Quality Improvement Steering Committee (QISC)
Tuesday, February 4, 2020
12:30 – 3:30 p.m.
Conference Room 400 A & B
Agenda

I.	Welcome	T. Greason
II.	Introductions	T. Greason
III.	Approval of Agenda	T. Greason/Dr. Hudson-Collins
IV.	Approval of Minutes a. November 25, 2019 b. December 9, 2019	T. Greason/Dr. Hudson-Collins
V.	Review of Committee Requirements/Commitment	A. Siebert/T. Greason
VI.	Authority Updates	A. Siebert/Dr. Hudson-Collins
VII.	Peer Mentoring	J. C.
VIII.	Quality Improvement a. QAPIP Annual Evaluation (FY 2018-2019) b. QAPIP Work Plan (FY 2019-2020)	A. Siebert/T. Greason
IX.	Utilization Management a. Utilization Management Evaluation (FY 2018-2019)	K. Flowers/J. Miller
X.	Customer Service a. Customer Service Annual Report	M. Vasconcellos
XI.	NCQA Update	G. Parker
XII.	Other	
XIII.	Adjournment	

Quality Improvement Steering Committee (QISC)
Tuesday, February 4, 2020
1:30 p.m – 3:00 p.m
Conference Room 400 A & B
Meeting Minutes
Note Taker: Aline Hedwood

Committee Chairs: Dr. Margaret Hudson-Collins, Tania Greason, Provider Network QI Administrator

Member Present:
Dr. Margaret Hudson-Collins, April Siebert, Tania Greason, Starlit Smith, Allison Smith, Crystal Palmer, Dhannetta Brown, Donna Coulter, Fareeha Nadeem, Gail Parker, Kimberly Flowers, Michele Vasconcellos, Ortheis Ward, Robert Spruce, John carter, Latoya Garcia-Henry, Rostesa Baker, Debra Glenn, Jennifer Miller, Winifred Williamson, Jessica Collins, J.C. , Margaret Keyes-Howard and Dorian Johnson, Ortheia Ward

Members Absent:
Dana Lasenby, Eric Doeh, Alicia Oliver, Allison Lowery, Bernard Hooper, Carla Spight-Mackey, Justin Zeller, Judy Davis, Mignon Strong, Nasr Doss, Tina Forman, June White, Shirley Hirsch, Andre Johnson, Angela Harris, Bill Hart, PhD, Chery Fregolle, Donna Smith, Sandra Ware, Stacie Bowens, Dr. Sue Banks, Virdell Thomas, Jennifer Smith, and Dr. B. Jones.

Staff Present: April Siebert, Tania Greason, Starlit Smith and Aline Hedwood.

1) Item: Welcome: Tania Greason

2) Item: Introduction: group

3) Item: Approval of February 2020 Agenda: Agenda was approved by Dr. Hudson-Collins.

4) Item: Approval of November 25, and December 9, 2019 minutes: Group approved November and December 2019 minutes with noted revisions

5) Item: Authority Updates: The group welcomed DWIHN's new Chief Medical Officer Dr. Margaret Howard-Collins.

6) Item: Review of Committee Requirement/Commitment – Tania Greason

Goal: Provide update of DWMHA activities/initiatives

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

NCQA Standard(s)/Element #: X QI# 1 ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Decisions Made		
• The QISC meetings is an advisory group with responsibility for ensuring system wide representation and planning implementation support evaluation of DWIHN's Quality Improvement Program. • The QI Work Plan has been created for FY 2019-21 and will be used as a guide for the QISC meetings. • 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 the DIHN's continuous quality improvement program. The QISC provides ongoing operational leadership of continuous quality improvement activities for DWIHN. The QISC 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 includes the Medical Director and is composed of directors of the DWMHA's units or designee, chairpersons 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, Developmental Disabilities, and Co-Occurring Disorders • QISC meets every 4th Tuesday of each month at less 9 time of year from 1:30 pm – 3:00 pm. Members will be notified If there is a time/date change.		
Discussion	**Assigned To**	**Deadline**
Action Items	**Assigned To**	**Deadline**
None Required		

7) Item: Peer Monitoring – J. C. Goodwill Industry of Greater Detroit
Goal: Review of the QISC Requirements
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access **X Customer/Member Experience** ☐ Finance ☐ Information Systems ☐ Quality ☐ Workforce
NCQA Standard(s)/Element #: X QI# 5 ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Decisions Made		
J. C. is a Peer Mentor through Goodwill Industry of Greater Detroit, J.C has been a Peer for over four (4) years and is very pleased with his accomplishments and his ability to assist other members. John is a member of the QISC and will continue to provide us with updates and information as it relates to Peer Mentoring services through Goodwill.		
Discussion	**Assigned To**	**Deadline**
Action Items	**Assigned To**	**Deadline**
Ongoing updates as it relates to Peer Mentoring services at Goodwill Industries	J.C.	On-going

8) Item: QAPIP Annual Evaluation FY 2018-19 – April Siebert
Goal: Review and approval of the QAPIP Annual Evaluation
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 # ___

Decisions Made		
April Siebert provided an overview of the Annual QAPIP Evaluation report for FY 2018-19. The QAPIP evaluation is based on six (6) pillars that are identified in DWIHN's Strategic Plan. The QAPIP evaluation reflects ongoing activities throughout the year and addresses areas of timeliness, accessibility, quality and safety of clinical care, quality of services, performance monitoring, member satisfaction and performance improvement projects. The data collected analyzes and evaluates the year to year trends analysis of the overall effectiveness of the QI program, indicating progress for decision making to improve services and the quality of care for members. The data that the quality improvement unit (QI) collected and analyzed are from each of the identified pillars and used for the decision making process for the members DWIHN serve. The evaluation includes each of the Strategic Plan (6) Pillars which include Customer Services, Access, Workforce, Finance, Quality and Advocacy. The PPC Board is responsible for oversight of DWIHN's QAPIP. The QAPIP is reviewed and approved biennial by DWIHN's governing body. Through this process, the governing body gives authority for implementation of the plan and all of its components. The PPC Board is responsible for oversight of DWIHN's QAPIP. The QAPIP is reviewed and approved biennial by DWIHN's governing body. Through this process, the governing body gives authority for implementation of the plan and all of its components. The QAPIP evaluation report is submitted to the Program Compliance Committee (PCC) of the Board, for review and approval annually. The QISC is the leadership and the decision-making body of this plan with the oversite of DWIHN Chief Medical Director to ensure that identified activities are moving in a positive direction and providing recommendation feedback in term of processes and improvement, program planning and evaluations. For additional information please review "DWIHN Quality Assurance Performance Improvement Plan Annual Evaluation FY 2019"		

Discussion	Assigned To	Deadline

Action Items	Assigned To	Deadline
The QAPIP Annual Evaluation for FY 2019- was approved per Dr. Hudson-Collins and the Committee with no noted revisions	QI Unit	Complete

9) Item: Mission Michigan PPI Measurement Update - Tania Greason (add on)
Goal: Review MMBPI FY 2019 Data
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		
Tania Greason discussed the importance of the MMBPI data and how we can measure the access of services for our member served, which include hospitalizations, 7 day follow up, and new/ongoing services. The QI unit discusses and evaluates this data to the QISC to show quarterly and annual comparisons, noting any areas that require improvement. During FY 2019, during FY 2019, based on the analysis of Q1, Q2, Q3 and Q4 the data indicates a steady increase in performance for Indicator # 4a and #4b with an overall compliance score of 96% and 95% from the previous quarters. This increase can be contributed to ongoing efforts which include educating our provider network. Ongoing efforts to include review of potential barriers for members that are not following through with their 7-day follow up appointments. Providers are noting that members cancel or do not show up for scheduled appointments, DWIHN has noted that although providers can count members as no shows or cancellations as exceptions, they still are required to reach out to members for engagement efforts when members do not show or constantly cancel follow up appointments. For Indicator #10 (Recidivism), DWIHN failed to meet the threshold of 15% or less during each quarter. The correlation between Indictor 4a (follow-up care within 7 days) and Indicator 10 (Recidivism) for Q3 identifies that 33 (10%) members are readmitted and have not been assigned to a Clinically Responsible Service Provider (CRSP). The correlation also shows, as illustrated below, 122 (38%) members did not make 7-day follow up appointment and were readmitted within 30 days. Q4 identifies that 38 (9%) members are readmitted and have not been assigned a CRSP, 132 (31%) members did not 7-day follow up appointment. QI is working with the Integrated Healthcare, UM, and Crisis Access units have developed a recidivism workgroup to review members that are readmitted more than one time during each quarter. The Recidivism workgroup meets monthly and will include efforts to reach out to CRSP providers to conduct Interdisciplinary meetings for members that have multiple readmissions. Additional efforts include identifying and assigning members that are not assigned to a CRSP as well as updating and educating providers on the re-engagement process.		
Discussion	**Assigned To**	**Deadline**
Action Items	**Assigned To**	**Deadline**
Continue to evaluate MMBPI Indicators not meeting the performance standard. Recidivism workgroup to continue to meet monthly**.**	QI Unit	Ongoing

10) Item: Utilization Management Annual Program Evaluation FY 2019 – Kimberly Flowers and Jennifer Miller
Goal: Review and approval of 2019 UM Annual Program Evaluation
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems ☐ Information Systems ☐ Workforce
NCQA Standard(s)/Element #: ☐ QI# ___ ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Decisions Made		
Jennifer Miller reviewed with the committee the process for the UM evaluation. Utilization Management (UM) functions are driven by Detroit Wayne Integrated Health Network (DWIHN) Board's commitment to the provision of effective, consistent and equitable behavioral health services that produce functional outcomes, as articulated in the Strategic Plan. The Utilization Management Program Description reflects the expectations and standards of the Michigan Department of Health and Human Services (MDHHS) and the Center for Medicare and Medicaid Services (CMS). The Chief Medical Officer has substantial involvement in the development, implementation, supervision and evaluation of the UM program. The Board of Directors has the ultimate responsibility for ensuring overall quality of the behavioral healthcare services delivered to Wayne County residents, including oversight of UM functions. 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. Kim Flowers presented and reviewed the PowerPoint on the "DWIHN Annual UM Program Evaluation for FY 2018-2019 (UM 1 Element C). The review included highlights of the 7 program goals by strategic pillar and a summary of Technology Recommendations pertaining to UM. Jennifer Miller presented the Summary of Inter-rater Reliability Testing within the Learning Management System of MCG for FY 19(UM 2, Element C) and that 185 staff from the screening entities, ACT providers, DWIHN UM and Residential staff successfully completed the IRR studies. Details regarding testing administration and recommendations for improvement can be found within the report.		
Discussion	**Assigned To**	**Deadline**
Action Items	**Assigned To**	**Deadline**
The Utilization Management Annual Program Evaluation FY 2019 was approved per Dr. Hudson-Collins and the Committee with no noted revisions.		

12) Item: Customer Service (CS) Annual Report – Michele Vasconcellos
Goal: Review and approval of CS 2019 Annual Report
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access **X Customer/Member Experience** ☐ Finance ☐ Information Systems ☐ Quality ☐ Workforce
NCQA Standard(s)/Element #: X QI# 4 ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Decisions Made		
Michelle Vasconcellos discussed with the committee the role of the Customer Service Unit (CS). Customer Service is a mandated department that is responsible for orienting new individuals to services and benefits, including how to access services, rights protection processes, helping individuals with due process i.e., complaints, grievances and appeals. In addition to tracking and reporting on patterns and/ or issues of concern. It is committed to being the front door to the Authority. It is responsible for conveying an atmosphere that is welcoming, helpful and informative. Areas of Responsibility include: • Welcome Reception Center and Switchboard • Call Center Operations • Rapid Response Program • Medical Records Request & Subpoenas • Member Grievances • Member Consumer Appeals and Medicaid State Fair Hearings • Performance Monitoring of Customer Service Standards; VI- Customer Service, VII- Grievances, VIII- Enrollee Rights and XIV- Appeals (Authority, Access Center and Provider Network) • Family Subsidy • Member Engagement • Outreach • Training / Education • Peer Support/Mentoring • Member Experience (Surveys) • Ambassador Program • Quarterly Consumer Newsletter- “Person Points of View” • Monthly Consumer Calendar – “What’s Coming Up’ • Quarterly Constituent's Voice Meetings • Quarterly Provider Customer Service/ Grievance and Coordinators Meetings • 27 Customer Service related Policies/Procedures		

Customer Services' 18/19 fiscal year proved to be extremely busy with its finalizing of systems transformation and the removal of all the MCPNs. The MCPNs had an intricate role in monitoring the Customer Service function of their contracted provider network. Detroit- Wayne monitored their oversight to insure compliance with mandated Standards, VI- Customer Service, Standard VII- Grievances, Standard VIII- Enrollee Rights and Standard XIV – Appeals. With the MCPN removal, necessary modifications and enhancements were made to the Customer Service department. For additional information please review Customer Service FY 2018-2019 Year End Report.		
Discussion	**Assigned To**	**Deadline**
Action Items	**Assigned To**	**Deadline**
The Customer Service FY 2018-2019 Year End Report was approved per Dr. Hudson-Collins and the Committee with no noted revisions.	CS Unit	Complete

13) Item: NCQA Update – Gail Parker
Goal: Review of NCQA Status Report
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		
On the February 15, 2020 DWIHN conducted a mock review of the 2019 NCQA documentation that has been updated within the NCQA unit folders. Each unit will receive points for documentation submitted thus far. This MOCK survey will allow for DWIHN to determine our standing while focusing on areas that receive low points. NCQA updates will continue to be reviewed during the QISC meetings.		
Discussion	**Assigned To**	**Deadline**
Action Items	**Assigned To**	**Deadline**
Ongoing NCQA Updates	Gail Parker	February 2021

New Business Next Meeting: Tuesday March 15, 2020 4th Floor Conference Room 400 A & B.

Adjournment: 3:30 pm

ah/4/08/2020