DETROIT WAYNE INTEGRATED HEALTH NETWORK

QUALITY ASSURANCE PERFORMANCE IMPROVEMENT PLAN

(QAPIP) DESCRIPTION

FY 20-21 and FY 21-22

Approved:

Approved by the Quality Improvement Steering Committee (QISC)	1/12/2021
Approved by Program Compliance Committee (PCC)	1/13/2021
Approved by Full Board of Directors	1/20/2021

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Section 1: Introduction

The Detroit Wayne Integrated Health Network (DWIHN), a National Committee Quality Assurance (NCQA) accredited Managed Behavioral Health Organization (MBHO) is the Pre-Paid Inpatient Health Plan (PIHP) and Community Mental Health Service Provider (CMHSP) for Detroit and Wayne County. DWIHN is the largest community mental health service provider in the State of Michigan. The Quality Assurance Performance Improvement Plan (QAPIP) Description defines the program, purpose, structure, policy and procedure for DWIHN in the framework of DWIHN's Mission, Vision and Value. provides assurance that DWIHN achieves in alignment with healthcare reform. The QAPIP demonstrates to members, advocates, community organizations, health care providers and State policy makers that it has a distinct competency as a high-performing, member-focused, quality-focused, and evidence-based efficient provider of mental health and substance use disorder services and is an essential partner in helping healthcare reform to succeed. The QAPIP has the infrastructure necessary to improve the quality and safety of clinical care and services to our members and to oversee the QI program by ensuring desired member health status, quality of life and member satisfaction.

The term of the QAPIP begins October 1, 2020 and ends September 30, 2022. Upon expiration of the term, the QAPIP shall remain in effect until the DWIHN's Board of Directors approves a new QAPIP. The QAPIP incorporates by reference, any and all policies and procedures necessary to operate as a Prepaid Inpatient Health Plan and Community Mental Health Services Program. The DWIHN's Board of Directors hereby approves all current and subsequent policies and procedures through the approval of the QAPIP.

Mission, Vision and Values

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

Mission

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

Vision

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

Values

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

Quality Assurance Performance Improvement Plan (QAPIP)

The QAPIP provides the framework necessary to improve the quality, safety and efficiency of clinical care. The QAPIP provides structure and governance to guide the formal processes for evaluating and improving the quality and appropriateness of health care services and the health status of the populations we serve. It also defines the authority, scope and content of the QI program, including the roles and responsibilities of committees and individuals supporting program implementation.

The QAPIP contains the core functions of DWIHN's Board approved Strategic Plan, and the (6) pillars which serve as the foundation of the commitment of DWIHN to continuously improve the quality and safety of clinical care and quality of service. These functions will be conducted by DWIHN and its network of contracted service providers. It is the responsibility of DWIHN to ensure that the QAPIP meets applicable Federal and State laws, contractual requirements and regulatory standards.

Scope of the QAPIP

The scope of the quality improvement activity includes DWIHN contracted service providers. It identifies the important processes and aspects of care, both clinical and non-clinical, required to ensure quality supports and services for persons in the system. DWIHN requires all contracted Clinical Responsible Service Providers (CRSP) to have a mental health and substance use disorder quality improvement plan relevant to the services they provide. DWIHN assures that all demographic groups, care settings and types of services are included in the scope of the QAPIP by including members, advocates, contracted service providers and community groups in the quality improvement process using a Continuous Quality Improvement (CQI) perspective.

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

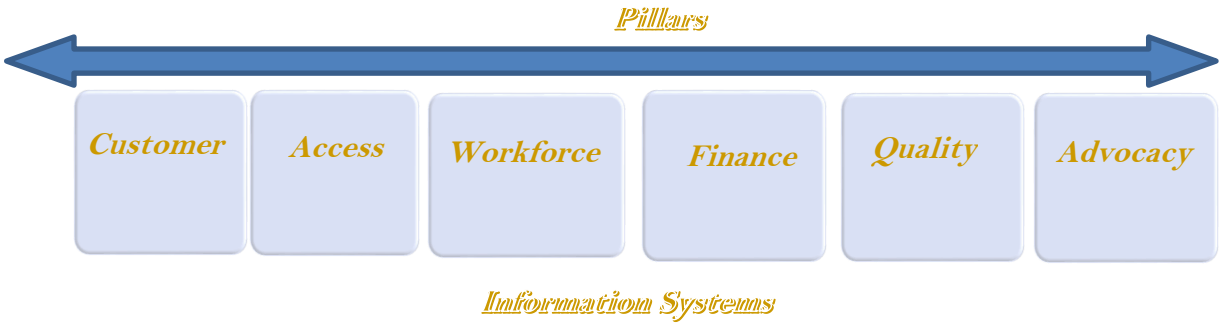
Quality Improvement Program (QIP)

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

DWIHN maintains a network-wide commitment to quality and industry best practices and standards as set forth by state and federal regulations, as well as accrediting organizations. The QAPIP defines the program purpose, structure, policy and procedure for DWIHN in the framework of DWIHN's Mission and Values.

Quality Improvement Program (QIP) Governance

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



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

Cultural and Linguistic Needs

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

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

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

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

DWIHN monitors the delivery of care and services in relation to the provision of culturally competent services through review of Staff Training Records, Member Satisfaction Surveys and Provider Satisfaction Surveys.

Framework for Quality Improvement

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

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

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

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

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

Continuous Quality Improvement Activities

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

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

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

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

The Michigan Department of Health and Human Services (MDHHS) requires that DWIHN provide a written description of the QAPIP plan for approval by the Board of Directors. The contract with MDHHS requires DWIHN to annually conduct an effectiveness review of its QAPIP. The effectiveness review includes an analysis of whether there have been improvements in the quality of health care and services for members as a result of quality assessment and improvement activities and interventions carried out by DWIHN. The analysis takes into consideration trends in service delivery and health outcomes over time and include monitoring of progress on performance goals and objectives. The QAPIP is also reviewed for effectiveness of the methods used to implement, monitor and evaluate the quality improvement processes and for any necessary revisions and adjustments on a monthly basis. The review of the QAPIP includes members, providers, Quality Improvement Steering Committee (QISC), Program Compliance Committee (PCC) of the DWIHN's Board of Directors, and other stakeholders. Information on the effectiveness of DWIHN's QAPIP is provided annually to our stakeholders and to members upon request.

At a minimum, the QAPIP specifies the following elements:

a. An adequate organizational structure that allows for clear and appropriate administration and evaluation of the QAPIP.

b. Responsibilities of the governing body for monitoring, evaluation and making improvements to care.

c. Objectives and timelines for implementation and achievement.

d. Role of recipients of services and other stakeholders in the QAPIP plan.

e. Mechanisms or procedures used for adopting and communicating process and outcome improvements.

f. Description of a designated senior official responsible for QAPIP implementation.

g. Performance measures to address access, availability, quality, efficiency and outcome of services, using standardized indicators based upon the systematic, ongoing collection and analysis of valid and reliable data.

h. Performance improvement projects that address clinical and non-clinical aspects of care that are directed as the state and the DWIHN established aspects of care. Clinical areas include high volume services, high-risk services and continuity and coordination of care. Non-clinical areas include grievances and appeals, complaints and access to and availability of services.

i. Process from the review and follow-up of Critical/ Sentinel Events and events that place members at risk of harm.

j. Periodic quantitative (i.e., survey) and qualitative (i.e., focus group) assessments of member experiences with services. These assessments must address issues of quality, availability and accessibility of care.

k. Process for the incorporation of members receiving services into the review and analysis of the information obtained from quantitative and qualitative reviews.

l. Written procedures to determine whether physicians and other licensed health care professionals are qualified to perform their services.

m. Written procedures to ensure non-licensed providers of care or support are qualified to perform their jobs.

n. The organization’s process for the initial credentialing and re-credentialing of providers.

o. Identification of staff training needs and provision of in-service training, continuing education and staff development activities.

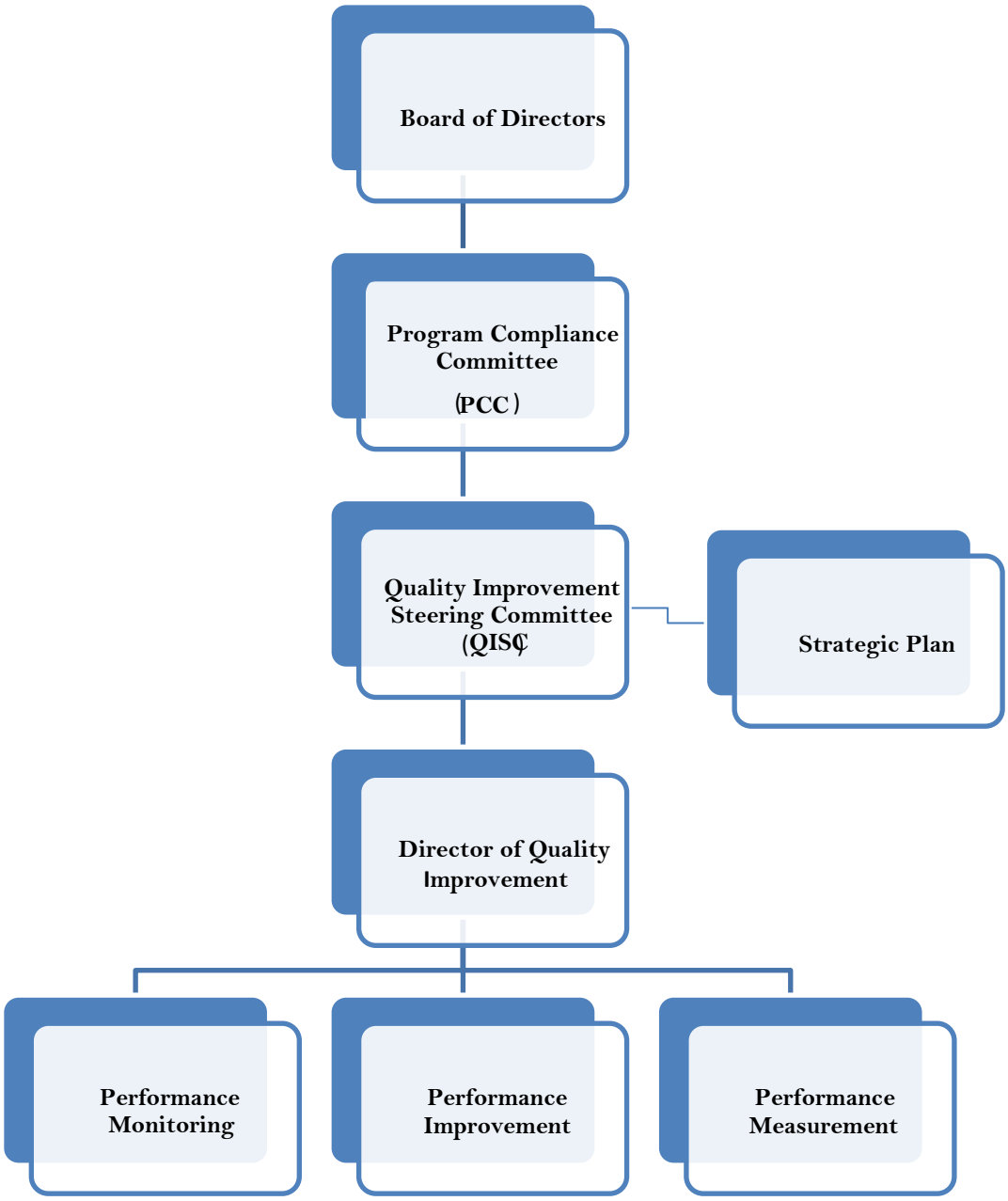
p. DWIHN process to verify whether services reimbursed by Medicaid were actually provided to enrollees by affiliates and service providers.

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

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

SECTION 2: Leadership and Structure

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



GOVERNING BODY

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

Director of Quality Improvement

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

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

SECTION 3: Quality Improvement (QI) Unit

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

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

Performance Improvement

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

To meet the regulatory requirements for MDHHS and NCQA requirements, DWIHN conducts all Performance Improvement Projects (PIPs) that are approved through the Improving Practices Leadership Team (IPLT) and the Quality Improvement Steering Committee (QISC). The purpose of the PIPs is to provide and promote continuous quality improvement through on-going measurement and interventions that are clinical and/or non-clinical services with beneficial effect on health outcomes and member satisfaction. DWIHN requires its provider network to participate in the PIPs related to their respective programs and services. In addition, each of the providers in the network are expected to conduct PIPs based on their own self-assessment of need, risk, frequency and performance. In addition, DWIHN's contract with MDHHS requires a State mandated performance improvement activity as well as, activities identified by QISC.

During the waiver renewal period DWIHN has at least two affiliation-wide Performance Improvement Projects (PIPs). These are conducted to promote continuous quality improvement through on-going measurement, intervention as well as verifiable and sustained improvement in significant aspects of clinical care and/or non-clinical services. These projects are expected to have a beneficial effect on health outcomes, member safety and satisfaction.

The MDHHS Quality Improvement Council identifies the project topic on at least one of the PIPs and DWIHN identifies at least one project topic. The DWIHN PIP topic is to address performance issues that have been identified through the External Quality Review (EQR), the Medicaid Site Review, the Needs Assessment, the Performance Indicator system, the performance monitoring and measurement system.

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

The Substance Use Disorder Providers and the Clinical Responsible Service Providers (CRSP) are expected to participate in DWIHN's PIP related to their programs and services. They are also expected to conduct PIPs based on their own self-assessment of need, risk, frequency and performance.

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

In partnership with stakeholders Quality Improvement activities include:

- Assessment of needs, quality of services, accessibility of care, availability of care, outcomes of services provided and beneficiary experiences with services
- Evaluation of systems, programs and services
- Collect performance data utilizing effective quantitative metrics that are specific, measurable, actionable, relevant and timely for Michigan Mission Based Performance Indicator System, MDHHS and DWIHN Performance Improvement Projects, QAPIP Status/Outcomes, Satisfaction Surveys (Member and Provider), Standardized HCPCS Code Utilization, Medicaid and Other Claim Verification, MDHHS and DWIHN Needs Assessments, and Network Policies
- Identification of positive and negative process trends
- Analysis of causes of positive and negative statistical variation and outliers
- Identification of opportunities for improvement
- Determination of goals and objectives
- Decision making and planning
- Stakeholder education/information sharing
- information and technical assistance regarding the quality improvement issues, trends, techniques and proposed outcomes
- Implementation of performance improvement activities
- Measure and monitor progress toward goal achievement
- Evaluate outcomes and modify performance improvement process as needed
- Implementation of standardized performance improvement activities
- Strategic and annual planning

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

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

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

This planned communication may take place through the following methods:

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

Performance Monitoring

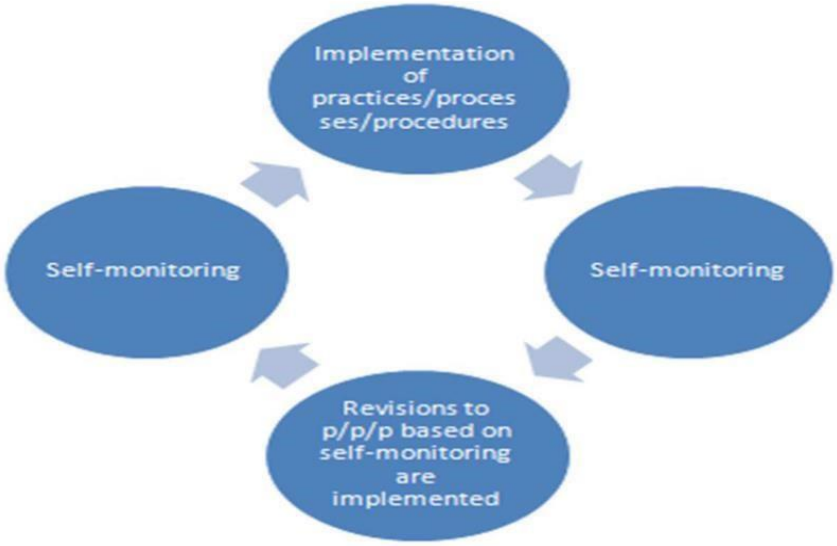
The continuous monitoring of DWIHN's service provider network includes any affiliates or subcontractors to which it has delegated managed care functions. The standards used to assess contractors are the applicable sections of the Social Security Act, the Code of Federal Regulations (CFR), the Center for Medicare and Medicaid (CMS), MDHHS Operations Manuals, Michigan's Medicaid State Plan, and the Michigan Medicaid Provider Manual.

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

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

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

Figure 1.

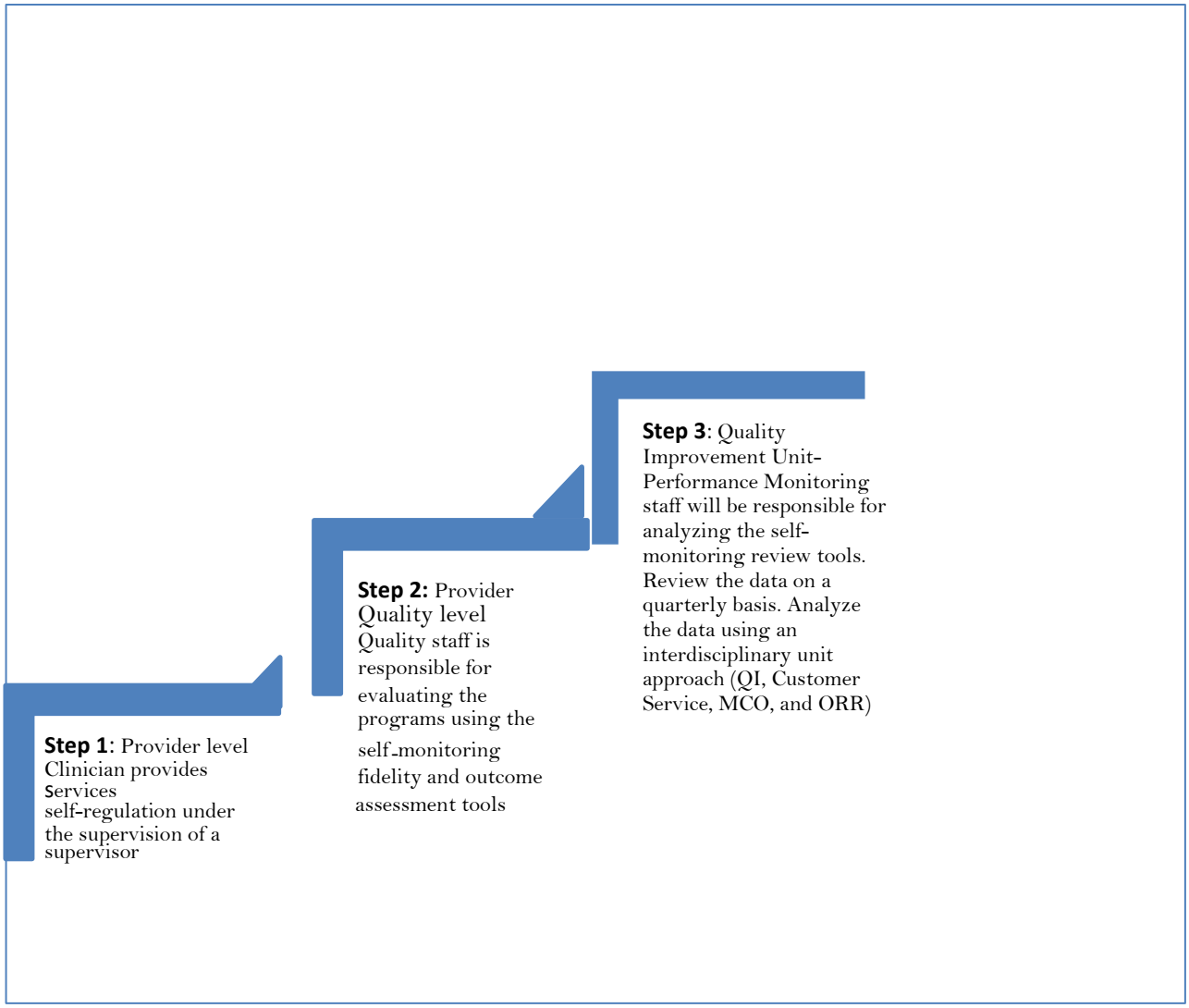


The Performance Monitoring Plan is geared to improve quality and measure our performance in the delivery of service and compliance with required standards. This plan requires the involvement, skills, expertise and input from DWIHN's Service Provider Network and internal staff. Requiring self-regulation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

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

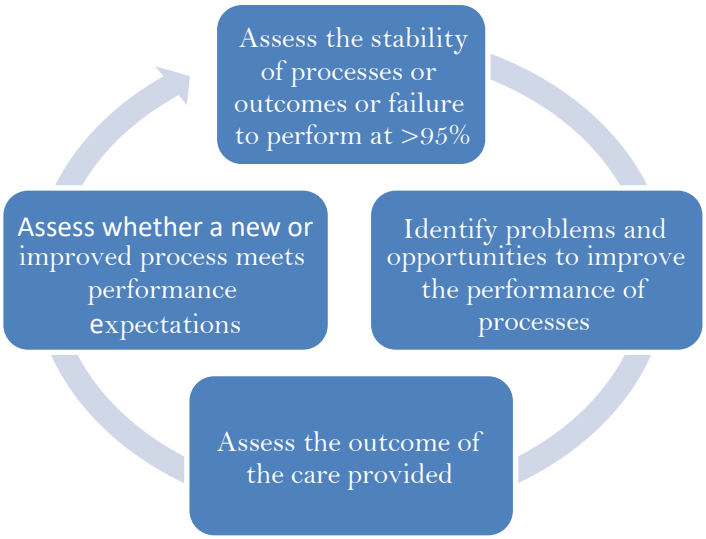
- Actions and/or process requirements are not open to different interpretations
- The process is made easier to understand
- Non-value-added steps are eliminated
- Effectiveness and efficiency are increased
- The process can be benchmarked to determine if it is excellent or to set new performance goals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

Process Steps of Performance Monitoring Pathway (defined by QI)

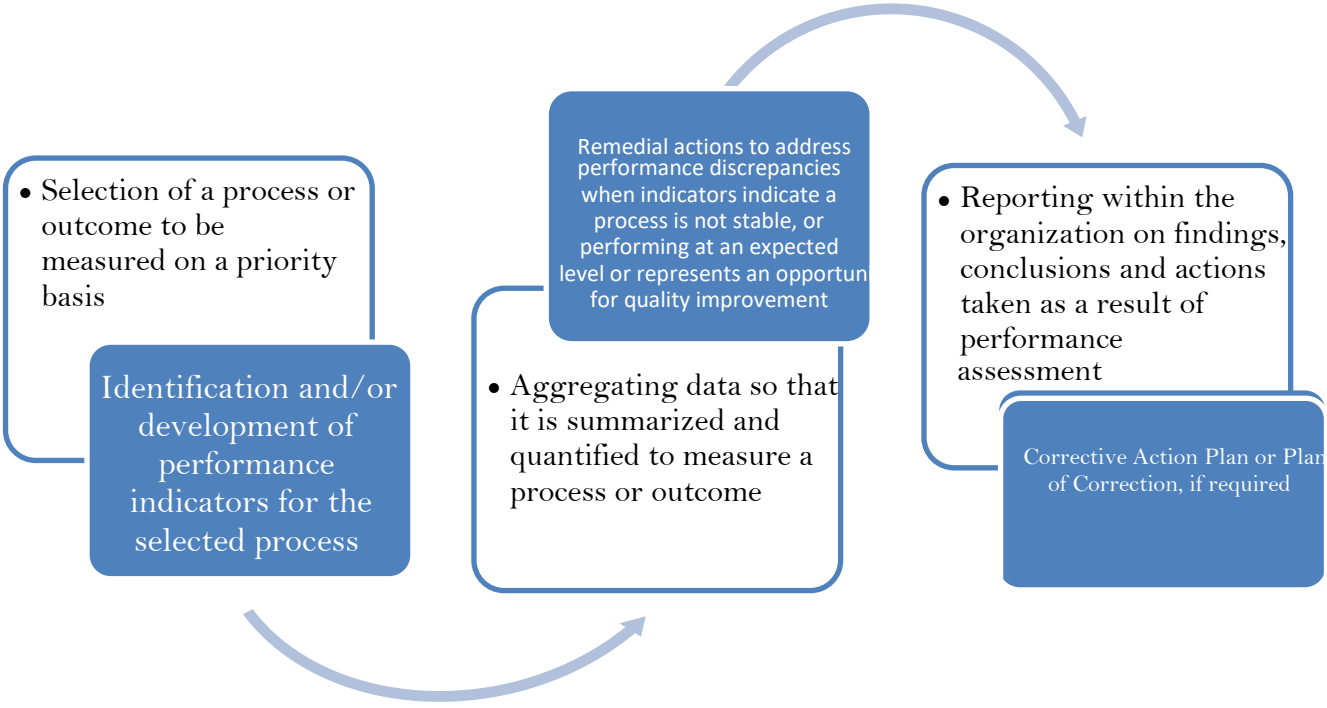


Performance Measurement

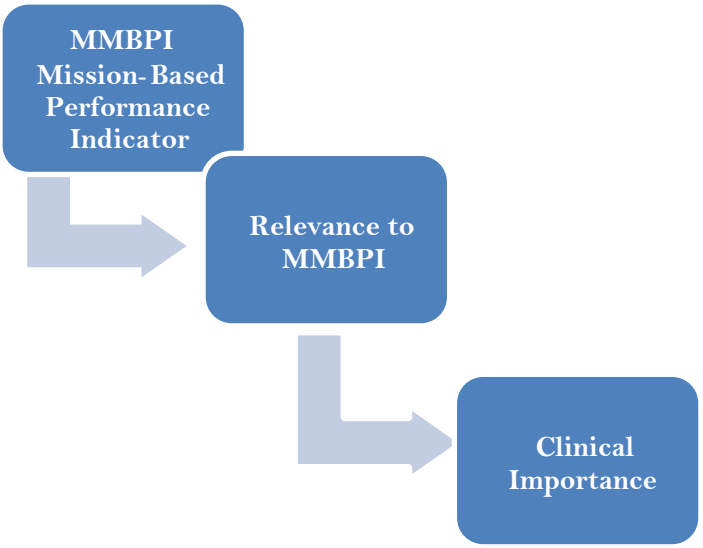
Performance measurement is a critical component of the PDSA cycle. Performance Measurement is the process of regularly assessing the data results produced by a program. The ***purpose*** of measurement and assessment is to:



Measurement and assessment ***involve***:

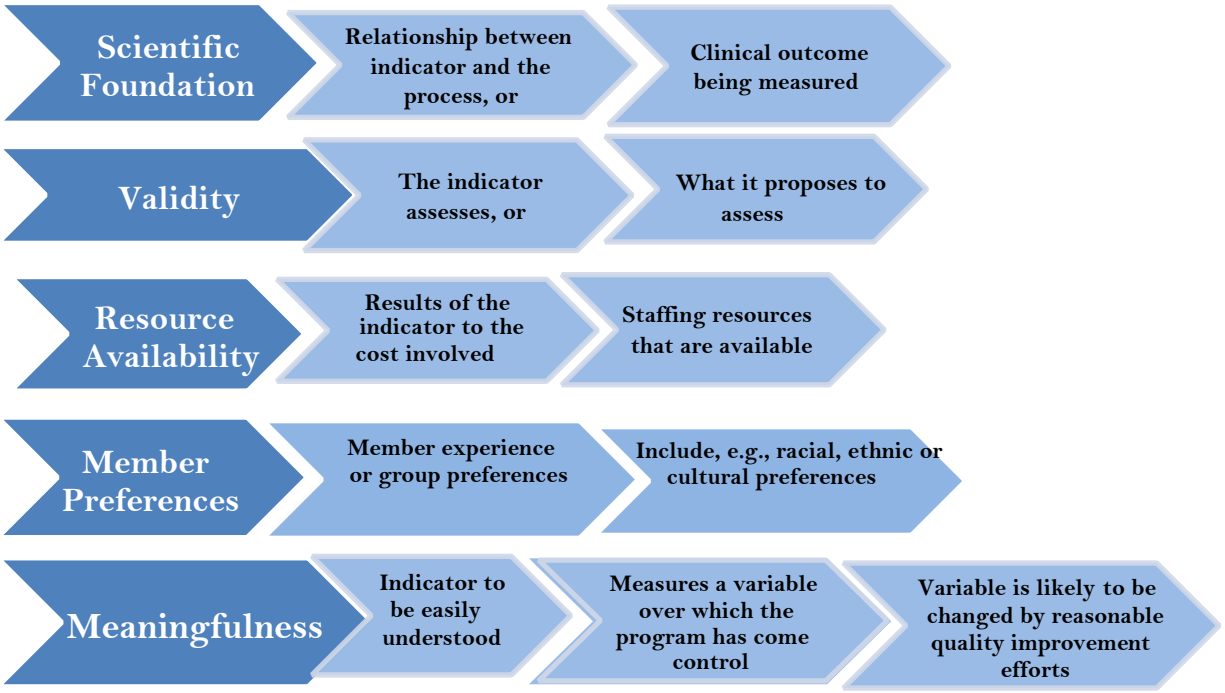


Selection of a Performance Indicator



Characteristics of a Performance Indicator

Factors to consider in determining which indicator to use include:



The Performance Indicators Selected for the DWIHN'S Quality Improvement Plan FY 21-23 from the Strategic Plan

For purposes of this plan, an indicator(s) comprises five (5) key elements: name, definition, data to be collected, the frequency of analysis or assessment, and preliminary ideas for improvement. The following ten (10) performance indicators will be the focus using the Board approved Strategic Plan, Pillars and Focus Areas.

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

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

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

Performance Indicators Assessment

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

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

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

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

SECTION 4: Committee Structure

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

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

Program Compliance Committee (PCC)

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

Membership:

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

Function of the Committee:

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

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

Quality Improvement Steering Committee (QISC)

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

Membership:

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

Function of the Committee:

- Establish and annually review committee operational guidelines, such as confidentiality, meeting frequency, management of information requests, number of members required for a quorum, membership, etc.
- Establish committee goals and timelines for progress and achievement
- Participate in the development and review of quarterly/annual reports to the Program Compliance Committee and the Full Board of Directors regarding the Quality Improvement System
- Annually review and evaluate the effectiveness of the Quality Assessment Performance Improvement Program
- Oversee a circular communication process in order to ensure that all involved constituencies, including the Board of Directors, DWIHN staff, and members, providers and other stakeholders are a part of the Quality Improvement Process
- Provide recommendations and feedback on process improvement, program implementation, program results and program continuation or termination
- Examine quantitative and qualitative aggregate data at predetermined and critical decision-making points and recommend courses of action
- Review reports from regulatory DWIHN reviews
- Review of DWIHN improvement plans and make recommendations based on these reviews
- Monitor progress and completion of plans of correction in response to recommended remedial actions identified for the DWIHN or by regulatory organizations
- Review quality Improvement operating procedures and propose changes in procedures as needed
- Oversee a process for establishing, continuing or terminating subcommittees, standing committees, improvement teams, task groups and work groups

- Identify training needs and opportunities for staff development in the quality Improvement process
- Identify future trends and make recommendations for next steps
- Develop standardized forms required for the work of the Steering Committee
- Initiate and participate in recognition and acknowledgement of successes in quality Improvement for the DWIHN and the community mental health system
- Leadership in practice improvement projects

Improving Practices Leadership Team (IPLT)

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

Membership:

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

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

Function of the Committee:

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

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

- Enable structures and process capabilities
- Improve cultural capacity
- Demonstrate their progress in system transformation by implementing evidence based, promising and new and emerging practices

Standing Committees

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

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

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

Critical/Sentinel Events Committee (CSEC)

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

Membership includes but not limited to:

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

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

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

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

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

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

Death Review Committee (DRC)

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

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

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

Membership includes but not limited to:

- Medical Director
- Clinical Practice Improvement
- Managed Care Operations

- Quality Improvement
- Office of Recipient Rights
- Integrated Health Care
- Substance Use Disorders

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

Peer Review Committee (PRC)

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

Membership:

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

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

Behavioral Treatment Advisory Committee (BTAC)

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

at the PIHP level. The committee submits quarterly BTPRC data analysis reports to MDHHS.

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

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

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

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

Credentialing Committee

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

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

Membership:

- Medical Director
- Network Providers
- DWIHN Staff

Risk Management

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

Membership:

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

Function of the Committee:

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

Cost Utilization Steering Committee

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

Membership:

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

Function of the committee:

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

Compliance Committee

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

Membership:

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

Function of the Committee:

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

Customer Service Committee

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

Membership:

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

Function of the Committee:

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

Recipient Rights Advisory Council (RRAC)

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

Membership:

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

Function of the committee:

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

Research Advisory Committee (RAC)

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

Membership

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

Function of the committee:

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

Constituent's Voice

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

Membership:

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

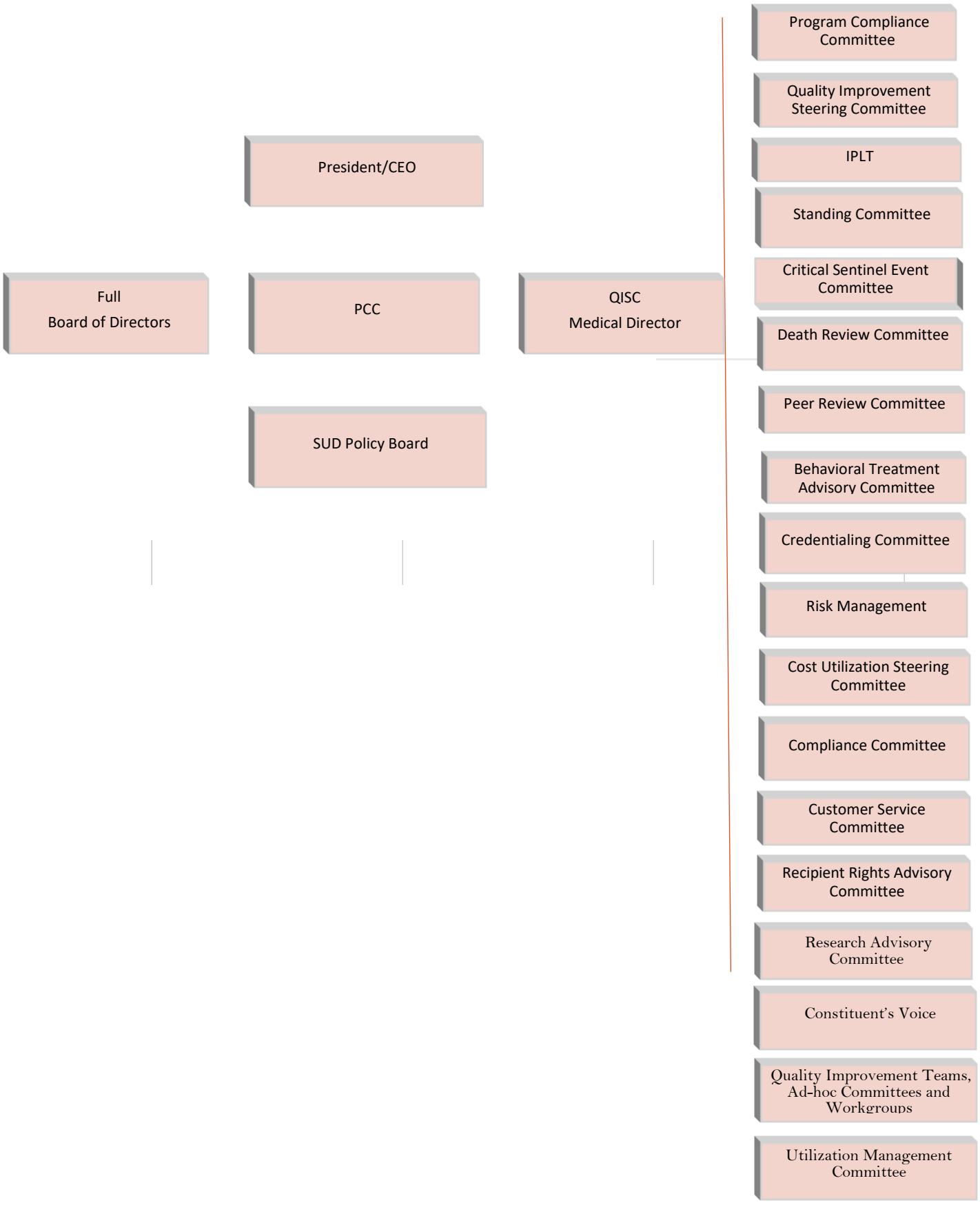
Function of the Constituent's Voice:

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

Quality Improvement Teams, Ad Hoc Committees and Workgroups

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

Utilization Management Committee (UM) – see UM Program Description for further information.


President/CEO
Full
Board of Directors
PCC
QISC
Medical Director
SUD Policy Board
Program Compliance Committee
Quality Improvement Steering Committee
IPLT
Standing Committee
Critical Sentinel Event Committee
Death Review Committee
Peer Review Committee
Behavioral Treatment Advisory Committee
Credentialing Committee
Risk Management
Cost Utilization Steering Committee
Compliance Committee
Customer Service Committee
Recipient Rights Advisory Committee
Research Advisory Committee
Constituent's Voice
Quality Improvement Teams, Ad-hoc Committees and Workgroups
Utilization Management Committee

SECTION 5: Quality Improvement Evaluation

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

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

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

Plan Actions for 2021

In FY 2021, the QAPIP work plan will be reviewing these areas to achieve continuous quality improvement in the quality and safety of clinical care, quality of service and member experience.

- Maintain NCQA accreditation.
- Telehealth services have emerged as essential technology for providing services to our members during Covid-19. It is imperative to ensure adequate and efficient services are being provided to the people we serve and that proper monitoring of this service delivery is accomplished.
- Establish an effective Crisis Response System and Call Center
- Continuously improve the quality, appropriateness, availability, accessibility, coordination and continuity of health care services to members across the continuum of care.
- Improve member and provider satisfaction.
- Conduct reviews through virtual monitoring to ensure that telehealth services are compliant in accordance with regulatory standards.
- Ensure a high-quality network through credentialing, peer review and contracting processes.

- Continue to collaborate with providers to share ideas and implement strategies to improve care coordination and quality of service.
- Improve and manage member outcomes, satisfaction and safety.
- Maintain excellent compliance with state and federal regulatory requirements, and accreditation standards.
- Ensure DWIHN's organizational initiatives related to cultural competency and diversity for members and providers meet the needs of DWIHN members.
- Demonstrate and communicate DWIHN's commitment to improving progress toward influencing network-wide safe clinical practices.