforce that is able to implement evidence-based and best practice methods. Prior to COVID19, behavioral health workforce systems had a significantly high turnover rate. In efforts to address historical and future workforce retention challenges, the department continued efforts to focus on maintaining and expanding a centralized training program for allied health professionals. Focusing on the development of new professionals is integral to achieving a collaborative integrated healthcare system. The Health Resources and Service Administration recognized the innovative university and community partnership model nationally and regionally. Recently, a publication that shares the outcomes of the training model has been accepted for publication.

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

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

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

Future Workforce Initiatives

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

Credentialing and Re-Credentialing

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

Quantitative Analysis and Trending of Measures

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

Evaluation of Effectiveness

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

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

Workforce Shortages

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

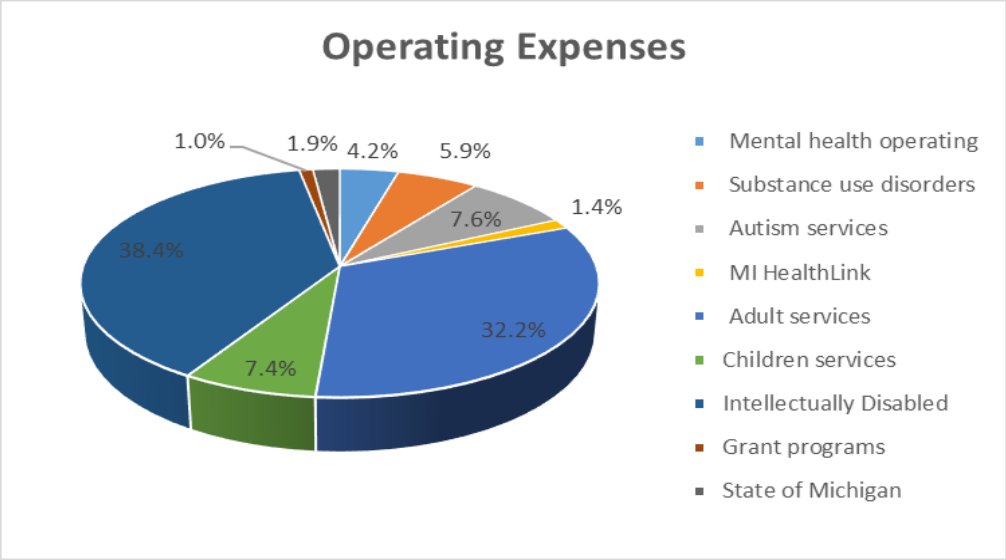
1. Covid-19 resulted in many staff resignations
    - More options to work from home
    - People changing career paths
2. Shortage of behavioral health workforce particularly: Master's Level Licensed Social Works, psychiatrists and Nurses.
    - Organizations are pulling from the same limited pool of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

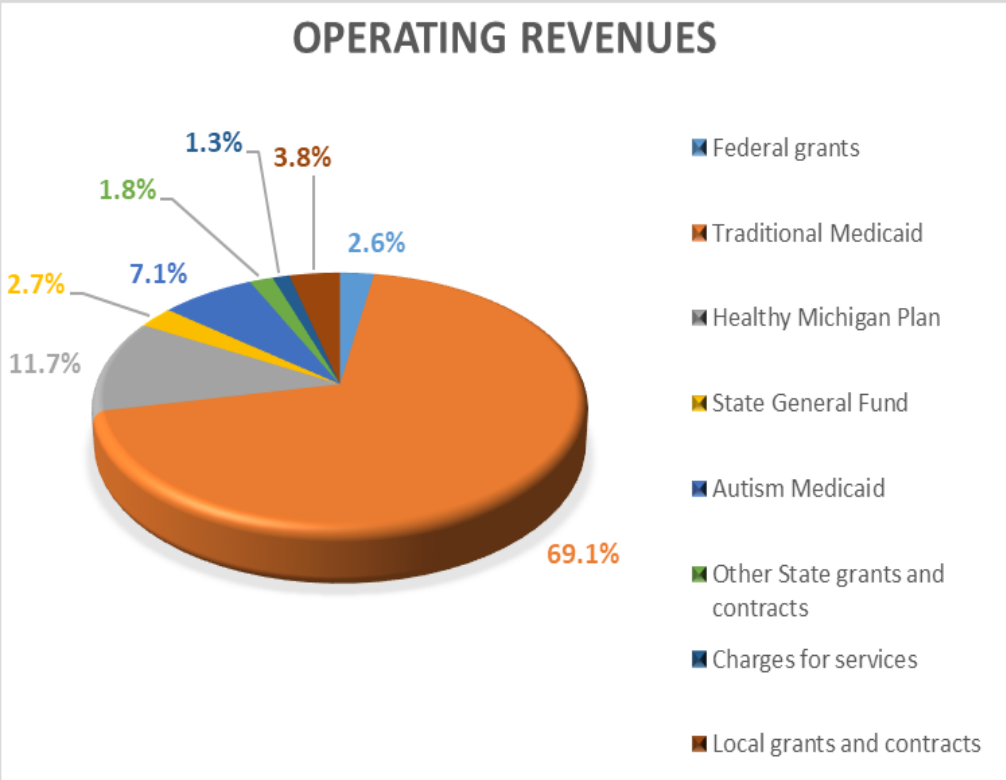
Opportunities for Improvement

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

Finance Pillar

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





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

Home and Community Based Services (HCBS)

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

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

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

Opportunities for Improvement
- Identify providers who have made the cultural shift to meet the HCBS standards to share best practices.
- Create a residential provider report card that offers an overall view of performance and tracks compliance. with standards, policy and procedures with the final rule.
- Advise providers on strategies to address the three core elements of implementation: assessment, remediation, outreach.
- Post HCBS resource materials on DWIHN website including direct linked resources from MDHHS.
- Work with other PIHP Leads in the regions through on-going training and sharing of best practices.
- Define person-centered planning requirements. This includes:
    - ✓ Plain language writing that is understandable by all parties, including the beneficiary.
    - ✓ Achievable, culturally sensitive goals that have meaning to the beneficiary.
    - ✓ Offering a choice of programs and demonstrating which programs and providers the beneficiary has chosen from available offerings.
    - ✓ Building in the philosophy of the dignity of risk with defined and agreed-upon measures to minimize risk to the beneficiary.
    - ✓ Using evidence-based, functional needs assessments to determine the clinically assessed need tied to the beneficiary's disability.

Community Outreach

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

Social Media

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

Self-Management Performance Improvement

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

Ask the Doc

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

DWIHN Website

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

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

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

Find a Provider

https://dwihn.org

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

Sharing Information

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

- Quality Improvement Steering Committee (QISC)
  - QISC Agenda
  - QISC Minutes
- Quality Assurance Performance Improvement Plan (QAPIP)
  - QAPIP Description Plan FY 2019-2021
  - QAPIP Description Plan FY 2021-2023
- QAPIP Annual Evaluation
  - QAPIP Annual Evaluation FY 2017
  - QAPIP Annual Evaluation FY 2018
  - QAPIP Annual Evaluation FY 2019
  - QAPIP Annual Evaluation FY 2020
  - QAPIP Annual Evaluation FY 2021
  - QAPIP Annual Evaluation FY 2022
- Home and Community Based Services (HCBS)
  - For HCBS Questions please E-Mail to Quality@dwihn.org and HCBSInfor.PIHP@dwihn.org.

DWIHN Accreditation

DWIHN has been accredited for three years through the National Committee for Quality Assurance (NCQA). In FY2021, DWIHN received high marks and perfect scores in several critical areas including Member Experience, Self-Management Tools, Clinical Practice Guidelines, Clinical Measurement Activities, Coordination of Behavioral Healthcare and Collaboration between Behavioral Health and Medical Care. DWIHN scored 92.49 out of a possible 100 points. This goal will continue.

External Quality Reviews

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

Preformance Improvement Project (PIP)

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

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

Performance Indicator Results

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

Evaluation of Effectiveness

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

Identified Barriers

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

Opportunities for Improvement

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

Performance Measures Validation (PMV)

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

Quantitative Analysis and Trending of Measures

In FY22, HSAG reviewed DWIHN's performance indicators reporting data for validation. The reporting cycle and measurement period was from October 1, 2020 through December 31, 2020. DWIHN received a full compliance score of 100% with no Plan of Correction (POC), for the second consecutive year.

Evaluation of Effectiveness

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

Identified Barriers
No barriers Identified

Opportunities for Improvement

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

Compliance Review

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

Quantitative Analysis and Trending of Measures

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

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

Evaluation of Effectiveness

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

Identified Barriers

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

Opportunities for Improvement

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

Utilization Management

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

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

Adequacy of Quality Improvement Resources

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

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

Title	Department	Percent of time per week devoted to QI
Medical Director	Administration	100%
Director of Quality Improvement	Quality Improvement	100%
Quality Improvement Administrator	Quality Improvement	100%
Director of Utilization Management	Utilization Management	50%
Clinical Officer	Clinical Practice Improvement	50%
Director of Customer Service	Customer Service	50%
Director of Integrated Health Care	Integrated Health Care	50%
Director of Managed Care Operations	Managed Care Operations	10%
Strategic Planning Manager	Compliance	5%
Information Technology	Information Technology	1%
Practitioner Participation	Provider Network	100%

Overall Effectiveness

An evaluation of DWIHN's QI Work Plan for FY2022 has been conducted. This evaluation included review of trended results for QI measures over time, comparison against performance objectives, quantitative and qualitative analyses for completed and ongoing QI activities. Overall, improvements were achieved in planned QI initiatives, both clinical and service. In addition, programs that address member safety were implemented. The Quality Improvement Steering Committee (QISC) and the Program Compliance Committee (PCC) Board reviewed and approved the 2022 QAPIP Evaluation and FY2022 Work Plan (Attachment A). The FY2022 QI Work Plan was implemented in accordance with the plan. The indicators measured cover a broad spectrum, including quality of clinical care, quality of service and safe clinical practices. The QI initiatives are relevant to the needs of the residents of Wayne County and in alignment with DWIHN's mission and vision. DWIHN's organizational structure and resources are adequate and supportive of the QI process.

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

IT also deployed a nationwide NCQA accredited Care Coordination platform that supports the calculation of HEDIS measures and enables us to partner with Health Plans to manage Behavioral and Physical Health services. As part of the 21st Century Cures Act, the Centers for Medicare & Medicaid Services (CMS) is requiring states to implement an Electronic Visit Verification (EVV) system, during FY' 2021 DWIHN finalized testing that integrates with our main MHWIN system for timely and accurate data delivery.

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

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

Analysis

DWIHN believes there are adequate practitioner involvement and consultation to meet the objectives of the Quality Program. No changes are anticipated for FY 2023.

Committee Structure

After evaluating the QI program committee structure, DWIHN committee involvement is adequate and all committee members regularly attend and actively participate in QISC committee meetings. DWIHN's commitment to quality is strong and shared across all levels of the organization. DWIHN believes the structure supports effective governance and align key strategic initiatives to ensure adequate guidance to help DWIHN reach goals and objectives. No changes are anticipated for FY2023.

Practitioner Participation

DWIHN continues to have substantial practitioner participation in our QISC committees, Quality Operations Workgroup and adhoc provider advisory workgroups as needed. This represents input from the provider network and practitioner leadership. The practitioners actively participate in the planning, design, implementation and program evaluation, through data collection and analysis. Their activities ensure program alignment with evidence-based care and overall population management between the health plan, care delivery systems and community partners. In addition to serving on the QISC committee, DWIHN enlists practitioner input regarding key initiatives. After evaluating the practitioner participation, DWIHN believes there are adequate practitioner involvement and consultation to meet the objectives of the Quality Program. No changes are anticipated for FY2023.

QI Program Effectiveness

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

DWIHN's commitment to continuous improvement is integral to achieving excellent health outcomes and an excellent overall member experience. In 2023, DWIHN will continue to address identified opportunities for improvement to ensure optimal member experience.

2023 Work Plan Goals and Objectives

In FY 2023, the QAPIP work plan will be reviewing these areas to achieve continuous quality improvement in the quality and safety of clinical care, quality of service and member experience.

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

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

Work Plan Summary and Work Plan FY 2022-2023

DWIHN Quality Improvement goals are integrated and communicated throughout the organization with a structure Work Plan, with identified goals objectives that are owned at the departmental level. DWIHN's organizational monitoring activities, reports and documented processes are reviewed throughout the year by the Quality Improvement Steering Committee (QISC) and Program Compliance Committee (PCC) no less than quarterly to identify opportunities for improvements. These activities, in addition to ongoing Performance Improvement Projects (PIPs), form the basis of the organization's Work Plan and support all services offered by DWIHN. The Behavioral Healthcare landscape, key strengths and opportunities for improvement guided DWIHN's overall quality-related efforts in FY2022.

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
Customer Pillar							
Goal I (Members Experience and Quality of Service)	**Improve Members Experience with Services**						
I.1	ECHO Annual Satisfaction Surveys (Adult and Children)	Director of Customer Service	The 2022 Echo Survey will be distributed to members/guardians/families by Q4 (July 1, 2022 - September 30,2022) of FY 2022. The results of surveys will be collated, reviewed, analyzed and reported by Q1 (October 1, 2022 - December 31, 2022) of January 2023.	The target goal is to increase each score response rates from the 2021 reports for both Adults and Children. **Adults:** Improve member access to behavioral health services for the 3 reporting measures scoring < 50% which include:1) Perceived Improvement 29%; 2)Getting Treatment Quickly 46% 3). Office Wait 44%. **Children: I**mprove member access to behavioral health services for the 2 reporting measures scoring < 50% which include: 1). Perceived Improvement 28% 2). Getting Treatment Quickly 46%.	Previously identified issues are to increase outcomes for the 5 reporting areas scoring <50% during FY2021 for Adults and Children. This is a continuation goal from FY2022.	**Target goal not met.** Results of the ECHO® survey for (Adult and Children) is not available for FY2022. The preliminary ECHO® reports will be available in Q3 (April 1, 2023 - June 30, 2023) of FY 2023, with final reports available Q4 (July 1, 2023 - September 30, 2023) of FY 2023.The results will be shared with stakeholders and contract providers to promote use of findings to inform and improve service delivery. This will be a continuation goal for FY2023.	Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 3 of FY-2023.

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

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

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

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

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

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

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

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

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	Michigan Mission Based Performance Indicators (MMBPI)						
II.1	Indicator 1(a) and 1(b) - Percentage of pre-admission screenings for psychiatric inpatient care (Children and Adults) for whom disposition was completed within three hours.	Director of Quality Improvement	FY 2021-2022 (October 1, 2021 through September 30, 2022). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to meet or exceed performance standard. Standard is 95% or above.	No previously identified issues during FY2021.	**Target goal met.** Results: FY2022 standard met for all 4 quarters. Total population rate (97.97%). This will be a continuation goal for FY2023.	Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.
II.2	Indicator 2(a) and 2(b) - Percentage of persons (Children and Adults) receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.	Director of Quality Improvement	FY 2021-2022 (October 1, 2021 through September 30, 2022). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to achieve comparable scores within the region to the state wide average. No standard/benchmark for performance indicator has been established by MDHHS. No exceptions allowed.	Previously identified issues. Targeted goal not met; scores was the lowest within the region during FY2021 for all population served. The statewide average during FY2021 (63%).	**Target goal met.** This measure allows for no exceptions. MDHHS has not established a minimum threshold for this measure. Results: Q1(52.85%), Q2 (59.23%), Q3 (37.84%) and Q4 (44.26%). Total population rate (48.30%). This will be a continuation goal for FY2023.	Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.

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QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
II.3	Indicator 3(a) and 3(b) - Percentage of persons (Children and Adults) needed on-going service within 14 days of a non-emergent assessment with a professional.	Director of Quality Improvement	FY 2021-2022 (October 1, 2021 through September 30, 2022). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to achieve comparable scores within the region to the state wide average.	No previously identified issues during FY2021. No standard/benchmark for performance indicator has been established by MDHHS.	**Target goal met.** This measure allows for no exceptions. MDHHS has not established a minimum threshold for this measure. Results: Q1(82.36%), Q2 (87.27%), Q3 (84.66%) and Q4 (88.32%). Total population rate (85.71%). This will be a continuation goal for FY2023.	Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.
II.4	Indicator 4a(1) and 4a(2) - Percentage of discharges from a psychiatric inpatient unit (Children and Adults) who are seen for follow up care within 7 days.	Director of Quality Improvement	FY 2021-2022 (October 1, 2021 through September 30, 2022). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to meet or exceed performance standard. Standard is 95% or above.	No previously identified issues during FY2021.	**Target goal partially met.** Results: FY22 standard was not met for the following quarters/populations Q2 Child (93.75%), Q3 Child (86.44%) and Total Child (94.27%) and Q1 Adult (94.80%). Total population rate (96.14%). This will be a continuation goal for FY2023.	Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.

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

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QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
II.7	Complex Case Management	Director of Integrated Health Care	FY 2021-2022 (October 1, 2021 through September 30, 2022) results will be collated, reviewed, analyzed and reported by February 2023.	The target goals are to improve medical and behavioral health concerns and increase overall functional status by 10% in PHQ scores, provide early intervention for members appropriate for Complex Case Management to prevent recurrent crisis or hospitalizations, increase participation in the number of members who attended two out-patient behavioral health services within 60 days of starting CCM services who were open for at least 60 days and improve member satisfaction scores by 20%.	No previously identified issues during FY2021.	**Target goal met.** Improve medical and/or behavioral health concerns, overall 10% improvement in PHQ scores, overall 10% reduction in Emergency Department (ED) utilization and an overall 10% reduction in hospital admissions from 90 days prior to receiving CCM services to 90 days after receiving CCM services for members at closure who were enrolled for at least 60 days and a 80% or greater member satisfaction scores for members at closure who have received CCM services. This will be	Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.

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

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III.1	Maintain Competent Workforce	Director of Workforce Development, Provider Network Administrator Credentialing, Director of Quality Improvement, Director of Clinical Practices Improvement, Director of Managed Care Operations	FY 2021-2022 (October 1, 2021 through September 30, 2022). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to ensure a competent workforce through performance reviews by evaluating job performance and competency, and maintaining and expanding a centralized training program for allied health professionals. Focusing on the development of new professionals is integral to achieving a collaborative integrated healthcare system.	No previously identified issues during FY2021.	**Target goal met.** DWIHN continues to provide continuing education platforms for stakeholders of the behavioral health workforce through Detroit Wayne Connect live and online courses. SUD Trainings are also available on Improving MI Practices posted at www.dwihn.org. This will be a continuation goal for FY2023.	Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.
Finance Pillar							
Goal IV (Quality of Service)	**Maximize Efficiencies and Control Costs**						

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

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

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

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V.7a	Improving the availability of a follow up appointment with a Mental Health Professional with-in 7 and 30 days after Hospitalization for Mental Illness.	Director of Integrated Health Care, Director of Quality Improvement	FY 2021-2022 (October 1, 2021 through September 30, 2022) Data reporting is collated, reviewed and analyzed quarterly.	The target goal is 45% (Adults) or higher in improving the availability of a follow up appointment with a Mental Health Professional within 7. The target goal is 58% or higher (Adults) 30 days after Hospitalization for Mental Illness.	Previously identified issue. Targeted goal of 45% or higher not met for the 7day follow-up (Adult) ; rate was 28.33% for FY2021. Target goal of 58% or higher not met for the 30 day follow-up (Adult); rate was 46.67%.	**Target goal not met for 7 day or 30 day follow-up**. This will be a continuation goal for FY2023.	Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2022 on the reporting measure. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.
V.7b	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Director of Integrated Health Care, Director of Quality Improvement	FY 2021-2022 (October 1, 2021 through September 30, 2022). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is 68.00% or higher. This measure analyzes the percentage of members 19 to 64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.	No previously identified issues during FY2021.	**Target goal not met**. In FY2021 results have trended down to 46.92%. This is a 32.42 percentage point decrease. This will be a continuation goal for FY2023.	Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2022 on the reporting measure. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.

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V.7c	Antidepressant Medication Management for People with a New Episode of Major Depression	Director of Integrated Health Care, Director of Quality Improvement	FY 2021-2022 (October 1, 2021 through September 30, 2022). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is 51% or higher. Improve the importance of a good clinician/patient relationship in addressing the importance of disease management and member's fear of taking medication as well as the risks and benefits of taking the medication.	Previously identified issue failed to meet the goal for FY 2021 (46.42%)	**Target goal not met.** Results was 13.36%. This is an 8.3 percentage point decrease compared FY2020. This will be a continuation goal for FY2023.	Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2022 on the reporting measure. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.
V.7d	Improving Diabetes Monitoring for People with Schizophrenia and Bipolar Disorder	Director of Integrated Health Care, Director of Quality Improvement	FY 2021-2022 (October 1, 2021 through September 30, 2022). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is 80% or higher. This measure analyzes the percentage of patients 18-64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening during the measurement year.	Previously identified issue failed to meet the goal for FY 2021 (64.86%)	**Target goal not met.** DWIHN results for 2021 was 64.86%, this is a 0.48 percentage point increase compared to FY2020. The goal of 80% was not achieved. This will be a continuation goal for FY2023.	Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2022 on the reporting measure. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.

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V.7e	Coordination of Care	Director of Integrated Health Care, Director of Utilization Management, Director of Quality Improvement	FY 2021-2022 (October 1, 2021 through September 30, 2022). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is 95% or higher for review of randomly selected cases through the performance monitoring process for compliance.	Previously identified issues failed to meet the goal for FY 2021 (82%).	**Target goal not met.** 68.8% for Quarters 1-3. Quarter 4 data will be available in Q3 of FY2023. This will be a continuation goal for FY2023.	Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2022 on the reporting measure. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.
V.7f	Case Finding for Opiate Treatment	Director of Substance Use Disorder	FY 2021-2022 (October 1, 2021 through September 30, 2022). Data reporting is collated,	The target goal is 79% or higher.	Previously identified issue targeted goal not met during FY2021 (55%).	**Target goal not met.** 60%, Goal at 79%. This will be a continuation goal for FY2023.	Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2022 on the reporting measure. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.
V.7g	PHQ-9 Implementation	Director of Clinical Practice Improvement	FY 2021-2022 (October 1, 2021 through September 30, 2022). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is 95% or higher.	Previously identified issue targeted goal not met during FY2021.	**Target goal met** at 99.1%. This will be a continuation goal for FY2023.	Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2022 on the reporting measure. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.

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V.7h	PHQ-A Implementation	Director of Children's Initiative	FY 2021-2022 (October 1, 2021 through September 30, 2022). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is 95% or higher.	Previously identified issue targeted goal not met (75%) during FY2021.	**Target goal met** at 99.2%. This will be a continuation goal for FY2023.	Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2022 on the reporting measure. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.
V.7i	Decreasing Wait for Autism Services	Director of Children's initiative	FY 2021-2022 (October 1, 2021 through September 30, 2022). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is 95% or higher.	No previously identified issue during FY2021.	**Target goal not met** at 67.50%. This will be a continuation goal for FY2023.	Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2022 on the reporting measure. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.
	Advocacy Pillar						
Goal VI.	**Increase Community Inclusion and Integration**						

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VI.1	Home and Community Based Services (HCBS)	Director of Quality Improvement	FY 2021-2022 (October 1, 2021 through September 30, 2022). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is 100% compliance of the Network with the HCBS requirements.	Previously identified issue targeted goal not met during FY2021.	**Target goal not met.** This will be a continuation goal for FY2023.	Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.
Goal VII (Quality of Service)	**External Quality Reviews**						

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

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

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
VII.2	NCQA Accreditation	Director of Quality Improvement, Director of Managed Care Operations, Director of Customer Service, Director of Recipient Rights , Deputy Chief Financial Officer, Director of Workforce, Provider Network Administrator Credentialing, Director of Integrated	January 1, 2022-January 1, 2024. Reports and collated, reviewed and analyzed during the required look back period.	The target goal is to achieve recertification in FY2024.	No previously identified issues during FY21.	DWIHN will be revaluated for re-certification in January 2024. This will be a continuation goal for FY2023.	Submit quarterly reports to PCC on the recertification process. DWIHN will be revaluated for re-certification in January 2024.

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

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

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

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

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

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

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

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

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
Customer Pillar							
Goal I (Members Experience and Quality of Service)	**Improve Members Experience with Services**						
I.1	ECHO Annual Satisfaction Surveys (Adult and Children)	Director of Customer Service	The 2022 ECHO® Survey (Children and Adult) results will be collated, reviewed, analyzed and reported by April of 2023.	The target goal is to increase each outcome reported during FY2021 for both Adults and Children. **Adults:** Improve member access to behavioral health services for the 3 reporting measures scoring < 50% which include:1) Preceived Improvement 29%; 2)Getting Treatment Quickly 46% 3). Office Wait 44%. **Children:** Improve member access to behavioral health services for the 2 reporting measures scoring < 50% which include: 1). Preceived Improvement 28% 2). Getting Treatment Quickly 46%.	Previously identified issues are to increase outcomes for the 5 reporting areas scoring <50% during FY2021 for Adults and Children. This is a continuation goal from FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 4 of FY-2024.

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
I.2	National Core Indicator Survey (NCI) for Adults	Director of Customer Service	In FY 2023 Q3 (April 1, 2023 through June 30, 2023) results of the surveys will be collated, reviewed, analyzed.	The target goal is to improve each score response rate to identify areas for system enhancement to improve areas of dissatisfaction, access to service and quality of care.	Previouly identified issue. DWIHN does not control or participate in the completion of this report. MDHHS has declined request to provide data of the actual survey. This is a continuation goal from FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY2024.
I.3	Provider and Practitioner Satisfaction Survey	Director of Strategic Operations, Director of Managed Care Operations (MCO)	In FY 2023 Q4 results of the Provider Satisfication surveys will be collated, reviewed, analyzed for comparision between FY2022 and FY2023. The 2022 Practitioner Satisfaction Survey results will be collated, reviewed, analyzed and reported by September of 2023.	The target goal is to increase the providers outcomes for the areas of Staff Availability, Timeliness of Responses, Knowledge of Staff to Answer Questions and Resolve issues and Credentialing/Impaneling from FY2022 by 10% or higher.	Previously identified issue. Provider Satisfaction survey questions were modified in FY2022, no data is avaialble for comparision until FY2023. This is a continuation goal from FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY2024.

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
I.4	Grievance/Appeals	Director of Customer Service	FY 2022-2023 (October 1, 2022 through September 30, 2023) results will be collated, reviewed, analyzed and reported by Q2 of January 2024.	The target goal is to improve outcomes by resolving grievances and appeals within the required time frame. Delivery of Service and Customer Services were consistently reported high over each of each of the the last two years. Interpersonal relations came in third with a total of 46 complaints during FY2021.	Previously identified issue. There was high number of grievances filed in the area of Delivery of Service and Customer Service in FY2021. This is a continuation goal from FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
I.5	Timeliness of Utilization Management Decisions	Director of Utilization Management	FY 2022-2023 (October 1, 2022 through September 30, 2023) Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to meet or exceed performance standards set by MDHHS/NCQA for timely UM decisions making, timeframes and notification. Threshold 90% .	No previously identified issues during FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
I.6	Practice Guidelines	Chief Medical Officer	FY 2022-2023 (October 1, 2022 through September 30, 2023). Guidelines are reviewed and dissemented throughout the provider network no less than every two years.	The target goal is to ensure guidelines are reviewed at least every two years and shared with the provider network for feedback through reports, clinical record reviews, and/or process indicators.	Previously identified issues. Lack provider feedback and participation to review practice guidelines as required. This is a continuation goal from FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
I.7	Cultural and Linguistic Needs	Director of Customer Service, Director of Managed Care Operations, Director of Quality Improvement Diversity, Equity & Inclusion Administrator	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to improve outcomes through cutural competency, language, and physical accessibility by identifiying existing racial and ethnic disparities within our provider network for all populations.	Previously Identified Issue: 31% of members reported their cultural needs were not met in FY2021 from the Member Satisfaction survey. This is a continuation goal from FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
Access Pillar							
Goal II (Quality of Service and Quality of Clinical Care)	**Improve members Access to Services, Quality of Clinical Care, and Health and**						

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
	Michigan Mission Based Performance Indicators (MMBPI)						
II.1	Indicator 1(a) and 1(b) - Percentage of pre-admission screenings for psychiatric inpatient care (Children and Adults) for whom disposition was completed within three hours.	Director of Quality Improvement	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to meet or exceed performance standard. Standard is 95% or above.	No previously identified issues during FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
II.2	Indicator 2(a) and 2(b) - Percentage of persons (Children and Adults) receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.	Director of Quality Improvement	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to achieve comparable scores within the region to the state wide average. FY22 results: Q1(52.85%), Q2 (59.23%), Q3 (37.84%) and Q4 (44.26%). Total population rate (48.30%).	Previously identified issues. This measure allows for no exceptions. MDHHS has not established a minimum threshold for this measure. This is a continuation goal from FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
II.3	Indicator 3(a) and 3(b) - Percentage of persons (Children and Adults) needed on-going service within 14 days of a non-emergent assessment with a professional.	Director of Quality Improvement	FY 2022-2023 (October 1, 2023 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to achieve comparable scores within the region to the state wide average. FY22 results: Q1(82.36%), Q2 (87.27%), Q3 (84.66%) and Q4 (88.32%). Total population rate (85.71%).	No previously identified issues during FY2022. This measure allows for no exceptions. MDHHS has not established a minimum threshold for this measure. This is a continuation goal from FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
II.4	Indicator 4a(1) and 4a(2) - Percentage of discharges from a psychiatric inpatient unit (Children and Adults) who are seen for follow up care within 7 days.	Director of Quality Improvement	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to meet or exceed performance standard. Standard is 95% or above.	No previously identified issues during FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
II.5	Indicator 4b - Percentage of discharges from a Substance Abuse Detox Unit who are seen for follow-up care within 7 days.	Director of Quality Improvement	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to meet or exceed performance standard. Standard is 95% or above.	No previously identified issues during FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
II.6	Indicator 10 (a) and 10 (b) - Percentage of readmissions (Children and Adults) to inpatient psychiatric unit within 30 days of discharge.	Director of Quality Improvement	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to meet or exceed performance standard. Standard is 15% or less. FY22 results Q2 (16.31%), Q3 (17.79%), Q4 (15.89%). Total population rate (15.43%).	Previously identified issues. Targerted goal not met with Recidivism for the adult population for three out of four quarters. This is a continuation goal from FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
II.7	Complex Case Management	Director of Integrated Health Care	FY 2022-2023 (October 1, 2022 through September 30, 2023) results will be collated, reviewed, analyzed and reported by Q2 of February 2024.	The target goals are to improve medical and behavioral health concerns and increase overall functional status by 10% in PHQ scores, provide early intervention for members appropriate for Complex Case Management to prevent recurrent crisis or hospitalizations, increase participation in the number of members who attended two out-patient behavioral health services within 60 days of starting CCM services who were open for at least 60 days and improve member satisfaction scores by 20%.	No previously identified issues during FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
II.8	Crisis Intervention Services	Director of Utilization Management, Director of Crisis Services	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to decrease number of re-hospitalization within 30 days of discharge to 15% or less for Adults. FY22 results Q2 (16.31%), Q3 (17.79%), Q4 (15.89%). Total population rate (15.43%).	Previously identified issues. Targerted goal not met with Recidivism for the adult population for three out of four quarters. This is a continuation goal from FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
Workforce Pillar							
Goal III. (Quality of Service)	**Develop and maintain a Competent Workforce through the Credentialing and Re-Credentialing Process**						

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
III.1	Maintain Competent Workforce	Director of Workforce Development, Provider Network Administrator Credentialing, Director of Quality Improvement, Director of Clinical Practices Improvement, Director of Managed Care Operations	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to ensure a competent workforce through performance reviews by evaluating job performance and competency, and maintaining and expanding a centralized training program for allied health professionals. Focusing on the development of new professionals is integral to achieving a collaborative integrated healthcare system.	No previously identified issues during FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
Finance Pillar							
Goal IV (Quality of Service)	**Maximize Efficiencies and Control Costs**						

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
IV.1	Verification of Services	Director of Quality Improvement, Corporate Compliance Officier	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed Bi-quarterly (1st & 2nd Quarter (October 1, 2022 - March 31, 2023); (3rd & 4th Quarter April 1, 2023 - September 30, 2023).	The target goal is to review 100% of randomly selected Paid Encounters/Claims to eliminate Fraud, Waste and Abuse in the provider network.	No previously identified issues during FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
Quality Pillar							
Goal V (Safety of Clinical Care)	**Improve Quality Performance, Member Safety and Member Rights system-wide**						
V.1	Provider Network Performance Monitoring - Clinically Responsible Service Provider (CRSP)	Director of Quality Improvement	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to increase the number of provider reviews from FY2022 by 15% or higher to ensure Continuous Quality Improvement.	No previously identified issues during FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V.2	Residential Treatment Providers	Director of Quality Improvement	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to increase number of Residential Treatment Provider reviews from FY2022 by 15% or higher to ensure Continuous Quality Improvement.	No previously identified issues during FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
V. 3	Long Term Supports Services (LTSS)	Director of Quality Improvement; Director of Customer Service	FY 2022-2023(October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	Target goal is to ensure the incorporation of individuals receiving LTSS into the review and analysis of the information obtained from quantitative and qualitative methods; and evaluate the effects of activities implemented to improve satisfaction.	Previously identified issues for FY2022 include no data collection or analysis for members receiving LTSS services.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
V.4	Provider Network Self Monitoring (Inter-Rater Reliability)	Director of Quality Improvement	FY 2022-2023(October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to increase Provider's participation in Self Monitoring reviews from the pervious year by 20% or higher to ensure inter rater reliability.	No previously identified issues during FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V.5	Autism Services	Director of Quality Improvement, Director of Children's Initiatives	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to increase the number of Providers reviewed from FY2022 by 15% or higher to ensure Continous Quality Improvement.	No previously identified issues during FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 FY-2024.
V.6	Critical/Sentinel/Unexpected Death and Risk Reporting	Director of Quality Improvement	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to meet MDHHS reporting requirements and monitor the safety of clinical care of members.	No previously identified issues during FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
V.7	Behavior Treatment Review	Director of Quality Improvement, Chief Medical Officer	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to meet the BTPRCs Technicial Requirements set by MDHHS through reviews of randomly selected cases. Threshold 95% or above.	No previously identified issues during FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
(Quality of Clinical Care)	**Quality Improvement Projects (QIP's)**						

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V.8a	Improving the availability of a follow up appointment with a Mental Health Professional with-in 7 days after Hospitalization for Mental Illness.	Director of Integrated Health Care Director of Quality Improvement	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is 45% or higher in improving the availability of a follow up appointment with a Mental Health Professional within 7 and 30 days after Hospitalization for Mental Illness.	Previously identified issue. Targeted goal of 45% or higher not met; rate was 29.57% for FY2022. This is a continuation goal from FY2022.		Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2023 on the reporting measure. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
V.8b	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Director of Integrated Health Care Director of Quality Improvement	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is 45% or higher. This measure analyzes the percentage of members 19 to 64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.	Previously identified Issue. Targeted goal not met for FY2022. This is a continuation goal from FY2022.		Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2023 on the reporting measure. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V.8c	Antidepressant Medication Management for People with a New Episode of Major Depression	Director of Integrated Health Care, Director of Quality Improvement	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is 51% or higher. Improve the importance of a good clinician/patient relationship in addressing the importance of disease management and member's fear of taking medication as well as the risks and benefits of taking the medication.	Previously identified issue. Targeted goal not met for FY 2022. Results was 13.36%. This is a continuation goal from FY2022.		Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2023 on the reporting measure. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
V.8d	Improving Diabetes Monitoring for People with Schizophrenia and Bipolar Disorder	Director of Integrated Health Care, Director of Quality Improvement	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is 80% or higher. This measure analyzes the percentage of patients 18-64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening during the measurement year.	Previously identified issue. Targeted goal not met for FY 2022 (64.86%). This is a continuation goal from FY2022.		Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2023 on the reporting measure. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V.8e	Coordination of Care	Director of Integrated Health Care, Director of Utilization Management, Director of Quality Improvement	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is 95% or higher for review of randomly selected cases through the performance monitoring process for compliance.	Previously identified issue. Targeted goal not met for FY 2022. This is a continuation goal from FY2022.		Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2023 on the reporting measure. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
V.8f	Case Finding for Opiate Treatment	Director of Substance Use Disorder	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated,	The target goal is 79% or higher.	Previously identified issue. Targeted goal not met FY22. This is a continuation goal from FY2022.		Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2023 on the reporting measure. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
V.8g	PHQ-9 Implementation	Director of Clinical Practice Improvement	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is 95% or higher.	No previously identified issue. Targeted goal met FY22 (99.1%)		Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2023 on the reporting measure. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V.8h	PHQ-A Implementation	Director of Children's Initative	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is 100%	No previously identified issue. Targeted goal not met FY22 (99.2%).		Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2023 on the reporting measure. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
V.8i	Decreasing Wait for Autism Services	Director of Children's initiative	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is 100%	Previously identified issue. Targeted goal not met (67.5%). This is a continuation goal from FY2022.		Continue to collect and analyze data, and report to QISC and PCC no less than quarterly in 2022 on the reporting measure. The Annual Evaluation Report for FY-2022 will be presented to QISC and PCC in Quarter 2 of FY-2023.
	Advocacy Pillar						
Goal VI.	**Increase Community Inclusion and Integration**						

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
VI.1	Home and Community Based Services (HCBS)	Director of Quality Improvement	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal not met; Provider network is not fully HCBS compliant.	Previously identified issue. Targeted goal not met for FY22. This is a continuation goal from FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
Goal VII (Quality of Service)	**External Quality Reviews**						

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
VII.1	MDHHS Annual 1915 © Waiver Review	Director of Quality Improvement, Director of Managed Care Operations, Director of Customer Service, Director of Recipient Rights , Deputy Chief Financial Officer, Director of Workforce, Provider Network Administrator Credentialing, Director of Integrated Health Care, Director of Human Resources	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collated, reviewed and analyzed quarterly.	The target goal is to achieve 95% or above in the Waiver compliance review.	No previously identified issues during FY2022.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 3 of FY-2024.

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
VII.2	NCQA Accreditation	Director of Quality Improvement, Director of Managed Care Operations, Director of Customer Service, Director of Recipient Rights , Deputy Chief Financial Officer, Director of Workforce, Provider Network Administrator	January 1, 2022-January 1, 2024. Reports and collated, reviewed and analyzed during the required look back period.	The target goal is to achieve recertification in FY2024.	No previously identified issues.		Submit quarterly reports to PCC on the recertification process. DWIHN will be revaluated for re-certification in January 2024.

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
VII.3	Health Services Advisory Group (HSAG)-Validation of Performance Projects (PIP)	Director of Quality Improvement	FY 2022-2023 (October 1, 2022 through September 30, 2023). Reports and collated, reviewed and analyzed during the required look back period.	The target goal is to verifies whether DWIHN's new PIP (reduce racial and ethnic disparity with African Americans for the percentage of discharges from a psychiatric inpatient unit that were seen for follow-up care within 7 day) used a sound methodology in the design, implementation, analysis, and reporting.	No previously identified issues during FY22.		Submit quarterly reports to PCC on performance outcomes. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 3 of FY-2024.

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
VII.3a	Health Services Advisory Group (HSAG)- Compliance Review	Director of Quality Improvement, Director of Managed Care Operations, Director of Customer Service, Director of Recipient Rights , Deputy Chief Financial Officer, Director of Workforce, Provider Network Administrator Credentialing, Director of Integrated Health Care, Director of Human Resources	FY 2022-2023 (October 1, 2022 through September 30, 2023). Reports and collated, reviewed and analyzed during the required look back period.	Previously identified issues. The target goal is to complete plans of action from (Year 1) and (Year 2) to address each deficiency identified during the Compliance Review in (Year 3) of August 2023.	Previously identified issue. Targeted goal not met in FY22; achieved an overall score 83.0%.		Submit quarterly reports to PCC on performance outcomes. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 4 of FY-2024.

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
VII.3b.	Health Services Advisory Group (HSAG) - Performance Measure Validation (PMV)	Director of Quality Improvement, IT Administrator, Claims Administrator	FY 2022-2023 (October 1, 2022 through September 30, 2023). Reports and collated, reviewed and analyzed during the required look back period.	The target goal is to achieve 95% or above.	No previously identified issues. Targeted goal met with no plan of correction during FY22.	I	Submit quarterly reports to PCC on performance outcomes. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 3 of FY-2024.

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
VII.4	Annual Needs Assessme	Director of Quality Improvement, Director of Managed Care Operations, Director of Customer Service, Director of Recipient Rights , Deputy Chief Financial Officer, Director of Workforce, Provider Network Administrator Credentialing, Director of Integrated Health Care, Director of Human Resources	FY 2022-2023 (October 1, 2022 through September 30, 2023). Reports and collated, reviewed and analyzed during the required look back period.	The target goal is to prioritize and implement planned actions as identified by our stakeholders, members and the provider network.	No previously identified issues during FY2022.		Submit quarterly reports to PCC on performance outcomes. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in Quarter 2 of FY-2024.
End							

DETROIT WAYNE INTEGRATED HEALTH NETWORK
BOARD ACTION

Board Action Number: BA 23-26R2 Revised: Y Requisition Number:

Presented to Full Board at its Meeting on: 2/15/2023

Name of Provider: Star Center Inc.

Contract Title: Substance Use Disorder Treatment Services Network Fiscal Year 2023

Address where services are provided: 'None'__

Presented to Program Compliance Committee at its meeting on: 2/8/2023

Proposed Contract Term: 10/1/2022 to 9/30/2023

Amount of Contract: $ 7,330,210.00 Previous Fiscal Year: $ 6,719,938.00

Program Type: Continuation

Projected Number Served- Year 1: 13,200 Persons Served (previous fiscal year): 1000

Date Contract First Initiated: 10/1/2022

Provider Impaneled (Y/N)?

Program Description Summary: Provide brief description of services provided and target population. If propose contract is a modification, state reason and impact of change (positive and/or negative).

The revised board action is to request an additional $232,000 in PA2 Funds to allocate funds consistent with prior year allocations. The funds will be allocated as follows:

CLASS - $159,000.00, Mariners - $54,000 and Black Family Development - $19,000;

The increase will allow providers to continue to provide sufficient prevention services to members in Wayne County and prevent any hardship for the existing staff and services.

Additionally, SUD is requesting an additional $15,000 to purchase:

1. SUD pamphlets, educational and informative ($12,000) items for SUD prevention, treatment and recovery events from Prevention & Treatment Resource Press (PTR Press) and Verde Environmental Technology (Deterra bags). These items will bring awareness to the community on the harms and effects of drugs on the human body; and,

2. Car seats for members that successfully complete the Parenting Post-Partum Women (PPW)Services program as an incentive. The incentive will increase enrollment and participation and decrease the number of no shows. Also, a Participation incentive of $1,000 each to Star Center participates in the PPW program to include STAR Center, Elmhurst Home and Central City Integrated Health for participating in the PPW program.

The revised FY23 Prevention Services program budget is $7,330,210.00 and consist of Federal Block Grant $4,974,210.00 and Public Act 2 funds of 2,356,000.00

DWIHN has the discretion to allocate the funds among the providers based upon utilization without board approval up to the approved not to exceed amount. As a result, budget may be decreased/increased among providers.

Outstanding Quality Issues (Y/N)? N If yes, please describe:

Source of Funds: Block Grant,PA2

Fee for Service (Y/N): N

Revenue	FY 22/23	Annualized
SUD Block Grant	$ 4,974,210.00	$ 4,974,210.00
PA2	$ 2,356,000.00	$ 2,356,000.00

Total Revenue	$ 7,330,210.00	$ 7,330,210.00

Recommendation for contract (Continue/Modify/Discontinue): Continue

Type of contract (Business/Clinical): Clinical

ACCOUNT NUMBER: MULTIPLE

In Budget (Y/N)? Y

Approved for Submittal to Board:

Eric Doeh, Chief Executive Officer

Signature/Date:

Signed: Tuesday, January 31, 2023

Stacie Durant, Chief Financial Officer

Signature/Date:

Signed: Tuesday, January 31, 2023

DETROIT WAYNE INTEGRATED HEALTH NETWORK
BOARD ACTION

Board Action Number: 23-27R2 Revised: Y Requisition Number:

Presented to Full Board at its Meeting on: 2/15/2023

Name of Provider: Novaceuticals LLC

Contract Title: Substance Use Disorder Treatment Services Network Fiscal Year 2023

Address where services are provided: 754 Lounsbery, Rochester MI 48037

Presented to Program Compliance Committee at its meeting on: 2/8/2023

Proposed Contract Term: 2/1/2023 to 9/30/2023

Amount of Contract: $ 10,778,670.00 Previous Fiscal Year: $ 7,830,900.00

Program Type: Continuation

Projected Number Served- Year 1: 2,500 Persons Served (previous fiscal year): 2500

Date Contract First Initiated: 10/1/2022

Provider Impaneled (Y/N)? N

Program Description Summary: Provide brief description of services provided and target population. If propose contract is a modification, state reason and impact of change (positive and/or negative).

The SUD Department is requesting $235,00.00 in PA 2 funds to purchase 2,500 Naloxone Kits at $94.00 each from
Novaceuticals, LLC.. This is due to the drug overdose deaths in Wayne County. Naloxone blocks or reverses the effects of opioid medication, including extreme drowsiness, slowed breathing, or loss of consciousness. Naloxone is
used to treat a narcotic overdose in an emergency situation. The intent of its use is to save lives in the Detroit Wayne
County area. DWIHN will continue to train and disseminate the medication to Wayne County community members
interested in having the lifesaving medication. The training will also educate individuals on how to access SUD prevention, treatment and recovery services in Wayne County. DWIHN will purchase the Naloxone kits, train and disseminate the medication for all community members at large in Wayne County per request.

The Treatment Services program of $10,788,670 consist of Federal Block Grant of $9,561,670 and Public Act 2 funds of $1,227,000.00

Funds may be reallocated between providers up to the not to exceed amount without board approval.

Outstanding Quality Issues (Y/N)? N If yes, please describe:

Source of Funds: PA2

Fee for Service (Y/N): N

Revenue	FY 22/23	Annualized
SUD Block Grant	$ 9,561,670.00	$ 9,561,670.00
PA2	$ 1,227,000.00	$ 1,227,000.00
Total Revenue	$ 10,788,670.00	$ 10,788,670.00

Recommendation for contract (Continue/Modify/Discontinue): Continue

Type of contract (Business/Clinical): Business

ACCOUNT NUMBER: MULTIPLE

In Budget (Y/N)? Y

Approved for Submittal to Board:

Eric Doeh, Chief Executive Officer

Signature/Date:

Signed: Tuesday, January 31, 2023

Stacie Durant, Chief Financial Officer

Signature/Date:

Signed: Monday, January 30, 2023

DETROIT WAYNE INTEGRATED HEALTH NETWORK
BOARD ACTION

Board Action Number: BA 23-35R Revised: Y Requisition Number:

Presented to Full Board at its Meeting on: 2/15/2023

Name of Provider: Detroit Recovery Project

Contract Title: Substance Use Disorder Treatment Services Network Fiscal Year 2023

Address where services are provided: 1121 W. McNichols, Det, 48203

Presented to Program Compliance Committee at its meeting on: 2/8/2023

Proposed Contract Term: 10/1/2022 to 9/30/2023

Amount of Contract: $ 1,030,820.00 Previous Fiscal Year: $ 1,254,060.00

Program Type: Continuation

Projected Number Served- Year 1: 1,000 Persons Served (previous fiscal year): 1000

Date Contract First Initiated: 10/1/2022

Provider Impaneled (Y/N)? Y

Program Description Summary: Provide brief description of services provided and target population. If propose contract is a modification, state reason and impact of change (positive and/or negative).

The Michigan Department of Health and Human Services awarded the SUD Department an additional $350,000 from the American Rescue Plan Act (ARPA) Grant (aka COVID 3). The new ARPA treatment grant amount is $685,000. The original board action also included the MDHHS allocation of COVID funds in the amount of $76,760 and ARPA Prevention of $269,060. The revised total for BA 23-35R is $1,030,820.

The ARPA funding will provide prevention services for Youth Community Centers which will cater to youth suffering from addictions, homelessness, trauma and other related behavioral health issues by utilizing peer recovery coaches. The services may include education, coaching and active assistance to access SUD services

The Authority has the discretion to allocate the funds among the providers based upon utilization as long as the total amount of the board action (i.e. contract amount) does not increase. As a result, budget may be decreased/increased among sub-recipients as long as overall budget does not change.

Outstanding Quality Issues (Y/N)? N If yes, please describe:

Source of Funds: Block Grant

Fee for Service (Y/N): Y

Revenue	FY 22/23	Annualized
APRA Treatment and Prevention grant	$ 954,060.00	$ 954,060.00
COVID federal grant	$ 76,760.00	$ 76,760.00
Total Revenue	$ 1,030,820.00	$ 1,030,820.00

Recommendation for contract (Continue/Modify/Discontinue): Continue

Type of contract (Business/Clinical): Clinical

ACCOUNT NUMBER: MULTIPLE

In Budget (Y/N)? Y

Approved for Submittal to Board:

Eric Doeh, Chief Executive Officer

Signature/Date:

Signed: Tuesday, January 31, 2023

Stacie Durant, Chief Financial Officer

Signature/Date:

Signed: Tuesday, January 31, 2023

DETROIT WAYNE INTEGRATED HEALTH NETWORK
BOARD ACTION

Board Action Number: 23-56 Revised: Requisition Number:

Presented to Full Board at its Meeting on: 2/15/2023

Name of Provider: LAHC Leaders Advancing and Helping Communities

Contract Title: Leaders Advancing and Helping Communities, (LAHC) Community Health, Workforce Development & Training

Address where services are provided: 'None'__

Presented to Program Compliance Committee at its meeting on: 2/8/2023

Proposed Contract Term: 3/1/2023 to 9/30/2023

Amount of Contract: $ 190,000.00 Previous Fiscal Year: $ 0.00

Program Type: New

Projected Number Served- Year 1: 10,000 Persons Served (previous fiscal year): 80,000

Date Contract First Initiated: 3/1/2023

Provider Impaneled (Y/N)? Y

Program Description Summary: Provide brief description of services provided and target population. If propose contract is a modification, state reason and impact of change (positive and/or negative).

This board action is requesting the approval for $190,000 for Leaders Advancing and Helping Communities (LAHC) for start up costs to develop a health, workforce development and training hub that will provide several programmatic and skill building programs. Skilled Building programs were significantly impacted by the pandemic and several programs were reduced or closed as a result the pandemic. In addition, program will be located in Dearborn and will provide outreach to a targeted underserved population. The program will also provide outreach services to members in Northwest Detroit, and Redford.

The hub will enable LAHC to expand on current successful programming (e.g., Cooking with Kids, FEAST, and other evidence-based education programs that benefit from hands-on cooking demonstrations) *and* establish a new workforce development track around the culinary sector.

LAHC will also offer multigenerational cooking classes that will connect older adults with younger generations (K-12th graders).

Finally, with the completion of the hub's construction, LAHC will be able to provide the community with a food pantry, which can also serve as an intake point for families who may require additional services.

Outstanding Quality Issues (Y/N)? N If yes, please describe:

Source of Funds: Local Funds

Fee for Service (Y/N): N

Revenue	FY 22/23	Annualized
LOCAL FUNDS	$ 190,000.00	$ 190,000.00
	$ 0.00	$ 0.00
Total Revenue	$ 190,000.00	$ 190,000.00

Recommendation for contract (Continue/Modify/Discontinue): Continue

Type of contract (Business/Clinical): Clinical

ACCOUNT NUMBER: 64931.817003.00000

In Budget (Y/N)? Y

Approved for Submittal to Board:

Eric Doeh, Chief Executive Officer

Signature/Date:

Signed: Wednesday, February 1, 2023

Stacie Durant, Chief Financial Officer

Signature/Date:

Signed: Wednesday, February 1, 2023

DETROIT WAYNE INTEGRATED HEALTH NETWORK
BOARD ACTION

Board Action Number: 23-57 Revised: N Requisition Number:

Presented to Full Board at its Meeting on: 2/15/2023

Name of Provider: Bizanalytix Technologies LLC

Contract Title: Claims Audit and Utilization Review Systems (CAURS)

Address where services are provided: 6837 Dulles Dr. Powell, OH 43065

Presented to Program Compliance Committee at its meeting on: 2/8/2023

Proposed Contract Term: 3/1/2023 to 2/29/2024

Amount of Contract: $ 147,600.00 Previous Fiscal Year: $ 0.00

Program Type: New

Projected Number Served- Year 1: 3 Persons Served (previous fiscal year): 0

Date Contract First Initiated: 2/1/2023

Provider Impaneled (Y/N)? N

Program Description Summary: Provide brief description of services provided and target population. If propose contract is a modification, state reason and impact of change (positive and/or negative).

This board action is requesting the approval for a one year contract with two one year renewal options effective March 1, 2023 through February 29, 2024 for an amount not to exceed $147,600 for a claims audit software. The contract amount consist of both a software and implementation amount of $51,600 (capitalized) and an annual licensing fee of $96,000 (expensed).

In response to a RFP issued in January 2023, Bizanalytix Technologies LLC was deemed the most responsive.

The Claims Audit and Utilization Review System (CAURS) unlike claim processing subsystems that process one claim at a time, CAURS can be used to analyze post payment data for multiple claims at a time to identify suspicious provider billing patterns along with conducting audit both internally as well as externally working with providers.

The reports generated by the system well be used to assist in the detection of program fraud and abuse, monitor quality of services, and provide a function for the development of program policy.

Outstanding Quality Issues (Y/N)? N If yes, please describe:

Source of Funds: Multiple

Fee for Service (Y/N): N

Revenue	FY 22/23	Annualized
Multiple	$ 147,600.00	$ 147,600.00
	$ 0.00	$ 0.00
Total Revenue	$ 147,600.00	$ 147,600.00

Recommendation for contract (Continue/Modify/Discontinue): Continue

Type of contract (Business/Clinical): Business

ACCOUNT NUMBER: various

In Budget (Y/N)?

Approved for Submittal to Board:

Eric Doeh, Chief Executive Officer

Signature/Date:

Signed: Thursday, February 2, 2023

Stacie Durant, Chief Financial Officer

Signature/Date:

Signed: Thursday, February 2, 2023