Quality Improvement Steering Committee (QISC)
Tuesday, January 12, 2021
1:30 – 3:00 p.m.
Via BLUE JEAN PLATFORM
Agenda

I.	Welcome	Tania Greason
II.	Introductions	Tania Greason
III.	Announcement/DWIHN Updates	Tania Greason
IV.	Approval of October 26, 2020 Minutes	Tania Greason
V.	NCAQ Updates	Gail Parker
VI.	Customer Service (CS) • Echo Survey Results (Adults) FY 2019-20 • Practitioner Survey Results	Margaret Keyes-Howard
VII.	Quality Improvement (QI) Program Description FY 2020-21 & FY 2021-22)	April Seibert
VIII.	Utilization Management (UM) • UM Evaluation (FY 2019-20) • UM Program Description • UM Annual Interrater Reliability Summary	John Pascaretti & Jennifer Miller
IX.	Integrated Healthcare • Complex Case Management Evaluation (FY 2019-20) **(tabled)** • Complex Case Management Description (**tabled)**	Ashley Bond
X.	Performance Improvement Projects (PIP') • Improving the availability of a follow up appt with a Mental Health Proffession within 7 days of Hospitalization for Mental Illness • Adherence to Antipsychotic Medications for Individuals with Schizophrenia - • Antidepressant Medication Management for People with a New Episode of Major Depression • Improving Diabetes Monitoring of People with Schizophrenia and Bipolar • Decreasing Wait for Autism Services	 A. Oliver **(tabled)** A. Oliver **(tabled)** A. Oliver (**tabled)** A. Oliver (**tabled)** Sabrina Bergman

Quality Improvement Steering Committee (QISC)
Tuesday, January 12, 2021
1:30 p.m. – 3:00 p.m.
Via BLUE JEAN PLATFORM
Meeting Minutes
Note Taker: Aline Hedwood

Committee Chairs: Dr. Leonard Rosen, Medical Director and Tania Greason, Provider Network QI Administrator

Member Present:
Dr. Leonard Rosen (present, technical difficulties unable to approve or discuss agenda items), Allison Smith, April Siebert, Ashley Bond, Cheryl Fregolle, Crystal Palmer, Darlene Owens, Dhannette Brown, Donna Coulter, Ebony Reynold, Fareeha Nadeem, Gail Parker, Jennifer Miller, Jessica Collins, John Pascaretti, June White Justin Zeller, Kimberly Flowers, Latoya Garcia-Henry, Margaret Keyes-Howards, Melissa Eldredge, Miriam Bielski, Oluchi Eke, Rhianna Pitta, Robert Spruce and Tania Greason.

Members Absent:
Alicia Oliver, Angela Harris, Benjamin Jones, Bernard Hooper, Dr. Bill Hart Blake Perry, Carla Spright-Mackey, Donna Smith, Eric Doeh, Jennifer Smith, Judy Davis, Michele Vasconcellos, Mignon Strong, Nasr Doss, Ortheia Ward, Rotesa Baker, Sandy Ware, Shirley Hirsch, Starlit Smith and Dr. Sue Banks.

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

1) Item: Welcome: Tania Greason

2) Item: Introduction: Tania asked the group to place their names and email addresses into the chat box for attendance.

3) Item: Approval of January 12, 2021 Agenda: approved by group with revisions

4) Item: Approval of October 2020 Minutes: approved by group.

5) Item: Announcement: Tania Greason & April Siebert

- Welcome to DWIHN new Medical Director Dr. Leonard Rosen
- QISC February 2021 meeting will be held on February 9th, from 10:30 am – 12:00 pm due to NCQA Preparation.
- The QISC meetings will be held every last Tuesday of each month from 10:30 am – 12:00 pm going forward.
- Tania will be sending a letter of recommendation to become part of the QISC out to members prior to the February 9th meeting.
- DWIHN has a updated the Critical and Sentinel Events module in MHWIN to include providers the ability to review and archive their provider data.
- There is free mental health assessment tool titled “Mind Wise” available on DWIHN’s website. The tool is confidential and offers available resources if needed.

6) Item NCQA Updates – Gail Parker
Goal: Discuss the status of DWIHN's NCQA Reaccreditation
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems ☐ Quality ☐ Workforce
NCQA Standard(s)/Element #: ☐ QI# ___ ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Discussion		
Gail Parker informed the QISC members that DWIHN is in the last month of preparations for our upcoming NCQA reaccreditation. DWIHN appreciates the committee's participation and recommendations for the Quality Improvement Project's (QIP's) which are included as part of the NCQA quality standards. The QISC meetings are a critical part of the quality process. Every QISC members feedback is an essential part for review of reports that are being presented allowing the organization and our provider network to continue the continuous quality improvement process to provide better service and outcomes for members that we serve.		
Decisions Made	**Assigned To**	**Deadline**
Action Items	**Assigned To**	**Deadline**
None Required.		

7) Item: Customer Services (CS) - Margaret Keyes-Howard
Echo Survey Results (Adults) FY 2019-20
Goal: Review of the ECHO Adult Survey for recommendations of noted barriers
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems **X Quality** ☐ Workforce
NCQA Standard(s)/Element #: X QI# 5 ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Discussion		
Margaret Keyes-Howard shared with the group some highlights of the findings from the Experience of Care & Health Outcomes Survey (Echo) Adult survey for FY 2020. The experience of healthcare and outcomes presentation will be available on DWIHN's website for review. Customer Service (CS) worked in conjunction with Wayne University School of Urban Studies with conducting the ECHO survey. The purpose of the survey was to assess the experiences of adults who have received mental health or substance use disorder services through DWIHN in the previous 12 months. DWIHN provided the Center with a randomly selected listof 5,999 members, out of the approximately 77,000 adults receiving services. 966 DWIHN members responded to the survey in which 752 members reported receiving services in the past year (82% of the 915 who responded to this question). DWIHN scored well on several of the ECHO reporting measures, notably members reporting receiving information on patient rights (91%) and confidence in the privacy of their information (91%). There were three measures with scores of lessthan 50%: Perceived improvement (31%); Office wait (36%); and Getting treatment quickly (43%). For additional information please review CS PowerPoint presentation" Experience of Care and Health Outcomes Echo Adult Survey" on the following highlight topics: • Methodology • Survey Highlights • Sample and Respondent Profile • Respondent Demographics • ECHO Reporting Measures • Detailed Findings: 1. ECHO Reporting Measures 2. Statistically Significant Differences by Subgroup		
Decision Made	**Assigned To**	**Deadline**
Action Items	**Assigned To**	**Deadline**
The ECHO Adult and Children surveys will be forwarded to the QISC committee for review. Recommendations from both surveys for adult &children will be reviewed at the QISC meeting in March 2021 meeting for discussions of barriers and improvement strategies for compliance scores of less than 50%.	QISC Members and Margaret Keyes-Howard	March 30, 2021

8) Item: Item: Customer Services - Margaret Keyes-Howard
Practitioner Survey Results
Goal: Review and Approval of the Practitioner Survey Results for recommendations of noted barriers
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems ☐ Quality ☐ Workforce
NCQA Standard(s)/Element #: ☐ QI# ___ ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Discussion		
Margaret Keyes-Howard provided a brief overview of the Practitioner Survey Results for FY20. Customer Service (CS) is responsible for the coordination of surveys, ensuring that DWIHN submits and receives the requested information/data from all approved surveys. CS coordinates with each of DWIHN's departmental units, providers and members to share data and outcomes from surveys conducted. This year CS is working closely with MCO for the review and analysis of the provider and practitioner surveys for FY20. The survey is designed to measure DWIHN's contracted provider organizations and practitioner's assessment of its performances. The survey covered 5 components: 1. DWIHN's effectiveness in meeting our contractual obligations 2. DWIHN's support of providers in meeting the needs of DWIHN's members 3. DWIHNs responsiveness to providers. 4. Uncover gaps and/or deficiencies in DWIHN's operation. 5. Identify opportunities for improvement and /or for corrective actions where needed. The survey was distributed to approximately 450 provider organizations and approximately 2,000 individual practioners. The survey was comprised of 76 questions and covered all areas of DWIHN's operation inclusive of the following departments: Utilization Management, Claims, Residential, Managed Care Operations, Quality Management and Credentialing. DWIHN experienced a significant increase in the survey response rate from FY 19. The response rate increased 50% for provider organizations and 21% for individual practitioners. The total number of actual respondents from provider organizations was 180 out of 354 and 572 respondents out of 1,500 individual practitioners. In total 753 surveys were returned out of approximately 3,000 emailed surveys with an overall percentage response rate of about 25%. "*Note DWIHN's targeted response rate is 50-60% response rate".* An ad-hoc group will be formed in early 2021 to review the FY 2019 and FY 2020 survey results, survey tool as well as the specific requests for improvement submitted by providers/practitioners as noted in the comment section. The ad-hoc group will be charged with tailoring the survey to best fit our contracted provider organizations and practitioners to achieve a higher response rate; as well as gain a better understanding of how we can support and maintain a strong provider network that will provide high quality supports and services to our members. Once this survey is approved by DWIHN Program Compliance Committee (PCC) it will be posted on the website. For additional information please review CS handout "Fiscal Year 20 Provider/Practitioner Survey Summary" on the following topics below: • Response Rate FY 2020		

• Barriers a) The survey results revealed the following opportunities for improvement b) Provider organizations and individual practitioners' request for the following • Planned Next Steps, Corrective Action & Follow-up • Conclusion		
Decision Made	**Assigned To**	**Deadline**
Action Items	**Assigned To**	**Deadline**
The QISC approved the FY 20 Practitioner Survey as written. The Practitioner Survey will be forwarded to Dr. Rosen for final approval. The group will review the Practitioner Survey for barriers and recommendation at the QISC March 2021 meeting.	Dr. Rosen and QISC Members	3/25/2021

9) Item: QAPIP Program Description FY 2020-2021 and FY 2021-2022 – April Siebert
Goal: Review and approval of the QAPIP Program Description
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems **X Quality** ☐ Workforce
NCQA Standard(s)/Element #: X QI# 1 ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Discussion		
April Siebert provided an overview of the QAPIP Program Description for FY 2020-2021 and FY 2021-2022. 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. MDHHS requires that each PHIP has a documented Quality Assurance and Improvement Plan that meets Federal regulations. These standards are based upon the balance budget act of 1997 and The Center of Medicaid Service requirements. The QAPIP program description is a two-year plan FY 2020-2021 and FY 2021-2022. The QAPIP description design the purpose, structure, procedures and framework of DWIHN mission, visions and values. There were a few updates made to the QAPIP description plan. For the HSAG compliance review, DWIHN received 100% score for the QAPIP plan and structure. QI made minor updates to ensure that the QAPIP is align with NCQA's focus areas which include quality, safety of clinical care, quality of service, and members experience; ensuring that the QAPIP emphasizes DWIHN commitment to the noted areas. 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. For additional information please review power pointe presentation the "(QAPIP) Program Description covers FY 2020 - 2021 and FY 2021-2022" for the following highlighted areas below: Strategic Plan Pillars:		

1) Customer Services 2) Access 3) Workforce Development 4) Finance 5) Quality 6) Advocacy		
Decision Made	**Assigned To**	**Deadline**
Action Items	**Assigned To**	**Deadline**
QI QAPIP Description was approved by the QISC The QAPIP Description will be forwarded to Dr. Rosen for final approval.	Dr. Rosen and QISC Members	3/25/2021

10) Item: Utilization Management Annual Program Evaluation (FY 2019-20) – John Pascaretti

Goal: Review and approval of the UM Annual Program Evaluation (FY2019-2020)

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

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

Discussion		
John Pascaretti provided an overview of the UM Annual Program Evaluation FY20. As part of continuous quality improvement process and on an annual basis, the UM Program is evaluated and incorporated into the annual Quality Assurance Performance Improvement Plan (QAPIP). This report is submitted to the DWIHN Utilization Management Committee (UMC), to the Quality Improvement Steering Committee (QISC) and the DWIHN Board of Directors for approval. UM authorizes services and Levels of Care that require prior authorization in the following's areas inpatient, outpatient, partial hospitalization, crisis residential, SUD and Autism services. UM currently has a staff of 33 employees on its team. UM program goals were aligned with DWIHN Strategic Plan six pillars Access, Finance, Quality, Customer Service, Workforce Development and Advocacy. For the highlight accomplishments, key metrics and identify opportunities for improvement please review power pointe presentation DWIHN "Annual Utilization Management Program Evaluation Fiscal Year 2020.		
Decision Made	**Assigned To**	**Deadline**
Action Items	**Assigned To**	**Deadline**
The UM Annual Program Evaluation (FY20) was approved by the QISC. The UM Annual Program Evaluation (FY20) will be forwarded to Dr. Rosen for final approval. The UM PowerPoint along with this presentation will be provided to the QISC for review prior to the next meeting the for recommendations and follow-up during the QISC meeting scheduled for March 2020.	Dr. Rosen and QISC Members	3/25/2021

11) Item: UM Program Description FY 2020-2021 and FY 2021-2022- John Pascaretti.
Goal: Review and approval of the UM Program Description for FY 2020-2021 and FY 2021-2022
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		
John Pascaretti provided an overview of the UM program description. The purpose of the UM Program Description is to define and describe processes that will align the Utilization Management program with DWMHA's Strategic Plan as identified by the Board of Directors. As part of the review process, UM has included the Utilization Management Community (UMC) within our provider network as part of the approval process to include revisions and recommendations. No noted revisions, recommendations or changes were received. For additional information please review power point presentation the Utilization Management Program Description.		
Discussion	**Assigned To**	**Deadline**
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Action Items	**Assigned To**	**Deadline**
The UM Annual Program Evaluation (FY20) was approved by the QISC. The UM Annual Program Description will be forwarded to Dr. Rosen for review and final approval. The UM Program Descriptions PowerPoint will be sent out to the group and Dr. Rosen for review for recommendation of noted barriers during the QISC meeting scheduled for March 2021.	QISC	3/25/2021

12) Item: UM Interrater Rater-Reliability Testing Summary – Jennifer Miller

Goal: Review and approval of the IRR Testing Summary

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

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

Discussion		
Jennifer Miller provided an overview of the Interrater-Rate Reliability test summary. In order to ensure consistency m application of medical necessity criteria, staff making utilization management (UM) decisions are required to test annually for inter-rater reliability. Detroit Wayne Integrated Health Network implemented use of the MCG medical necessity criteria for the higher levels of care network wide in June 2017. Each year since then and consistent with the medical necessity policy and inter-rater reliability procedure, the UM Department utilizes the MCG/Learning Management System to test staff making UM decisions. This report will focus on testing administered during October 1,2019 through September 30, 2020. During FY 19/20, staff making Utilization Management Decisions and using the MCG criteria and Indicia software were assigned case studies to review, accompanied by questions that tested the application of the behavioral health guidelines and medical necessity criteria to ensure interrater reliability among reviewers. The groups/entities which received cases studies include Cope, The Guidance Center, New Oakland, Children's Center, ACT Programs (9 Providers), DWIHN - UM, Residential, SUD, Autism. The number of case studies varied by entities based on their authorization function, and the number of studies available within the MCG/Learning Management System by patient population. Studies are designed from actual clinical scenarios and questions are designed to test users on the appropriate application of nationally recognized and evidence-based guidelines. For additional information which include recommendations and findings, please review handout" Summary of Inter-Rater Reliability Testing within the Learning Management System of MCG FY 2019-20.		
Decision Made	**Assigned To**	**Deadline**
Action Items	**Assigned To**	**Deadline**
The IRR Testing Summary was approved by the QISC Members The IRR Testing Summary will be forwarded to Dr. Rosen for Review and final approval.		

13) Item: PIP's Decreasing Wait for Autism Services - Sabrina Bergman
Goal: Review and approve continuation of the Decreasing Wait for Autism Services (PIP)
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems **X Quality** ☐ Workforce
NCQA Standard(s)/Element #: X QI# 10 ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Decisions Made		
Sabrina Bergman provided an overview of the Autism PIP Decreasing Wait Time for Autism Services. The overall goal is to increase the number of staffs working within the Autism Benefit and increase the number of ASD Benefit members receiving Applied Behavioral Analysis within 90 days of MDHHS approval. DWIHN's ABA Provider Network continues to have a 8:1 or less ratio of staff to consumer but struggles to provide services within 90 days of MDHHS approval (15:1 is the requirement set forth by the national guidelines of the Behavior Analysis Certification Board). Review of interventions were noted with rates not currently meeting the comparison goals. For additional information please review power pointe presentation DWIHN "Autism Benefit" on the following highlighted area: • Service Request project • Measurements • Timeliness • Meaningful/Measurable Intervention		
Discussion	**Assigned To**	**Deadline**
Action Items	**Assigned To**	**Deadline**
The QISC team approve the continuation with Decreasing Wait for Autism Services PIP. Autism PIP will be forwarded to Dr. Rosen for review and final approval for continuation. PowerPoint will be forwarded to the QISC members for review of recommendations at the meeting scheduled in March 2021.		

New Business Next Meeting: Tuesday February 9, 2021 Via Blue Jean Link Platform.

Adjournment: 3:56 pm

ah/01/13/2021