Quality Improvement Steering Committee (QISC)
Tuesday, August 31, 2021
10:30 a.m. – 12:00 p.m.
Via ZOOM PLATFORM
Agenda

I.	Welcome	Tania Greason
II.	Introductions	Tania Greason
III.	DWIHN Updates	Dr. Shama Faheem
IV.	Approval of QISC August 31, 2021 Agenda	Dr. Shama Faheem& Committee
V.	Approval of QISC June 28, 2021 Minutes	Dr. Shama Faheem Committee
VI.	Clinical Practice Guidelines • Diabetic Guidelines • Multi Medication Guidelines	Dr. Shama Faheem
VII.	Review of Quality Improvement Project (QIP) a. Decreasing the Use of Multiple Antipsychotic b. Decreasing the Risk of Hepatitis, A	Alicia Oliver
VIII.	Follow up Items: **(tabled)** a. ECHO Adult b. Review of Barriers & Recommended Intervention	Margaret Keyes-Howard
IX.	MMBPI Report Quarters 1 & 2	Justine Zeller
X.	PI 2a Review	Tania Greason
XI.	Adjournment	

Quality Improvement Steering Committee (QISC)
Tuesday, August 31, 2021
10:30 a.m. – 12:00 p.m.
Via ZOOM PLATFORM
Meeting Minutes
Note Taker: Aline Hedwood

Committee Chairs Dr. Shama Faheem, DWIHN Chief Medical Officer and Tania Greason, Provider Network QI Administrator

Member Present:
Alicia Oliver, April Siebert, Ashley Bond, Blake Perry, Carl Hardin, Cheryl Fregolle, Cheryl Medeja, Fareeha Nadeem, Ebony Reynold, Jessica Collins, John Pascasretti, Justin Zeller, Kim Batts, Melissa Eldredge, Rhianna Pitts, Dr. Shama Faheem, Starlit Smith, Tania Greason, Taquaryl Hunter and Trent Stanford, Lindon Munro, Rotesa Baker

Members Absent:
Allison Smith, Angela Harris, Benjamin Jones, Bernard Hooper, Dr. Bill Hart, Carla Spright-Mackey, Cassandra Phipps, Cherie Stangis, Dhannetta Brown, Donna Coulter, Donna Smith, Jennifer Smith, John Rykert, Judy Davis, June White, Latoya Garcia-Henry, Dr. Leonard Rosen, Margaret Keyes-Howards Melissa Moody, Melissa Hallock, Mignon Strong, Michele Vasconcellos, Miriam Bielski, Nasr Doss, Oluchi Eke, Ortheia War, Robert Spruce, Sandy Blackburn, Shirley Hirsch, Dr. Sue Banks, Tiffany Hillen and Vicky Politowski.

Staff Present: April Siebert, Tania Greason, Justin Zeller, Fareeha Nadeem, Starlit Smith, and Aline Hedwood.

1) Item: Welcome: Tania Greason

2) Item: Introduction: Tania asked the group to put their names and email addresses into the chat box for proof of attendance.
3) Item: Approval of August 31, 2021 Agenda:

4) Item: Approval of June 28th, 2021 Minutes: approved by Dr. S. Faheem and committee with noted revisions

5) Item: Announcement/DWIHN Update: Dr. S. Faheem

Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems ☐ Quality ☐ Workforce

NCQA Standard(s)/Element #: ☐ QI# ___ ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Decisions Made		
Dr. Faheem informed the committee of the following DWIHN updates: • DWIHN Opium Awareness Day drive through event, August 31, 2021 from 12:00 pm – 4:00 pm at 707 W. Milwaukee, Detroit, MI 48202 free Narcan Kits give away. • Congratulations to our CIT Team, under the leadership of Andrea Smith. CIT International has awarded DWIHN the Gold CIT Certification for the Detroit Wayne program. The award stated "the Detroit Wayne CIT program has the infrastructure of a mature regional CIT program: a diverse steering community, a very strong 40-hour training program for CIT officers and a strong coordinator team. • Eric Doeh has been selected as DWIHN Chief Executive Officer and Jackie Davis has been promoted to the Clinical Officer position effective August 2021.		
Discussion	**Assigned To**	**Deadline**
Action Items	**Assigned To**	**Deadline**
None Required.		

6) Item: Clinical Practice Guidelines – Dr. Sharma Faheem

- **Diabetic Guidelines**
- **Multi- Medication Guidelines**

Goal: Review of the Clinical Practice Guidelines

Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems **XQuality** ☐ Workforce

NCQA Standard(s)/Element #: X QI# 6 ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Decisions Made		
Dr. Faheem provided an overview of the screening members with schizophrenia and bipolar disorder on atypical antipsychotic medications for diabetes and the Multi Medication Guidelines. Discussed were the areas noted below: • Educate members and support staff on treatment options. • Treatment must be person-centered planning and individualized. • For atypical antipsychotic medications within fourteen (14) days of labs being ordered a follow up should be completed. • HEDIS measure diabetes screening for people with schizophrenia or bipolar disorder who are using multiple antipsychotic medications. • Please document changes to target symptoms. For additional information please review presentation **"Screening members with schizophrenia and bipolar disorder on atypical antipsychotic medications for diabetes"** for the following highlighted areas: • Screening for diabetes • Treatment and Follow-up • Monitoring		
Discussion	**Assigned To**	**Deadline**
Action Items	**Assigned To**	**Deadline**
None Required		

7a) Item: Review of Quality Improvement Project (QIP) - Alicia Oliver

a. Decreasing the Risk of Hepatitis, A

Goal: Review of PIP Decreasing the Risk of Hepatitis

Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems **XQuality** ☐ Workforce

NCQA Standard(s)/Element #: X QI# 11 ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Decisions Made		
Alicia Oliver discussed with the committee that the Hepatitis A PIP has been presented and approved by IPLT to sunset. DWIHN worked in collaboration with the Detroit Health Department (DHD) and the Wayne County Health Department (WCHD). With the approval of MDHHS. Collaboration included education on hepatitis A and offering the hepatitis A vaccine at the opioid treatment program sites three times over the course of 6 months Clients were also assessed for any medical complications that would require a referral to the health department. Clients were educated in a group setting and given the opportunity to ask questions. Clients that opted to have the vaccine, CDC hep A immunization questionnaire was provided to each client and reviewed privately. Education and vaccine were provided on the same day of the visit to decrease the risk of missing an immunization opportunity. Immunization was recorded in the Michigan Care Improvement Registry (MCIR). This registry was also checked to determine client's past immunization record. **The overall goal** CDC recommends getting to 80% vaccination coverage for the populations at highest risk of exposure. However, the state is focusing on eliminating Hepatitis A. DWIHN is planning on replacing Hepatitis A PIP with a Hepatitis C PIP.		
Discussion	**Assigned To**	**Deadline**
Action Items	**Assigned To**	**Deadline**
Dr. Faheem and the committee agreed to sunset the Hepatitis A PIP and move forward with its replacement Hepatitis C.	QISC	9.1.2021

7b) Item: Review of Quality Improvement Project (QIP) - Alicia Oliver

b. Decreasing the Use of Multiple Antipsychotics

Goal: Review of Decreasing the Use of Multiple Antipsychotics PIP

Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems **X Quality** ☐ Workforce

NCQA Standard(s)/Element #: X QI# 11 ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Decisions Made		
Alicia reviewed with the committee updates for the Decreasing the Use of Multiple Antipsychotics. Interventions include the following: • Memo that includes guidelines on the use of antipsychotics and the problems associate with polypharmacy sent to providers CEO, chief medical officer and quality director. (New data system Vital Data) • Memos sent to administrators and prescribers with their rates of polypharmacy within their agency and the expectation of a decrease by a minimum of 10% over 6-8 months. (New data system Vital Data) New intervention • Provide access of the population health tool (Vital Data) to our providers enabling them to identify member on multiple antipsychotics within their patient population. DWIHN saw a decrease in the use of 3 or more antipsychotics for 45 days or more. Comparing baseline measurement rate 48% to first remeasurement rate 35%, there is a 13-percentage point decrease. This decrease may be attributed to the key interventions as noted in the report. Comparing remeasurement 2 rate to remeasurement 1 rate there was no change in the rate, the rate remained 35%. DWIHN has not met its goal of 38% for this measure and will continue to identify specific prescribers with high rates of polypharmacy and request they re-evaluate the medication regime for these individuals. **The barriers identified**: Chief Medical Officer vacancy, Removal of CMT/Proact a population health tool to our providers enabling them to identify member on multiple antipsychotics within their patient population. Alicia reported that the noted interventions will help educate DWIHN members, providers and decrease the number of members who are prescribed 3 or more multiple antipsychotics.		
Discussion	**Assigned To**	**Deadline**
Action Items	**Assigned To**	**Deadline**
For measurement 3 period July – June 2021 data will be reconfigured to include Vital Data Hedis scores.	IHC (Alicia Oliver)	October 30, 2021

8) Item: MMBPI Report Quarters 1 & 2 – Justin Zeller
Goal: Review of MMBPI Data for Q1 and Q2
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems **X Quality** ☐ Workforce
NCQA Standard(s)/Element #: X QI# 4 ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Decisions Made		
Justin Zeller provided an overview of the comparison report for MMBPI data for Quarter 1 and Quarter 2. Overall analysis includes the following: • MDHHS benchmark is 95% the Quarter 1 was met for the total population for PI# 1, 4a, 4b and PI# total population for 4a and 4b also was met for Quarter 2. • PI #1 has slipped slightly below the 95% complaint rate DWIHN clinical officer is working with the CRSP providers on the barriers and DWIHN is at 94% for the 3rd quarter. • PI #2a dropped 13% there are no exception for PI 2a, 2b and 3, no standards or benchmark has been set. During Q3 of FY 2020, PI #2a criteria changed to a new person receiving completed biopsychosocial assessment within 14 days for non-emergent request. The change also eliminated exceptions for PI #2a & 2b. • Also, during Q3 of FY 2020, PI# 3 criteria changed for any new person starting medically necessary ongoing covered services within 14 days of a non-emergent biopsychosocial. This indicator also eliminated exceptions with no set benchmarks. • DWIHN has continued to score lower than other PHIP's for PI #2a. • QI has sent a request to the assigned providers requesting a POC and root cause analysis. Requested POC and RCA's for Q2 data are due to QI by August 26th, 2021. • For PI #10 the standard is 15% or less. DWIHN has not met this standard (Adults) and the numbers continues to decrease with an overall decrease of 4 % from the previous quarters. Q2 data was reported at 17.34% (Adults).		
Discussion	**Assigned To**	**Deadline**
Discussion ensued with the committee regarding the following: • Are members able to access transportation to their appointments or is DWIHN working with the providers to assistant the members with transportation. • Providers are receiving referrals after the 14 days window. • Provider will open slots so that members so they keep their schedule appointment inside of the 14 days standards.		

Action Items	Assigned To	Deadline
Tania asked the providers to review DWIHN Re-Engagement policy posted on DWIHN website. Indicator PI# 2a will continue to be discussed and reviewed with the Committee and meetings will be scheduled with individual providers to discuss "Best Practices" and ongoing interventions.	DWIHN QI and Assigned Network Providers	On-going.

9) Item: PI 2a Review – Tania Greason
Goal: Review of PI# 2a Analysis and Interventions
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems **X Quality** ☐ Workforce
NCQA Standard(s)/Element #: X QI# 4 ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Decisions Made		
As discussed in Item (8), PI #2a has become a top priority at DWIHN in regards increasing DWIHN's current compliant rate of 36.82%. PI2a reporting criteria has been changed effective Q3 of 2020. Changes include the IBPS being completed with 14 days of "New" members request for non-emergent services and also excludes exceptions. The clock starts when a new member requests and consents for service at this point, the biophysiological assessment must be completed within 14 calendar days of the request. DWIHN has submitted to the provider network a memo outlining the new changes and requirements. QI will seek clarification from MDHHS regarding if the requirements for members that reengage after 90 days. Providers have voiced concerns in regards to the member showing up day 91 for services as the member should not be considered "New" because they have not yet been disenrolled from the provider and they are not seeking "New Services". Providers continue to reach out to the members, if members are not responsive and are disenrolled or the case is closed from the provider, the member must go through the access center for "New Services" DWIHN is in the process of developing a shortened IBPS for the provider to complete If the member is not disenrolled and the case is not closed. DWIHN will continue to review and consult with MDHHS and report back to the committee.		
Discussion	**Assigned To**	**Deadline**
Action Items	**Assigned To**	**Deadline**
Providers are to review DWIHN Re-engagement and Disenrollment Policy. DWIHN will seek clarification from MDHHS regarding completing the IBPS for members that are involved in reengagement and not case closure at the provider level. Information will be brought back to the QISC.	Providers and DWIHN (QI)	October 30, 2021

New Business Next Meeting: Tuesday September 28, 2021 Via ZOOM Platform.

Adjournment: 12:011 pm

ah/09/13/2021

Detroit Wayne Integrated Health Network
DWIHN
Your Link to Holistic Healthcare

drive-thru NARCAN pick-up

In recognition of International Overdose Awareness Day,
join the Detroit Wayne Integrated Health Network
as we continue to bring awareness to the opioid epidemic
by picking up a NARCAN® kit.

Tuesday, August 31, 2021 • 12 NOON - 4:00 pm

707 West Milwaukee Avenue (Lot B) • Detroit, Michigan 48202

For more information, please call Judy Davis at (313) 530-3227

Alicia Oliver RN, MSN
Review of Quality Improvement Project: Decreasing the Use of Multiple Antipsychotics
Presented to QISC August 31, 2021

1. **Eligibility**: Clients prescribed 3 or more Antipsychotics for 45 or more days
2. **Screening Method**: DWIHN used the population health metrics to identify individuals on 3 or more antipsychotics for 45 days or more.
3. **The overall goal** is to reduce the use of polypharmacy throughout the network by 10% for during 2019 and 2020.
4. **Interventions:**
    - Memo that includes guidelines on the use of antipsychotics and the problems associate with polypharmacy sent to providers CEO, chief medical officer and quality director. (New data system Vital Data)
    - Memos sent to administrators and prescribers with their rates of polypharmacy within their agency and the expectation of a decrease by a minimum of 10% over 6-8 months. (New data system Vital Data) New intervention
    - Provide access of the population health tool (Vital Data) to our providers enabling them to identify member on multiple antipsychotics within their patient population.
5. **Impact to Improvement:**

Quantifiable Measure	**Use of 3 or more Antipsychotics for 45 or more days**
Numerator	**All member prescribed 3 or more antipsychotic for 45 or more days**
Denominator	**All members prescribed antipsychotics for 45 days or greater**

Use of 3 or more Antipsychotics for 45 or more days

Measurement Period	**Measurement**	**Numerator**	**Denominator**	**Rate of Results**	**Comparison Goal**
July 2017-June 2018	**Baseline**	**38**	**80**	**48%**	**NA**
July 2018-June 2019	**Remeasurement 1**	**32**	**92**	**35%**	**38%**
July 2019-June 2020	**Remeasurement 2**	**29**	**82**	**35%**	**38%**
July 2020-June 2021	**Remeasurement 3**				

DWIHN saw a decrease in the use of 3 or more antipsychotics for 45 days or more. As the table indicates comparing baseline measurement rate 48% to first remeasurement rate 35%, there is a 13-percentage point decrease. This decrease may be attributed to the key intervention as indicated. Comparing remeasurement 2 rate to remeasurement 1 rate there was no change in the rate. The rate remained 35%. DWIHN has not met its goal of 38% for this measure and will continue to identify specific prescribers with high rates of polypharmacy and request they re-evaluate the medication regime for these individuals.

6. **The barriers identified**: Chief Medical Officer vacancy, Removal of CMT/Proact a population health tool to our providers enabling them to identify member on multiple antipsychotics within their patient population.

CC2 Element A Factor 4
Decreasing the Risk of Hepatitis, A with immunization and Education
Presented to QISC August 31, 2021

1. **Eligibilit**y: DWIHN SUD Program enrollees
2. **Screening Method**: Consumers enrolled in Detroit Wayne Integrated Health Network (DWIHN) substance use disorder (SUD) programs associated with the high-risk categories identified below:

- Person with history of substance use
- Currently homeless or in transient living
- Men who have sex with men
- History of incarceration
- Persons with underlying liver disease

3. **The overall goal** CDC recommends getting to 80% vaccination coverage for the populations at highest risk of exposure:
4. Intervention:
   DWIHN worked in collaboration with the Detroit Health Department (DHD) and the Wayne County Health Department (WCHD). With the approval of MDHHS. Collaboration included education on hepatitis A and offering the hepatitis A vaccine at the opioid treatment program sites three times over the course of 6 months Clients were also assessed for any medical complications that would require a referral to the health department.
   Clients were educated in a group setting and given the opportunity to ask questions. Clients that opted to have the vaccine, CDC hep A immunization questionnaire was provided to each client and reviewed privately. Education and vaccine were provided on the same day of the visit to decrease the risk of missing an immunization opportunity.
   Immunization was recorded in the Michigan Care Improvement Registry (MCIR). This registry was also checked to determine client's past immunization record.
5. **Impact to improvement and barriers**

Quantifiable Measure	**The percentage of SUD Program enrollees receiving the Hepatitis A vaccination that attended a Hep A educational session**
Numerator	**Number of SUD enrollee/members enrolled in an OTP program that received Hep A vaccination at the educational session and have been identified in DWIHN data base**
Denominator	**Number of SUD enrollee/members enrolled in an OPT program that have been identified in DWIHN data base**

Measurement Period	**Measurement**	**Numerator**	**Denominator**	**Rate or Results**	**Comparison Goal**
May 1, 2018-October 31, 2018	**Baseline**	**423**	**943**	**44.85%**	**80% Identified by the State of Michigan state wide**
November 1, 2018-April 30, 2019	**Remeasurement 1**	**100**	**272**	**36.76%**	**80% Identified by the State of Michigan state wide**
May 1, 2019 to October 31, 2019	**Remeasurement 2**	**151**	**454**	**33.25%**	**80% Identified by the State of Michigan state wide**

The numbers reported below are DWIHN numbers that were obtained at their provider clinics. DWIHN reported their numbers to MDHHS by using a survey that was completed monthly. MDHSS provided the results of the Hep A incentive on their website. The MDHHS website reports, the numbers of cases of Hep

A, hospitalizations and deaths. The report also identifies counties and the number of Hep A cases in each county. Detroit is reported separately from Wayne County.

In the baseline data starting in May 2018-October 31, 2018, 943 SUD consumers were offered the Hep A vaccine. Of that number 423 had the vaccine administered and 44.85%.

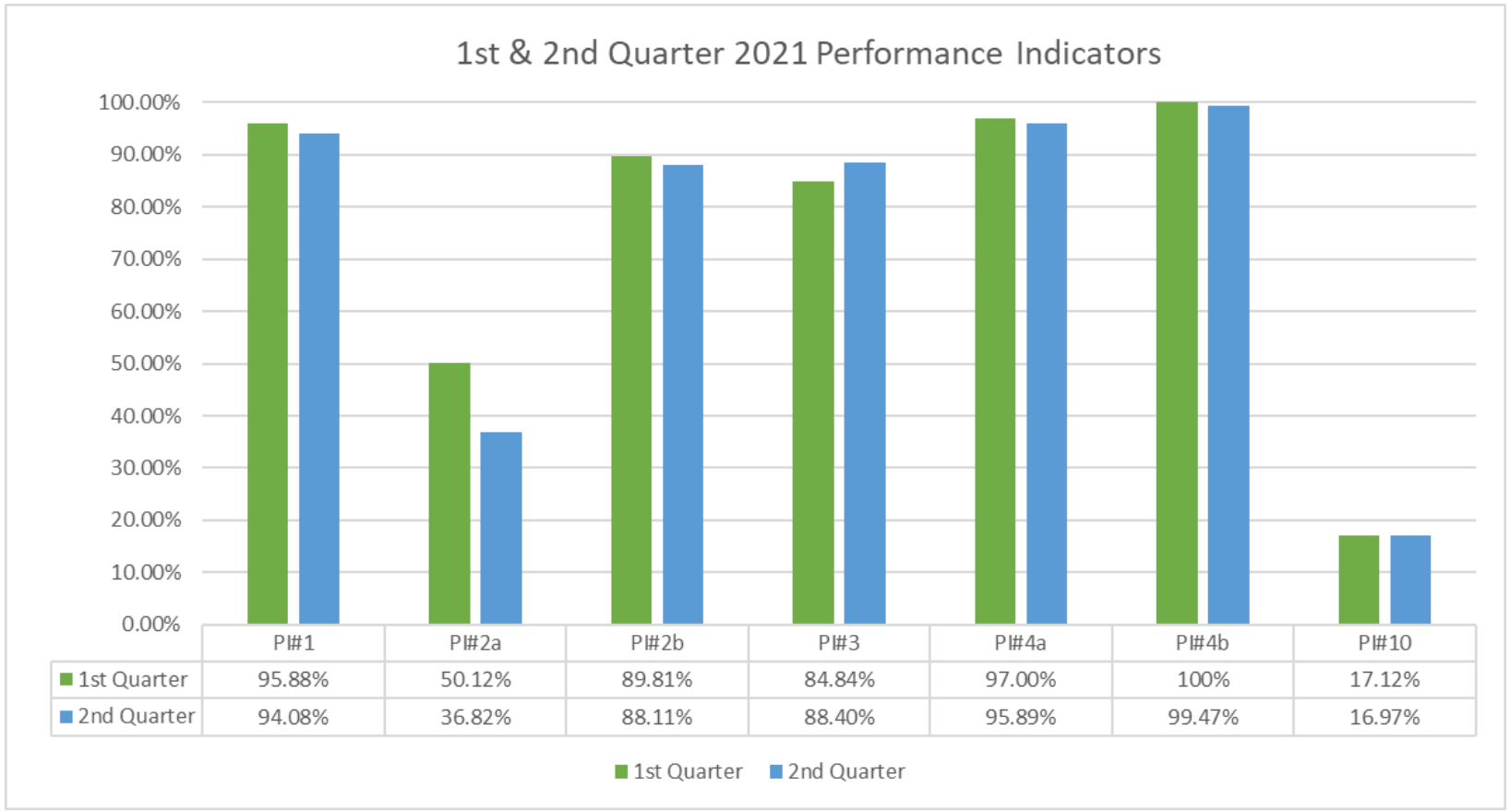
Remeasurement 1 November 1, 2018-April 30, 2019 272 SUD consumers were offered the Hep A vaccine. Of that number 100 had the vaccine administered 36.76%. This is a decrease of 8.09 percentage points. Barriers that contributed to the decrease in numbers were the inability to schedule a vaccine date with several of DWIHN providers. Several providers did not respond to DWIHN outreach to schedule a date. MDHHS stopped the survey in October 2018 stated the CDC reached the goal of 80% vaccination coverage for the populations at highest risk of exposure but encouraged counties to continue to offer the vaccinations.

Remeasurement 2 May 1 2019-October 31, 2019 454 SUD consumers were offered the Hep A vaccine. Of that number 151 had the vaccine administered 33.25%. This is a decrease of 3.51 percentage points. Scheduling with providers continued to be a barrier. An added barrier was the reconfiguration of the Detroit Health Department which caused a nursing shortage. Wayne County Health Department (WCHD) excludes Detroit. The Detroit Health Department (DHD) placed child immunizations first on their list. Once Hep A vaccination continued the DHD along with the WCHD had a shortage of Hep A vaccine, stating the State of Michigan was no longer providing the vaccine causing a continued decrease in the number of vaccinations administered.

Asking to sunset this PIP considering the State of Michigan has met it's goal of 80% and no longer providing vaccines to Detroit Health Department and Wayne County Health Departments.

All Health Departments are currently administering the COVID vaccine

The State has introduced a HEP C performance improvement plan. DWIHN is considering this plan as a replacement for Hep A.



	PI#1	PI#2a	PI#2b	PI#3	PI#4a	PI#4b	PI#10
1st Quarter	95.88%	50.12%	89.81%	84.84%	97.00%	100%	17.12%
2nd Quarter	94.08%	36.82%	88.11%	88.40%	95.89%	99.47%	16.97%

Analysis

The state's overall benchmark of 95% for FY2021(Q1) was met for indicators PI#1, PI#4a and PI# 4b. PI# 4a and 4b were also met for Q2. PI#1 slipped below the 95% compliance rate from Q1 to Q2. DWIHN's Crisis and Access is working with Crisis providers to address challenges/barriers for this indicator as it has slightly decreased over the last couple of quarters.

PI#2 dropped over 13% from Q1 to Q2. Beginning Q3 of FY 2020, separate indicators were developed for new persons receiving a completed Biopsychosocial Assessment within 14 calendar days of a non-emergency request for service and/or SUD Services. There are no exceptions for indicators 2a or 2b. No standard/benchmark for first year of implementation has been set by MDHHS.

Also, beginning Q3 of FY 2020, a separate indicator was developed for new persons starting any medically necessary on-going covered service within 14 days of completing a non-emergent Biopsychosocial Assessment. There are no exceptions for indicator 3. No standard/benchmark for first year of implementation has been set by MDHHS.

Indicator #2a review has become a top priority for DWIHN as the rates have continued to fall and reporting is significantly below the other PIHP's. Meetings are occurring within DWIHN to address ways to improve this indicator and reduce barriers. All areas involved in this process are being evaluated including the Access Center, CRSPs and members showing for scheduled appointments. CRSP providers were submitted information with requests for plans of corrections and root cause analysis. DWIHN continues to score well on PI#2b, #3, #4a total and #4b. #4a child events continue to be examined as we have missed the 95% mark for both of these quarters.

Lastly, Indicator #10 the state standard is 15% or less. DWIHN continues to not meet the 15% (Adult). The total for Q2 continues to demonstrate small decrease to go below 17%. This decrease is close to a 4% drop compared to one year ago. There are several departments within DWIHN that continue to meet and complete work in an attempt to reduce the adult recidivism rates. There are also external workgroups that include our provider network to address the identified issues/barriers for PI#10.