**Quality Improvement Steering Committee (QISC)**
**Tuesday, February 22, 2022**
**10:30 a.m. – 12:00 p.m.**
**Via ZOOM LINK PLATFORM**
**Agenda**

| | | |
|---|---|---|
| I. | Welcome & Introductions | Tania Greason |
| II. | DWIHN Updates | Dr. Shama Faheem |
| III. | Approval of QISC February 22, 2022 Agenda | Dr. Shama Faheem/Committee |
| IV. | Approval of QISC January 25, 2021 Minutes | Dr. Shama Faheem/Committee |
| V. | Utilization Management:<br>• Utilization Management Evaluation (FY 2020-21) **(Tabled)**<br>• Utilization Management Annual Interrater Reliability Summary | <br>Jennifer Jennings<br>Jennifer Miller |
| VI. | Customer Service Year End Report Operational Report | Michele Vasconcellos |
| VII. | Quality Improvement:<br>a. QAPIP Evaluation/Workplan (FY2020-2021)<br>b. QAPIP Workplan (FY2021-2022) | <br>April Siebert & Tania Greason<br>April Siebert & Tania Greason |
| VIII. | PI 2a Review Data Analysis Best Practices (Providers Discussion) | Justin Zeller & Tania Greason |
| IX. | MMBIP "View Only" Module | Justin Zeller |
| X. | Adjournment | |

**Quality Improvement Steering Committee (QISC)**
**Tuesday, February 22, 2022**
**10:30 a.m. – 12:00 p.m.**
**Via ZOOM LINK 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, Angela Harris, April Siebert, Blake Perry, Carl Hardin, Cheryl Fregolle, Danielle Hall, Fareeha Nadeem, Ebony Reynold, Jennifer Jennings, Jennifer Miller, Jessica Collins, Justin Zeller, Lindon Munon, Melissa Eldredge, Melissa Moody, Michele Vasconcellos, Michelle York, Orthieia Ward, Robert Spruce, Rotesa Baker Dr. Shama Faheem, Starlit Smith, Tania Greason, and Vickey Politowski.

**Members Absent:**
Allison Smith, Ashley Bond, Benjamin Jones, Dr. Bill Hart, Cassandra Phipps, Carla Spright-Mackey, Carolyn Gaulden, Cheryl Medeja, Cherie Stangis, Dhannette Brown, Donna Coulter, Donna Smith, Eric Doeh, Jennifer Smith, John Rykett, June White, Judy Davis, Kim Batts, Latoya Garcia-Henry, Dr. Leonard Rosen, Margaret Keyes-Howards, Manny Singla, Melissa Hallock, Mignon Strong, Miriam Bielski, Nasr Doss, Oluchi Eke, Rakhari Boynton, Rhianna Pitts, Sandy Blackburn, Dr. Shama Faheem, Shirley Hirsch, Dr. Sue Banks, Taquaryl Hunter, Tiffany Hillen and Trent Stanford.

**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 February 22, 2022 Agenda:** approved with revisions by group

**4) Item: Approval of August & June 2021 Minutes**:

- January 25, 2022 minutes tabled until March 2022 meeting

**5) Item: Announcement/DWIHN Update: Dr. Shama Faheem, DWIHN Chief Medical Officer**

Dr. Faheem informed the committee that DWIHN has started the "No Child Left Behind" initiative to help improve the quality and access of DWHIN mental health services for children. DWIHN will be monitoring HEDIS and performance indicators measures closely for the children population. Also, the Health Home Initiative is moving forward, however, the behavioral health homes are still in the progress stages and will be implemented within the next few months. DWIHN is the lead entity for CCBHC and the Opioids Health Homes initiatives.

**6) Item: Utilization Management (UM) Annual Interrater Reliability Summary – Jennifer Miller, UM**
**Goal: Review and approval of the Annual Interrater Reliability Summary**

**Strategic Plan Pillar(s):** ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems ☐ Quality ☐ Workforce
**NCQA Standard(s)/Element #:** ☐ QI# ___ ☐ CC# ___ **X UM #2** ☐CR # ___ ☐ RR # ___

| Decisions Made | | |
|---|---|---|
| Jennifer Miller provided an overview informing the committee that each year UM presents an annual summary of the annual interrater reliability testing, this report was presented to the UM committee and DWIHN IPLT.<br>The Annual IRR is completed in order to ensure consistency in 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 1,2020 through September 30, 2021. Recommendations for the future include the following:<br>• Due to the ongoing issues with COVID and the Delta variant, there continues to be significant staffing absences and staffing changes. A number of direct service staff have also voluntarily left employment. Users were found to be inactive, terminated, or in rare circumstances, not entered in the system.<br>***Recommendation:*** *Ensure all entities using LMS, notify system administrator(s) of staffing changes as they occur and on an ongoing basis.*<br>*Note: There was a large number of Corrective Action Plans required this year. System administrator(s) believes that due to COVID, many staff including new hires worked remotely, and there were supervisory changes which sometimes resulted in testing delays.<br>• A significant amount of time was devoted to assisting staff in the log-in process, training new supervisors, and ensuring staff are accessing the correct edition of the guidelines for testing.<br>***Recommendation:*** *Continue to distribute detailed instructions to assist users in accessing the Learning Management platform and the correct version of the guidelines*.<br>• The LMS system has a function to determine average test scores of all study attempts. However, based on our testing parameters, we are unable to maximize use of this. System | | |

| | | |
|---|---|---|
| administrators have to do a large number of manual calculations to ensure accuracy of testing administrations.<br>***Recommendation:*** *Continue to work with MCG to assist in developing functionality that are user-friendly to both front end users and system administrators.*<br>For additional information please review handout "DWIHN Summary of Inter-rater Reliability Testing Within the Learning Management System of MCG FY 2020-21" | | |
| **Discussion** | **Assigned To** | **Deadline** |
| | | |
| **Action Items** | **Assigned To** | **Deadline** |
| Dr. Faheem and the QISC members approved the Annual Interrater Reliability Summary as written. | Dr. Faheem and QISC | Complete |

**7) Item: Customer Service (CS) Year End Operation Report- Michele Vasconcellos, CS Director**
**Goal: Review and approval of the Customer Service (CS) Year End Operation Report**
**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 # ___

| Decisions Made | | |
|---|---|---|
| Michele Vasconcellos provided an overview of the CS Year End Operation Report for FY 2020/21. During the Fiscal Year of 2020/21, DWIHN's Customer Service Department (CS) continued to address opportunities to ensure members had a seamless process for obtaining Customer Services during COVID. Customer Service's mission has always been to assure the accessibility of effective behavioral health services and to continuously exceed its customers' expectations. During FY 20/21, the focus remained on:<br>***1. Improving customer experience with services.***<br>***2. Ensuring appropriate engagement in choice of service and care.***<br>***3. Ensuring customers enrollee rights***<br>***4. Monitoring the satisfaction of customers***<br>***5. Enhancing customer and public information awareness***<br>***6. Meeting NCQA re-accreditation and other contractor regulatory compliance expectations.***<br>***7. Ensuring members continue to receive uninterrupted Customer Service during COVID.***<br>Customer Service's Member Experience division continues to assess and initiate process improvement efforts as it pertains to member experiences. Policies and procedures were updated to address procedural guidelines for satisfaction surveys and reporting. .<br><br>For additional information please review handout "Detroit Wayne Integrated Health Network Customer Service FY 20/21 Report" | | |
| **Discussion** | **Assigned To** | **Deadline** |
| CS will discuss the grievance analysis at the next QISC April 2020 meeting. | Customer Service | April 30, 2022 |
| **Action Items** | **Assigned To** | **Deadline** |
| Dr. Faheem and the QISC members approved the CS Year End Operation Report. | Dr. Faheem and QISC | Complete |

**8a) Item: QAPIP Evaluation (FY2020-2021) – April Siebert, QI Director & Tania Greason, QI Network Administrator**
**Goal: Review and approval of the QAPIP Evaluation/Workplan FY 2021**
**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 QAPIP Annual Evaluation for FY 2020-21. The QAPIP Evaluation assesses the results, Improvements and outcomes DWIHN has made with respect to the 2021 Annual Work Plan.<br>QI Program goals were aligned with and evaluated using The Strategic Plan Pillars of Customer, Access, Quality, Advocacy, Finance and Workforce Development. The QAPIP report presented to the QISC will highlight the goals DWIHN partially met or not met and plans for achieving in FY 2021-22. Not all the goals will be addressed within the report, for additional information on the highlighted areas discuss please review PowerPoint presentation "DWIHN "QAPIP Annual Evaluation Fiscal Year 2021" on the following items below:<br>• Customer Pillar<br>• Access Pillar<br>• Quality Pillar<br>• Advocacy Pillar<br>• Finance Pillar<br>• Workforce Development Pillar<br>• Year End Monitoring Data FY 2021<br>• Autism Provider Reviews FY 21/22<br>• Substance Abuse Disorder Provider Reviews<br>• Contracted Hospital Reviews FY21<br>• Medicaid Claims Review 1st & 2nd Quarter<br>• Medicaid Claims Review 3rd & 4th Quarter<br>• FY 2021 HSAG Review of DWIHN Performance Improvement Project, Measurement Validation and Compliance Review Results | | |

| | | |
|---|---|---|
| Overall, most activities planned in the 2020-2021 Work Plan is at a (67%) completion, which is a slight increase from the previous fiscal year. The activities and outcomes that scored Partially Met may be attributed to the ongoing Covid-19 Pandemic. The activities that were Partially Met and or Not Met will be considered for continuation in the QAPIP 2021-2022 Work Plan. | | |
| **Discussion** | **Assigned To** | **Deadline** |
| | | |
| **Action Items** | **Assigned To** | **Deadline** |
| Dr. Faheem and the QISC members approved the FY 2021 QAPIP Evaluation as written | Dr. Faheem and QISC | Complete |

**8b) Item: QAPIP Workplan (FY2021-2022) – April Siebert, QI Director & Tania Greason, QI Network Administrator**
**Goal: Review and approval of the QAPIP Workplan (FY2021)**
**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 QAPIP Workplan FY 2021-22. DWIHN's goals that were partially met or not met for FY 2021 will be measured for consideration to ensure they are measurable and archivable goals. The Work Plan is divided by each of DWIHN pillars customer service, access, quality, advocacy, finance and Workforce Development aligned with the DWIHN strategic plan. The FY 2021 Work Plan was at a (67%) completion, which is a slight increase from the previous fiscal year. Once approved by the full board, the QAPIP Annual Evaluation and Work Plan will be placed on DWIHN website and each goal in the Work Plan will be addressed fully under the QAPIP annual evaluation section. QI will discuss the barriers and why the goals were not met or met, quality and trending measurement of the goals will be defined in QAPIP annual evaluation. | | |
| **Discussion** | **Assigned To** | **Deadline** |
| | | |
| **Action Items** | **Assigned To** | **Deadline** |
| Dr. Faheem and the QISC members approved the QAPIP Workplan (FY2021-2022) as written | Dr. Faheem and QISC | Complete |

**9) Item: PI #2a (Access 1st Request Timeliness) Data Analysis – Tania Greason, QI Network Administrator**
**Goal: Review and updated for MMBPI # PI #2a 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 | | |
|---|---|---|
| The MMBPI data PI #2a (Access 1st Request Timeliness) monitors the percentage of new persons during the ***Period receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service***. DWIHN continues to work with the provider network to increase the scores in this area and the current average PHIP's stare scores are 60-65%. For Q1 preliminary data DWIHN is currently at 52.7%. DWIHN as a system has made progress from from 44% reported for Q4 (FY2021). Providers are noting that staffing issues are their primary barrier with having open slots on their calendars. DWIHN continues to meet with providers to discuss barriers and incentive plans to assist with the noted challenges. If any provider has questions about PI #2a please reach out to QI (Justin Zeller or Tania Greason). | | |
| **Discussion** | **Assigned To** | **Deadline** |
| | | |
| **Action Items** | **Assigned To** | **Deadline** |
| QI, MCO and CPI will continue to meet with providers to review scheduling and barriers associated with PI# 2a. | QI, MCO, CPI | On-going |

**10) Item: MMBPI "View Only" Module – Justin Zeller, QI Clinical Specialist**
**Goal: Review of the MMBPI "View Only" Module**
**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 discussed with the committee that providers should have access to the view only MMBPI module in MH_WIN. DWIHN requires providers to have an assigned staff member review their data and update MMBPI data as required. The provider staff can review their data prior to QI sending out that information for PI #4a and #4b. If members are not showing up for their appointments and rescheduling that is an exception, please update data timely. | | |
| **Discussion** | **Assigned To** | **Deadline** |
| | | |
| **Action Items** | **Assigned To** | **Deadline** |
| Providers to review MMBPI data through the "View Only Module" in MH-WIN | Providers | Ongoing |

**New Business Next Meeting:** Tuesday March 29, 2022 Via Zoom Link Platform.

**Adjournment:** 3:00 pm

ah/02/23/2022

# Detroit Wayne Integrated Health Network
# Customer Service FY 20/21 Report

**Presented at QISC Meeting**

**February 22, 2022**

**By: Michele A. Vasconcellos, MSA**

**Director, Customer Service**

# Customer Service FY 20/21
# A Year in Review

- During the Fiscal Year of 2020/21, DWIHN's Customer Service Department continued to address opportunities to ensure members had a seamless process for obtaining Customer Services during COVID.
- Call Center Operations; Member Welcoming; Member Grievances; Member Local Appeals/Medicaid Fair Hearings; Family Support Subsidy, Outreach, Member Education, Peer Training, Customer Service Standards Monitoring and Reporting; as well as Member Engagement and Experience activity continued to be addressed remotely.

# Customer Service's Mission

Customer Service's mission has always been to assure the accessibility of effective behavioral health services and to continuously exceed its customers' expectations. During FY 20/21, the focus remained on:

***1. Improving customer experience with services.***
***2. Ensuring appropriate engagement in choice of service and care.***
***3. Ensuring customers enrollee rights***
***4. Monitoring the satisfaction of customers***
***5. Enhancing customer and public information awareness***
***6. Meeting NCQA re-accreditation and other contractor regulatory compliance expectations.***
***7. Ensuring members continue to receive uninterrupted Customer Service during COVID.***

# Welcome and Call Center Operations

During 2021 the Access Center transition into DWIHN. Customer Service oriented all new Access Center staff on Customer Service standards. Customer Service continued to make adjustments in staffing and procedures in attempt to ensure customer service standards remained in compliance. The department's Call Ctr. and Welcome Ctr. Switchboard, received a combined total of **25,657** calls.

The Call Center had an abandonment rate of **10.6%** and the Switchboard had an abandonment rate of **.09%.** The standard is **<5%.**

With the transitioning of the Access Center in house, the majority of Customer Service Call Center staff (5) were initially removed from the Call Center to staff the Access Center which placed Customer Service in a non-compliance status. The issue was later addressed by adjusting the staffing to (2) positions being added back into the unit.

Due to the closure of DWIHN's corporate office, the Welcome Center remained closed to walk-ins. The later part of FY2021 the building opened for two half days per week to the public.

# Family Support Subsidy

The Family Support Subsidy division continued to handle **6,456** phone calls, took in by mail,**1,385** applications, processed **1,220** applications to the state and conducted **12** audits. All activity was conducted remotely without any interruption of services.

# Due Process: Grievances and Appeals

Customer Service's Due Process division oversees grievances and appeals. This division was faced with additional responsibilities in FY 20/21. Changes to policies and procedures, a new grievance and appeals reporting process to the state, implementation of the state's MiCAL resolution module as well as a new Mediation initiative.

The division also assumed the monitoring and auditing of CRSP member re-engagement in services and disenrollments.

In FY 20/21 the Grievance division processed **324** calls. **113** grievances were reported whereby **193** grievance issues were identified and addressed. (*See Annual Grievance Summary Report)*

The division conducted numerous member educational venues and provider trainings to address updates and technical assistance. The top Grievance category trends were in the area of Interpersonal, Delivery of Service and Access to Services.

# Customer Service Appeals

The division processed **355** appeals related calls, **21** appeals cases were addressed and there were no State Fair Hearings conducted this fiscal year.

There was monitoring of **17,039** Advance and Adequate Adverse Benefit Determination Letters sent in FY 20/21 and **1,262** Autism related Applied behavioral analysis notices were sent out. In the area of SUD notices, there were **725** and **1,826** IDD related notices.

The Appeals division also conducted system-wide appeals training to the provider network.

The division prepared for the NCQA Appeals audit, resulting in a score of **100%.**

Weekly appeals technical assistance was made available to providers.

Audits were also conducted as part of the re-engagement and disenrollment initiative.

Customer Service implemented a Due Process Manager position as well as an appeals specialist position.

# Quality and Performance Monitoring

*C*ustomer Service's Quality and Performance Monitoring division conducted **39** CRSP provider site reviews to ensure compliance standards were addressed and maintained in the areas of Customer Service, Grievances, Appeals and Enrollee Rights. Plans of correction were addressed with network providers.

The division monitored and tallied Customer Service monthly provider network reports to address trends and patterns.

Quarterly Customer Service Provider meetings were held to ensure providers were advised of updates and the importance of Customer Service mandated standards. Due to COVID, meetings continued to be offered via virtual platforms.

The division welcomed a new Performance Monitor staff member as a result of a staff retirement.

The division was also responsible for updating and maintaining all member materials i.e. Member Handbook Provider Directory and member brochures.

# Member Engagement, Experience and Outreach

In response to COVID, the Member Engagement division continued to find new ways to connect with members and remediate the risk associated with social isolation and non-engagement. The staff continued outreach efforts using its Quarterly member meetings (EVOLVE), the Persons Point of View newsletter, member educational materials as well as the What's Coming Up calendar as a means of communicating with members

The divisions' initiative of hosting weekly Supportive Outreach Understanding Life Situations ( SOULS) telephone chats proved to be beneficial in keeping members engaged during COVI. In addition to the unit's promoting virtual platforms and dispensing **(70)** laptop computers and training to residential facilities and clubhouses.

In collaboration with the Constituent's Voice Advisory group, the Customer Service Member Engagement division organized members, peers and ambassadors to participate in the "Walk a Mile in My Shoes" rally and organizing the Annual Reaching for the Stars award ceremony.

The DWIHN Ambassador program participated in more than **170** outreach events, activities and trainings. A series of workshops and trainings throughout the fiscal year coordinated by the Member Engagement division kept members and community engaged.

# Member Experience

Customer Service's Member Experience division continued assessing and initiating process improvement efforts as it pertained to member experience, an element of the Quality Improvement process.

Policies and procedures were updated to address procedural guidelines for satisfaction surveys and reporting.

The division, in partnership with Wayne State University Center for Urban Studies, administered both the ECHO adult and children surveys. Provider satisfaction surveys were administered to the provider and practitioner network to assess their satisfaction with Detroit Wayne. As well as the division coordinated the facilitation of preparation for the Annual National Core Indicator project for MDHHS.

# Acknowledgements/Recognitions

DWIHN received a **$6,245** in-kind funding to administer an Oral Health Peer led initiative.

DWIHN drop-in centers received **$22,500** in grant funding for wellness and transportation services.

Seven DWIHN Members were selected to receive the Dreams Come True mini grant. **($500** each) Individuals were selected based on their ability to excel in various areas of life i.e. Education, employment, and socialization

Constituent's Voice member Jamie Junior was presented with the 2021 Partners in Excellence Award for her dedicated disability rights advocacy at the Community Mental Health Association of Michigan Conference.

DWIHN's Customer Service Director, was honored by the Community Mental Health Association of Michigan's with the 2021 David LaLumia Professional Service Award.

# DETROIT WAYNE INTEGRATED HEALTH NETWORK

# QAPIP Annual Evaluation

# Fiscal Year 2021

# QAPIP ANNUAL EVALUATION

- The QAPIP Evaluation assesses the results, Improvements and outcomes DWIHN has made with respect to the 2021 Annual Work Plan.
- QI Program goals were aligned with and evaluated using The Strategic Plan Pillars of Customer, Access, Quality, Advocacy, Finance and Workforce Development.
- The Next Slides Highlight Goal Accomplishments, Goals Partially Met or Not Met, and plans for achieving goals in FY2022 **(Not All Goals Will Be Addressed).**

# QAPIP ANNUAL EVALUATION

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

- There are six (6) objectives under the Customer Pillar. 4 of 6 objectives were met and 2 Not met.

The ECHO Child Reporting measures compared to adult reporting measures for FY21. There was variation in the overall rating for "Perceived Improvement" (28% compared to 29%); How Well Clinicians Communicate" (73% compared to 68%); and Rating Of Counseling And Treatment (54% compared to 51%).

| | Children | Adult |
|---|---|---|
| Getting treatment quickly | 46% | 46% |
| How well clinicians communicate | 73% | 68% |
| Getting treatment and information from the plan | 51% | 51% |
| Perceived Improvement | 28% | 29% |
| Rating of counseling and treatment | 54% | 51% |

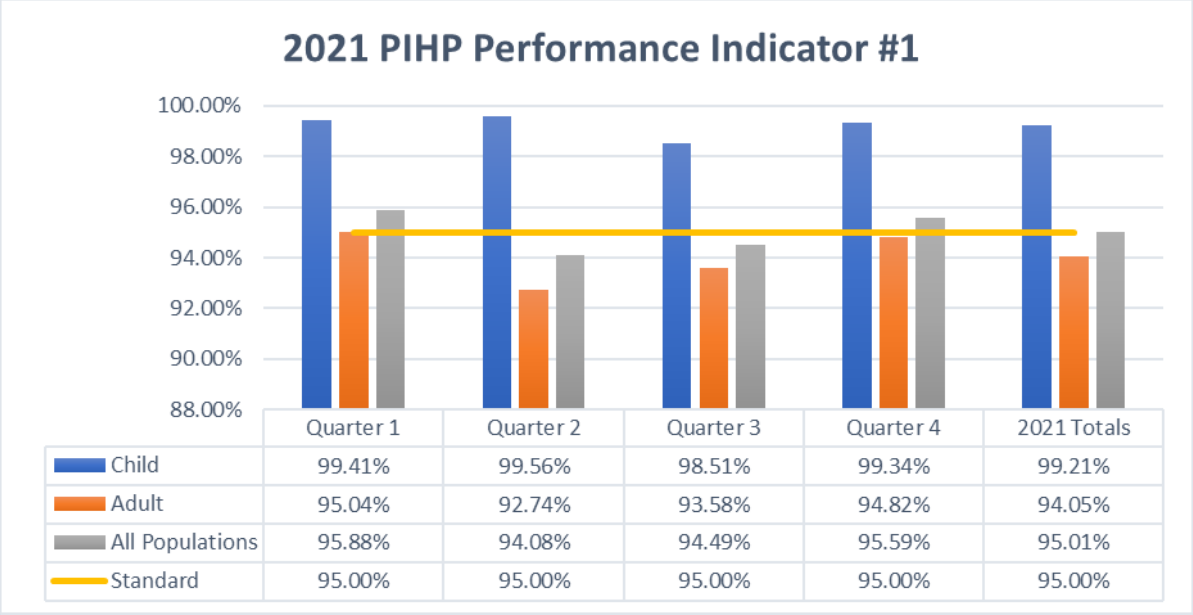
# QAPIP ANNUAL EVALUATION

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

- There are (6) objectives under the Access Pillar. 4 of 6 objectives were met and 2 Not met.
  - Certain Areas of DWIHN Data Reporting did Not meet the 95% threshold or 15% or less compliance for the Performance Indicators.

# INDICATOR 1: PRE-ADMISSION SCREENING WITHIN 3 HOURS (THRESHOLD 95%)

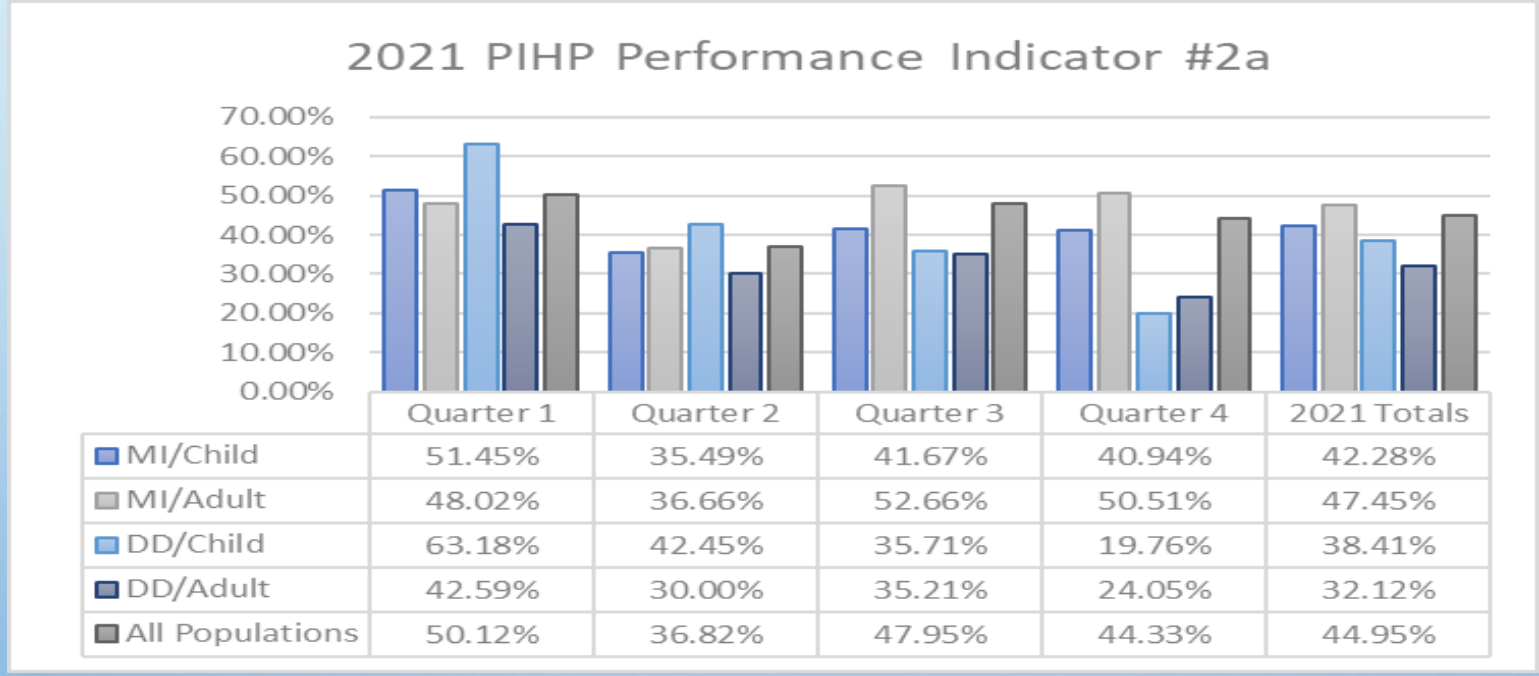
**Results:** FY21 standard met for all populations with the exception of Q2 Adult (92.74%), Q3 Adult (93.58%) and Q4 Adult (94.82.




| | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 | 2021 Totals |
|---|---|---|---|---|---|
| Child | 99.41% | 99.56% | 98.51% | 99.34% | 99.21% |
| Adult | 95.04% | 92.74% | 93.58% | 94.82% | 94.05% |
| All Populations | 95.88% | 94.08% | 94.49% | 95.59% | 95.01% |
| Standard | 95.00% | 95.00% | 95.00% | 95.00% | 95.00% |

# INDICATOR 2: IBPS IN 14 DAYS (STATE AVG 65%)

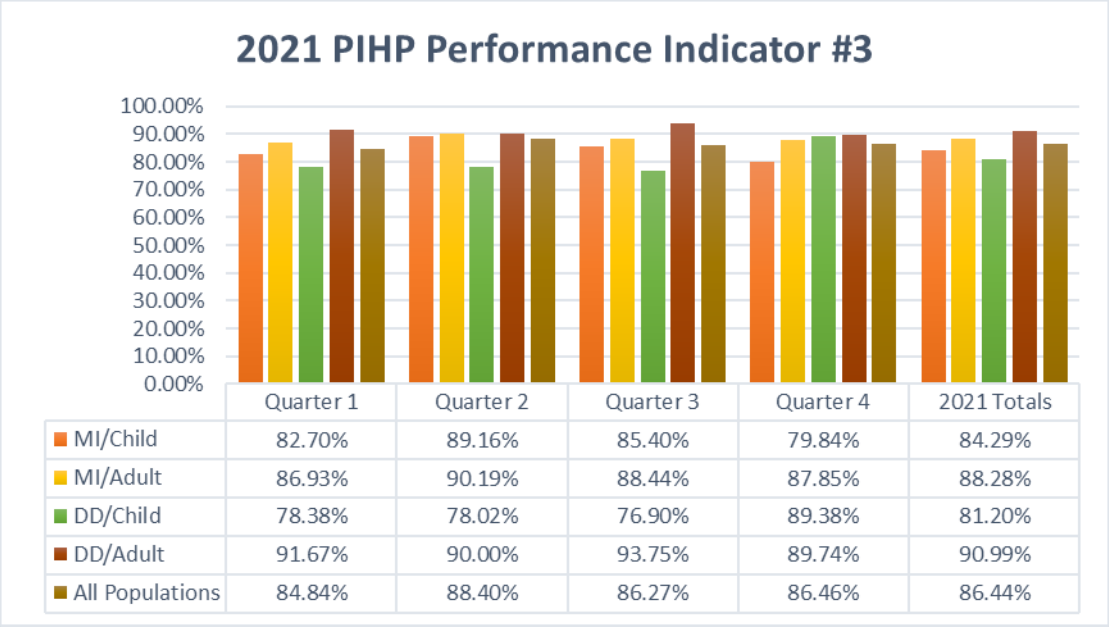
No standard/benchmark has been set by MDHHS. This measure allows for no exceptions.
**Results**: FY21 Q1(50.12%), Q2 (36.82%), Q3 (47.95%) and Q4 (44.33%).




| | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 | 2021 Totals |
|---|---|---|---|---|---|
| MI/Child | 51.45% | 35.49% | 41.67% | 40.94% | 42.28% |
| MI/Adult | 48.02% | 36.66% | 52.66% | 50.51% | 47.45% |
| DD/Child | 63.18% | 42.45% | 35.71% | 19.76% | 38.41% |
| DD/Adult | 42.59% | 30.00% | 35.21% | 24.05% | 32.12% |
| All Populations | 50.12% | 36.82% | 47.95% | 44.33% | 44.95% |

# INDICATOR 3 (STATE AVG. 80%)

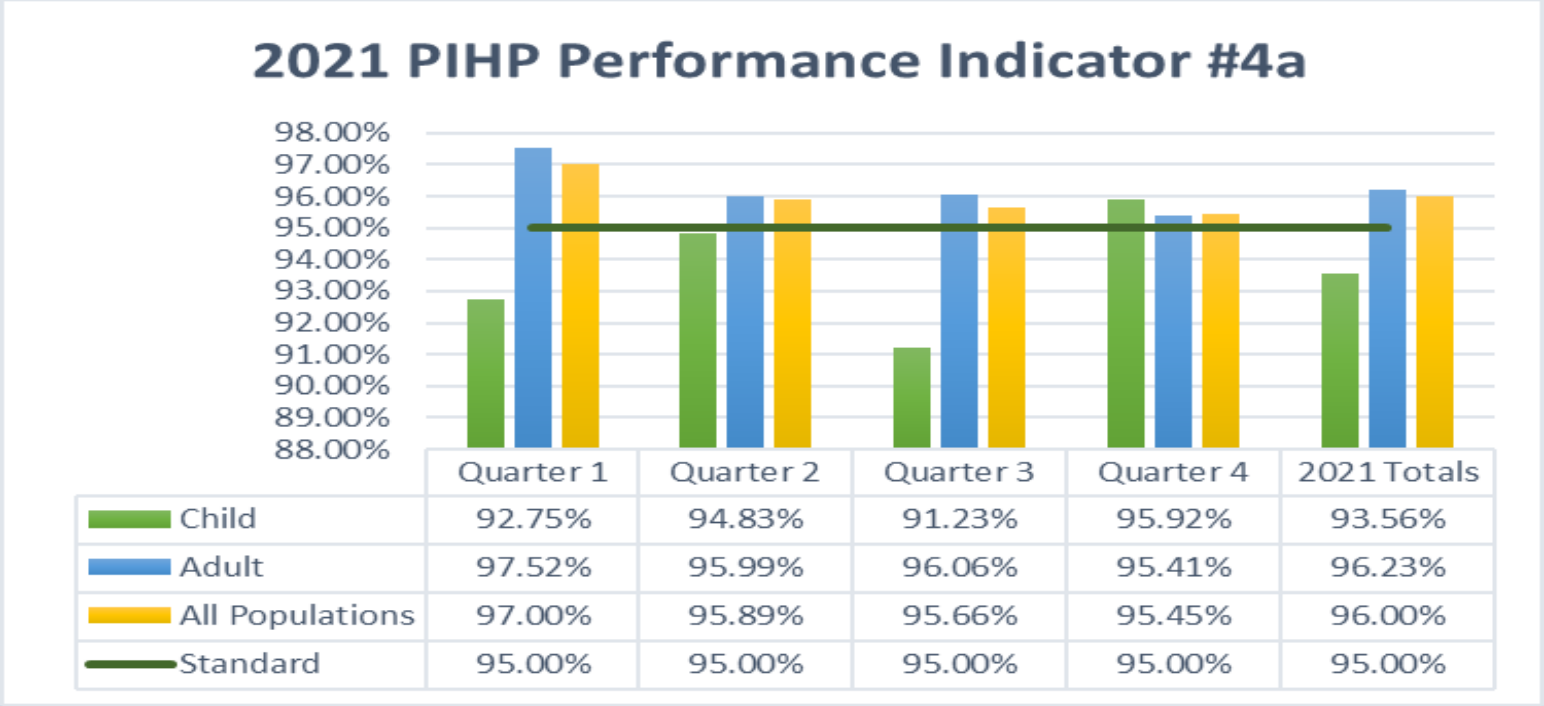
No standard/benchmark has been set by MDHHS. This measure allows for no exceptions.
**Results:** Q1(84.84%), Q2 (88.40%), Q3 (86.27%) and Q4 (86.46%).




| | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 | 2021 Totals |
|---|---|---|---|---|---|
| MI/Child | 82.70% | 89.16% | 85.40% | 79.84% | 84.29% |
| MI/Adult | 86.93% | 90.19% | 88.44% | 87.85% | 88.28% |
| DD/Child | 78.38% | 78.02% | 76.90% | 89.38% | 81.20% |
| DD/Adult | 91.67% | 90.00% | 93.75% | 89.74% | 90.99% |
| All Populations | 84.84% | 88.40% | 86.27% | 86.46% | 86.44% |

# INDICATOR 4: HOSPITAL DISCHARGE 7-DAY FOLLOW-UP (THRESHOLD 95%)

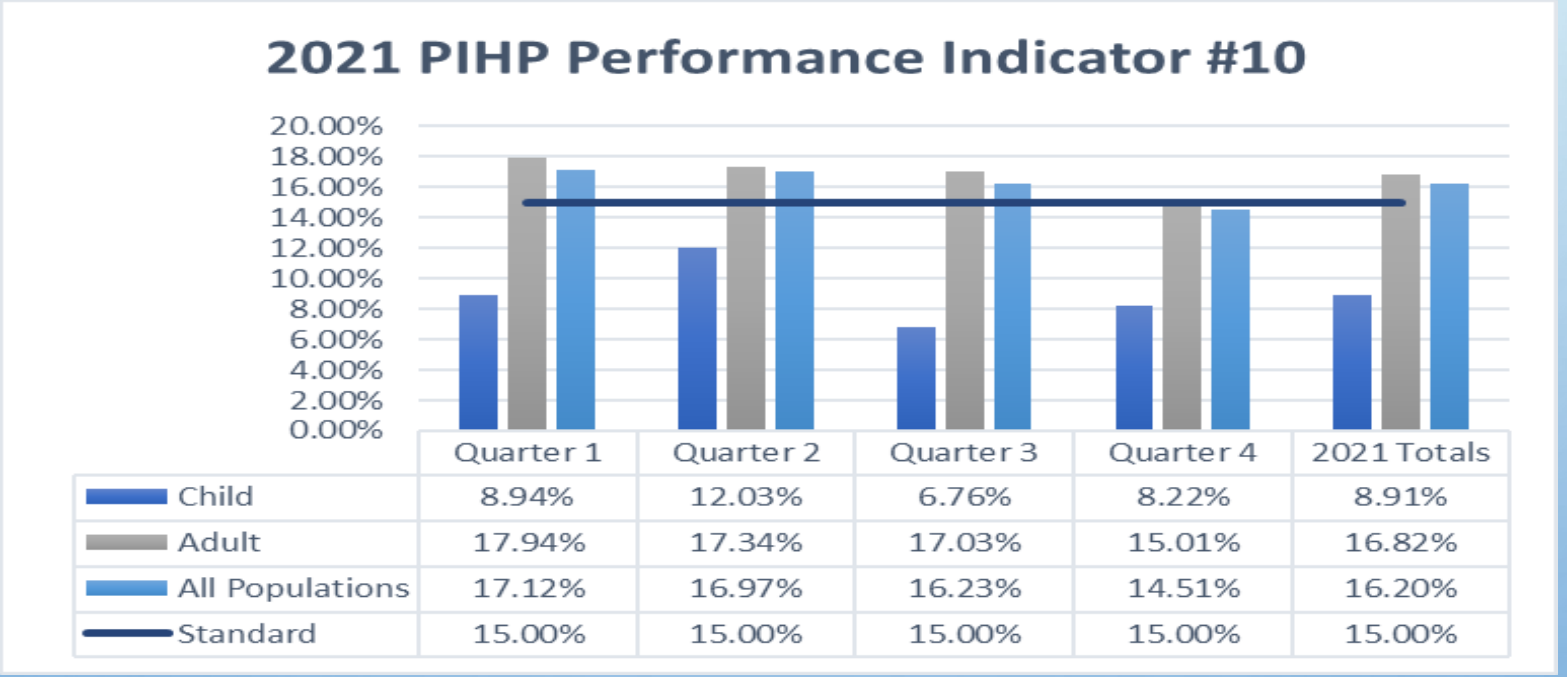
**Results**: FY21 standard met for all populations with the exception of Q1 Child (92.75%), Q2 Child (94.83%) and Q3 Child (91.23%).




| | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 | 2021 Totals |
|---|---|---|---|---|---|
| Child | 92.75% | 94.83% | 91.23% | 95.92% | 93.56% |
| Adult | 97.52% | 95.99% | 96.06% | 95.41% | 96.23% |
| All Populations | 97.00% | 95.89% | 95.66% | 95.45% | 96.00% |
| Standard | 95.00% | 95.00% | 95.00% | 95.00% | 95.00% |

# INDICATOR 10 (30-DAY INPATIENT READMISSION) THRESHOLD (15% OR LESS)

**Results:** FY21 standard met for the children population. Standard not met for the adult population for all quarters Q1 (17.94%), Q2 (17.34%), Q3 (17.03%), Q4 (15.01).




| | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 | 2021 Totals |
|---|---|---|---|---|---|
| Child | 8.94% | 12.03% | 6.76% | 8.22% | 8.91% |
| Adult | 17.94% | 17.34% | 17.03% | 15.01% | 16.82% |
| All Populations | 17.12% | 16.97% | 16.23% | 14.51% | 16.20% |
| Standard | 15.00% | 15.00% | 15.00% | 15.00% | 15.00% |

# QAPIP ANNUAL EVALUATION

The goal of the **Quality Pillar** is to improve quality performance, member safety and member rights through the use of standardized treatment protocols and guidelines.

- There are (6) objectives under the quality pillar. 5 of the 6 objectives were met and 1 not met.

# Year End Monitoring Data FY 2021

**CRSP Administrative Reviews**
**Total Number of CRSP Provider Review Protocols = 11**
**Overall Score = 96%**

**CRSP Case Record Reviews**
**Total Number of CRSP Case Records Audited = 118**
**Overall Score = 91%**

1st Q Case Records
Overall Score = 92%
Total 33 audits

2nd Q Case Records
Overall Score = 89%
Total 60 audits

3rd Q Case Records
Overall Score = 90%
Total 13 audits

4th Q Case Records
Overall Score = 93%
Total 13 audits

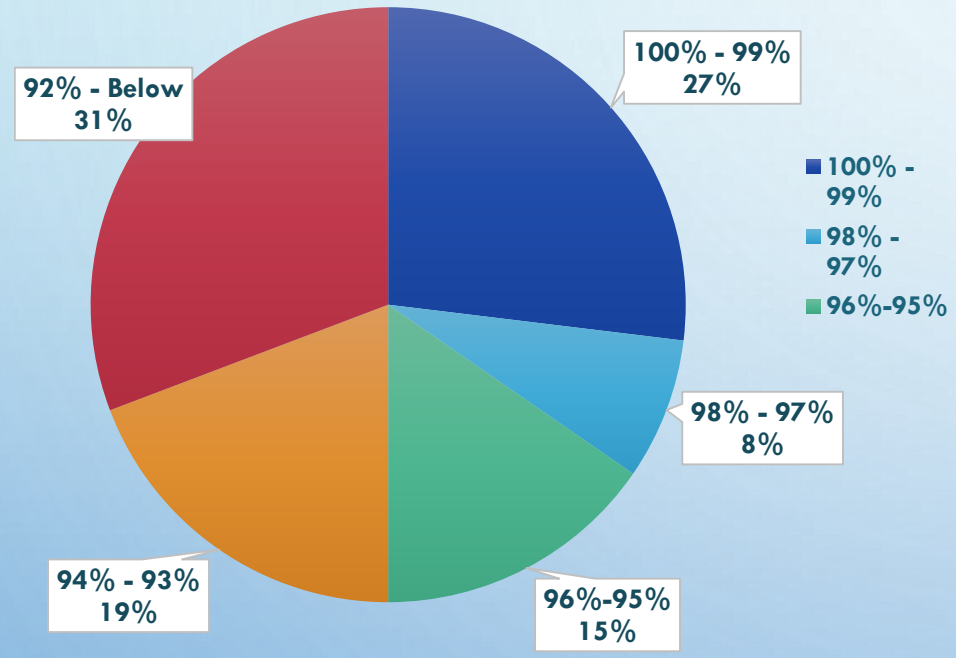
**Staff Qualification Reviews**
**Total Number of Staff Qualifications Audited = 274**
**Overall Score = 93%**

# Autism Provider Reviews FY 21/22

- All providers were reviewed during the FY 20/21. Average score for Autism Provider Clinical Score was 76% and the Staffing ranged from 91% to 100%
- Utilization Of Direct ABA Service and Supervision continues to remain low. Providers have indicated that they are struggling hiring Behavior Technicians.
- BCBA is then delivering Direct Service in place of the Technicians which then lower the amount of supervision.
- ABA Goals in the IPOS were also not aligning with the ABA Behavioral Treatment Plan. This has been addressed by DWIHN and trainings are being scheduled for FY 21/22 to continue to address this need.

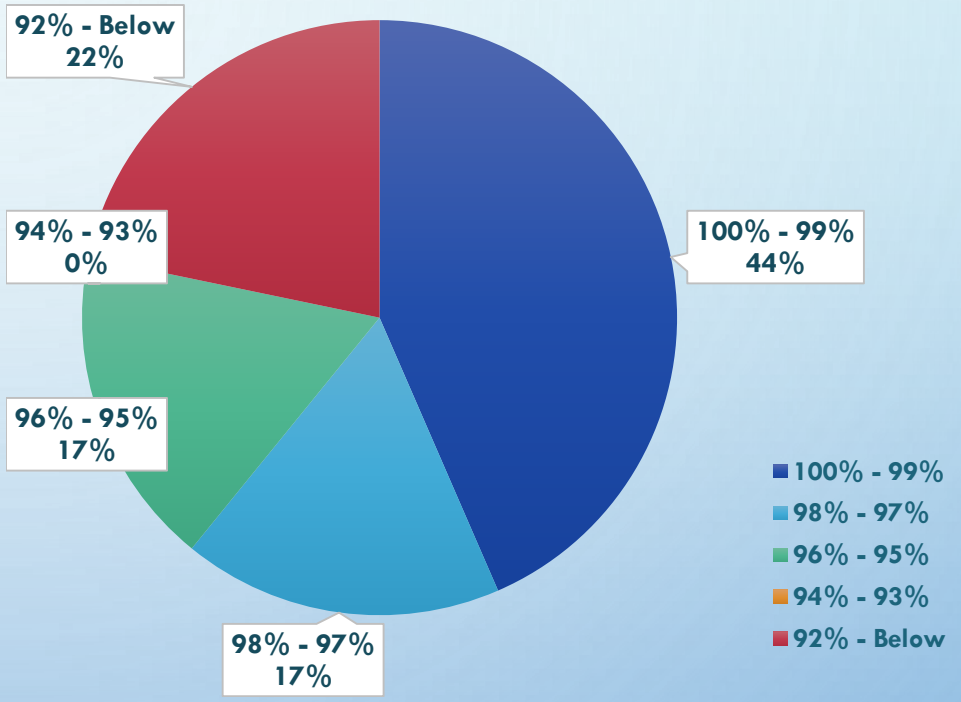
# Substance Abuse Disorder Provider Reviews

## Treatment Combined Case Record Scores




Areas of Non-Compliance included missing: no evidence of COC with PCP; progress notes failing to indicate client's progress on goal/objectives; no evidence of referrals, MTP is not being updated annually; no evidence client received a copy of MTP; amount, scope & frequency is not consistently documented; MTP Reviews do not identify client's progress on MTP

## Treatment Combined Staff Record Scores




Areas of Non-Compliance included missing: Annual Performance Appraisals; staff trainings, OIG/SAM.gov monthly checks; drivers licenses; pre-hire background checks

# Contracted Hospital Reviews FY21

- Eight Contracted Hospitals were reviewed for FY 2021. A Standardized Inpatient Hospital Review Tool Utilized Across PIPH's was used to assess the Hospital's implementation and compliance with established protocols based on requirements of The Mental Health Code, Medicaid And Medicare Guidelines, and Contractual requirements for the MI Health Link Program with DWIHN.

- The Review Process Included a review of Clinical Case Records for members enrolled in the MI Health Link Program and Medicaid Records, Reviewed Hospital Policies/Procedures.

# QAPIP ANNUAL EVALUATION

- The Goal of the **Workforce Pillar** is to lead the organization in Innovation by providing effective and efficient Workforce Development needs to the Provider Network. **Primary Focus:**
  - Workforce Development And Retention
  - Suicide Prevention
  - Community Collaboration
  - Public Safety Partnerships
  - Program Expansion
- There was (1) objective under the workforce pillar. The objective met the target goal.
  - ❑ DWIHN Approximately **134** Participants Attended A Program End "Virtual Young professional Conference On August 3, 2021, Partnered With Connect Detroit. In Addition, **360** Participants Attended DWIHN's Faith-based Youth Conference On August 19-20, 2021.
  - ❑ DWIHN was awarded a two-year grant from MDHHS to build upon prior trauma training and equip the provider workforce with a strong foundation for addressing the complexities of trauma.

# QAPIP ANNUAL EVALUATION

The goal of the **Advocacy Pillar** is to provide collaboration in shaping state and regional policies, procedures and practices relative to Quality Improvement and implementation of processes that promote full integration in the community.

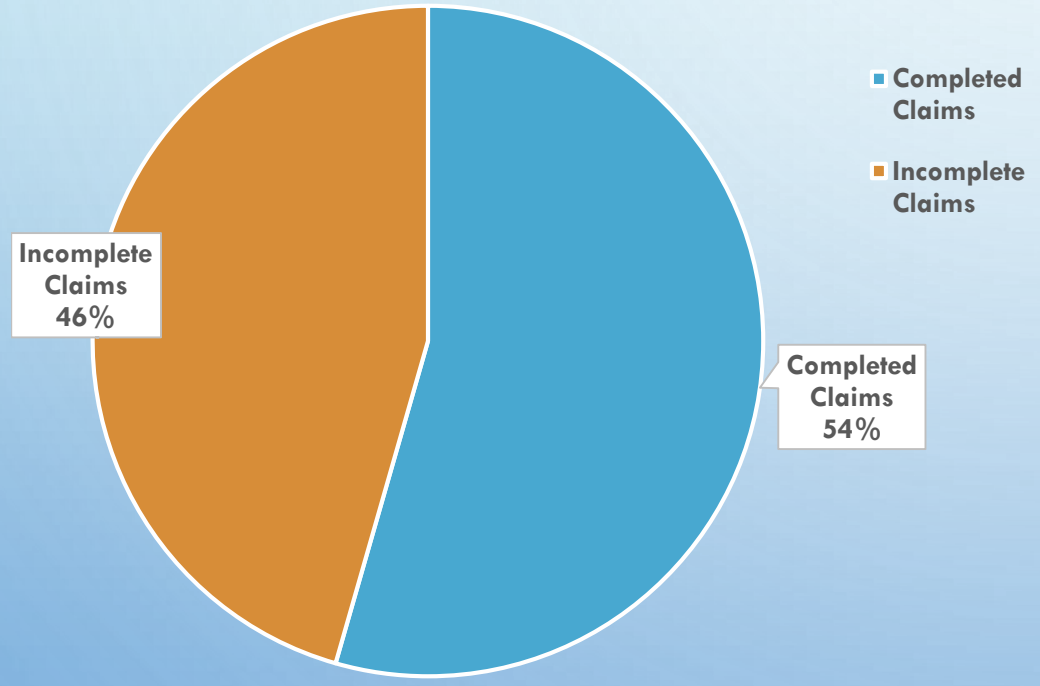
- There was (1) objective under the advocacy pillar. The objective was not Met.
  - Ensure full compliance in the network with the Home and Community Based Settings requirements.

# QAPIP ANNUAL EVALUATION

The goal of the **Finance Pillar** is to ensure financial stewardship and monitor financial solvency of DWIHN and network providers.

- There was (1) objective under the finance pillar. The objective Partially Met the target goal.
  - DWIHN conducted two (2) separate Medicaid Claims Verification Audits.
    - 1ST & 2ND Quarter (October 1 - March 31, 2021)
    - 3rd & 4th Quarter (April 1 - September 30, 2021)

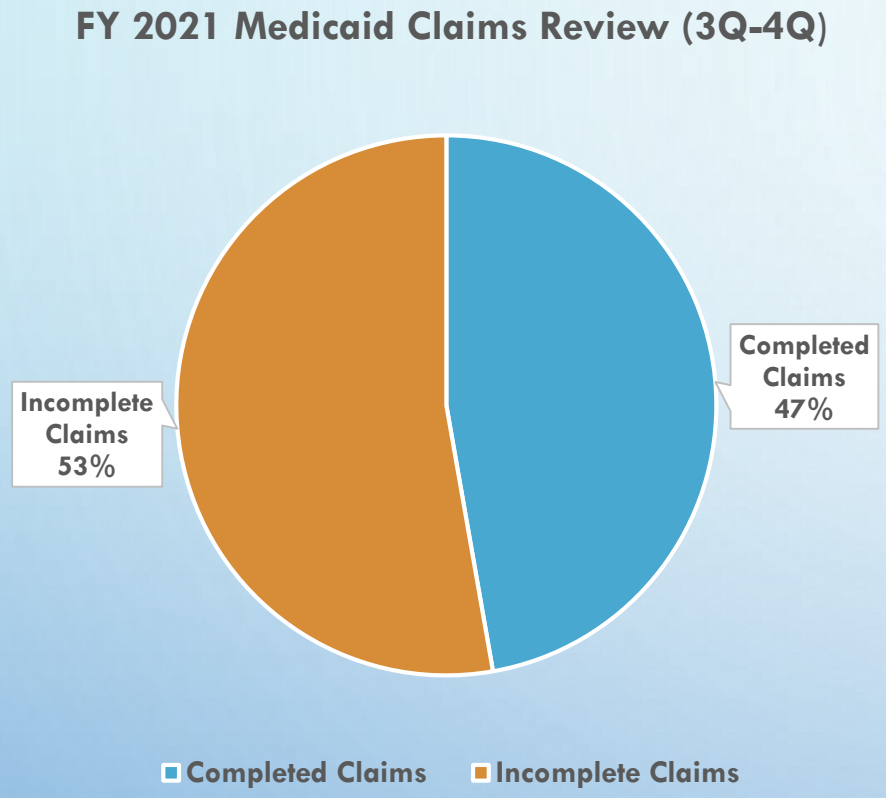
# Medicaid Claims Review 1st & 2nd Quarter




- For first and second Quarters of FY 2021 there were:
- A total of **1249** claims randomly selected for verification
- Of the 1249 Claims:
  - A total of 680 or 54% of the claims were reviewed.
  - A total of 569 or 46% of the claims were not reviewed.
- A total of 506, or 74% of the claims were compliant.
- A total of 174, or 26% of the claims reviewed had scores 95% ≤ and required a Plan of Correction.

- Of the **1249** claims there were a total number of 201 distinct providers
- Of those 201 distinct providers
  - 39 were placed on a Plan of Correction
  - 5 failed to submit requested documentation

# Medicaid Claims Review 3rd & 4th Quarter




- ***Number of distinct Providers in this population are:***
- 354 Providers
- ***Number of distinct Providers Tested (from the sample) are:***
- 201 Providers / Sites
- ***Number of Claims randomly selected are:***
- 1122 total claims
-
- Of the 1122 Claims:
- A total of 530 or 47% of the claims were reviewed.
- A total of 592 or 53% of the claims were not reviewed.
- Of the 592, a total of 416, or 78% of the claims were compliant.
- A total of 114, or 22% of the claims reviewed had scores ≤95%
  - Of those 114, providers were asked to submit Plans of Correction for 68 claims.
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# QAPIP ANNUAL EVALUATION

DWIHN departments have been engaged in continuous process improvement (Performance Improvement Projects). The guidance for all projects include improving the identification of both outcome and process measurements.

- ❑There are (4) PIP's under the quality pillar. 1 of the 4 PIP's did not meet the target goal.
  - *Improving diabetes monitoring for people with schizophrenia and bipolar disorder who are using antipsychotic medications*

| PIP Topic | Validation Status | Study Indicator | Study Indicator Results | | | |
|---|---|---|---|---|---|---|
| | | | Baseline | R1 | R2 | Goal |
| **Improving Diabetes Screening Rates for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications** | Not Met | The percentage of diabetes screenings completed during the measurement year for members with schizophrenia or bipolar disorder taking an antipsychotic medication. | 81.4% | 76.9% ↓ | 64.28 ↓ | 80.0 % |

# QAPIP ANNUAL EVALUATION

In FY21 HSAG conducted three (3) mandatory External Quality Reviews (EQR) as required to ensure compliance with regulatory requirements.

- Performance Improvement Project
  - Goal not met/outcome (64.28%) Target goal (80%)
- Performance Measurement Validation
  - Goal met received (100%) with no POC required.
- Compliance Review
  - Goal not met received an score of 77% with a corrective action plan.

# QAPIP ANNUAL EVALUATION

- Overall, most activities planned in the 2020-2021 Work Plan is at a (67%) completion, which is a slight increase from the previous fiscal year.
- The activities and outcomes that scored partially Met may be attributed to the ongoing Covid-19 Pandemic.
- The activities that were Partially Met and or Not Met will be considered for continuation in the QAPIP 2021-2022 Work Plan.