Quality Improvement Steering Committee (QISC)
January 31, 2023
10:30am – 12:00pm
Via Zoom Link Platform
Agenda

I.	Welcome	T. Greason
II.	Authority Updates	S. Faheem
III.	Approval of Agenda	S. Faheem/Committee
IV.	Approval of Minutes - September 27, 2022 - November 3, 2022	Dr. S. Faheem/Committee
V.	Availability of Services - Access to Timeless Reporting	Y. Bostic/Jacquelyn Davis
VI.	QAPIP Effectiveness	
	Quality Improvement - QAPIP FY2022 Evaluation - QAPIP FY2023 Work Plan	A. Siebert
	Integrated Health Updates (**Tabled**) - Population Assessment FY21 - Complex Case Management (CCM) FY21 - HEDIS Data and Goals	 A. Bond A. Bond A. Oliver

	Customer Service (**Tabled**)
	- NCI Survey
	- CEU Requirements
	  - Peer Support Specialists
	  - Peer Recovery Coaches
		M. Keyes-Howard

VII. PI# 2a Data Analysis (**Tabled**) J. Zeller/T. Greason

VIII. Adjournment

Quality Improvement Steering Committee (QISC)
January 31, 2023
10:30am – 12:00pm
Via Zoom Link Platform
Meeting Minutes
Note Taker: DeJa Jackson

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

Members Present: Jessica Collins**,** Ashley Bond, Angela Harris, Ortheia Ward, Lindon Munro, Fareeha Nadeem, Rotesa Baker, Delisa Marshall, April Siebert, Melissa Peters, Justin Zeller, Oluchi Eke, Starlit R. Smith, Alicia Oliver, Yvonne Bostic, John Rykert, Allison Smith, Robert Spruce, Lee Boynton, Cheryl Madeja, Tiffany Thisse, Angela Harris, Melissa Moody, Michelle York, Michele Vasconcellos, Cassandra Phipps, Marianne Lyons

Members Absent: Benjamin Jones, Carl Hardin, Carla Spright-Mackey, Carolyn Gaulden, Cherie Stangis, Daniel West, Danielle Hall, Dhannetta Brown, Donna Smith, Ebony Reynolds, Jacqueline Davis, Jennifer Smith, Judy Davis, Latoya Garcia-Henry, Maria Stanfield, Melissa Hallock, Mignon Strong, , Rachel Barnhart, Rakhari Boynton, Blackburn, Shana Norfolk, Shelley Nelson, Shirley Hirsch, Dr. Sue Banks, Trent Stanford and Vicky Politowski

1) Item: Welcome: Tania asked the committee to put their names, email addresses, and organization into the chat for attendance.

2) Item: Authority Updates: Dr. Faheem shared the following updates:

- Currently, DWIHN continues to work on the development of our crisis centers, with one location at 7 Mile Road. We are exploring another one in Downriver. We will keep our provider network posted as we get a little closer to having more information on the other projects.
- Home and community-based services (HCBS) is a CMS rule that was introduced in 2014 and will now become fully implemented by March of this year. Extensions have been provided. The HCBS rule is set in place to make certain that our members are in a compliance setting, including that there is freedom of movement and choices of living arrangements. There is currently a time restraint for coming into full compliance, participation from our provider network is extremely appreciated.
- Workforce shortages continue to be an identified issue. DWIHN is currently involved in a few projects, and we are in discussion with Wayne State University in terms of some grants that would allow an opportunity for interns to be allowed into the workforce. For immediate help, we are definitely hoping for our providers to come up with creative ways to provide services for members, at this point either we're not able to provide them or we're not able to provide them timely enough, which is definitely a concern for us.

3) Item: Approval of Agenda: Agenda for January 31st 2023 QISC Meeting approved by Dr. S. Faheem and Committee Members

4) Item: Approval of Minutes: Minutes for September 27th 2022 and November 3rd approved by Dr. S. Faheem and Committee Members.

5) Item: Availability of Services – Yvonne Bostic, Director of the Access Center

Goal: Access to Timeliness Reporting

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

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

Discussion		
Yvonne Bostic, Director of the Access Center shared with the committee the following updates: • The availability and scheduling within our 14-day guidelines for intake for CRSP and 7-day guidelines for scheduling hospital discharge appointments. During the first quarter of the 2022-2023 fiscal year, the preliminary data reflects we had an overall average of 45.1% access to schedule appointments for CRSP intakes within 14 days and 95% access to schedule hospital discharge appointments within 7 days (exceptions are able to be excluded for discharge appointments within 7 days. • MCO, QI, and the Access Call Center continue to meet regularly with our Crsp providers to discuss calendar issues, appointment availability, and the barriers that are encountered which may be hindering us from meeting the required standards. Barriers include staffing availability and transportation issues. • As we continue to meet with the CRSP providers we are discussing interventions that could be included to eliminate some of these barriers. Many of our providers have been able to hire additional staff, but then it takes a period of time for them to onboard the staff, adding to the delay in the ability to schedule appointments on time or in a timely manner. • DWIIHN will continue to address these concerns through our 30 days and 45day CRSP follow-up meetings, in which we will review ways that we can assist with resolving some of these issues or concerns. • DWIHN has formed a Access Committee that is charged with developing strategies and working within the organization to provide oversight for the timeliness standards and present findings to this committee and other Provider meetings. Results from CRSP meetings will be shared with the Access Committee to assist with solution driven strategies and action steps. Data along with obstacles, and strategies to address challenges will be discussed and action steps will be developed to ensure availability.		

Provider Feedback	Assigned To	Deadline
No provider feedback.		
Action Items	**Assigned To**	**Deadline**
Continued reporting of data and obstacles will be shared with this committee as reported.	DWIHN Access Call Center	Ongoing.

6) Item: QAPIP Effectiveness

Goal: Quality Improvement QAPIP FY2022 Evaluation and 2023 Workplan– April Siebert, Director of Quality Improvement

Strategic Plan Pillar(s): Advocacy Access Customer/Member Experience Finance Information Systems X Quality Workforce **NCQA Standard(s)/Element #:** QI 1 C# ___ UM #____ CR # ___ RR # ___

Discussion		
April Siebert shared with the committee the results and analysis for the QAPIP FY2022 Evaluation and QAPIP FY2023 Work Plan: **QAPIP FY2022 Evaluation:** • The QAPIP Evaluation is based on our 6 pillars that are identified in DWIHN's strategic plan and include the following: ○ Customer ○ Access ○ Quality ○ Advocacy ○ Finance ○ Workforce Development These pillars serve as the foundation of our commitment to continuous quality improvement and the quality and safety of our clinical care and the quality of services for our members. The 2022 QAPIP evaluation will reflect on ongoing activities that occur throughout the year, addressing areas of timeliness, accessibility, quality, and safety of clinical care, quality services, performance monitoring, and our member Satisfaction and performance improvement projects. Tania went over Critical Sentinel Events and Unexpected Deaths and Risk Reporting within the QAPIP Evaluation to include the following: • For the fiscal year 2022, our quality performance improvement team reviewed and processed a total of 1,915 critical/sentinel events. This number was a large decrease in critical/sentinel events from the fiscal year 2021, it was about a 39.3% decrease reported, and in fiscal year 2021 we had about 3,000+ events. • Some of our providers are not presenting critical/sentinel events, so we identified that there is a major issue with underreporting. The team is currently meeting with the identified providers to review the importance of CE/SE reporting requirements. Overall, most of our activities in the work plan for the fiscal year 2022 are at 70% completion, with a met, or partially met. The activities that were partially met or not met will continue going into our next		

work plan for the fiscal year 2022-2023. The full QAPIP Evaluation will be available on the website once fully approved by the Board.		
Provider Feedback	**Assigned To**	**Deadline**
Questions/Concerns from providers: 1. Were you able to use 2021's surveys for this evaluation? 2. How were you able to incorporate 2021 because you were writing the evaluation pretty much at the same time? It looks like you had the results then, but not now. Is it delayed? What's going on? 3. Do we need to have it back on the agenda to review the children's results of the Echo Survey or are there any other meetings where it will be a discussion? 4. With Critical/Sentinel reporting, what keeps us believing that the events are underreported rather than an improvement? 5. Do you only register these critical and sentinel events if it is reported by the provider or some of it, for example, if they get hospitalized, that also falls under that area, do you detect that as a critical event, or still the provider has to report that? 6. How do we get it with hospitals from medical records departments putting up roadblocks to getting consumer summaries and discharge paperwork? 7. I know that the goal was not met for some of the PIPs, but is this an increase from before or are we overall just going in the wrong direction? 8. If we have some concerns about the report, especially the customer pillar in terms of the objectives that are being displayed is not met, can we have a discussion before this is finalized? **Answers from Quality Improvement:** 1. Yes, that's how we based our upcoming goal for the fiscal year 2022. 2. The Echo Survey is a survey that is distributed to the members and the Guardians, and the survey was distributed in 2021. We receive a report regarding the adults and the children, and they did identify some areas that we need to improve in and so we made those areas a goal for this year for the fiscal year 2022. We just have not received the results. 3. We talked about the adult survey back in November, and the children's Echo Survey will be tabled again for our March meeting. It's still on the agenda to review the results. 4. We're having providers that have zero critical sentinel events reported for the entire year and we know that's not accurate. 5. Yes, the provider would need to report that information. To the Incident report first, and then the critical event. 6. We would like to hear the specifics because we have been using it with the hospitals. Our UM team will be trying to make sure that the discharge summary is being sent, and reminders, and if it's still not happening definitely, you will have to try certain other ways. If you know the specifics, if it's with certain hospitals, please make sure that you let us know those specifics, so that we can follow up with that. 7. Some of them are slight increases, without the goals being met. We can show improvements on the PIPs without meeting the required goal.		

8. We definitely can. And one of the things that we were hoping to have completed prior to presenting the goals is that a lot of this is a carry-over from our strategic plan. And a lot of this is, we should be discussing as we prepare these goals.		
Action Items	**Assigned To**	**Deadline**
Dr. S. Faheem and the Committee approved the 2022 QAPIP Evaluation and 2023 Workplan as written.	April Siebert	Complete.

New Business Next Meeting: February 28, 2023
Adjournment: 12:00 p.m.

DETROIT WAYNE INTEGRATED HEALTH NETWORK

QAPIP Annual Evaluation

Fiscal Year 2022

QAPIP Annual Evaluation

- The QAPIP Evaluation is based on six (6) pillars that are identified in DWIHN's Strategic Plan.
  - Customer
  - Access
  - Quality
  - Advocacy
  - Finance
  - Workforce Development
- The QAPIP Annual 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 of the overall effectiveness of the QAPIP plan, indicating progress for decision making to improve services and the quality of care for members served.
- Not all goals will be address. The Next Slides Highlight Goal Accomplishments, Goals Partially Met or Not Met, and plans for achieving goals in FY2023.

QAPIP Annual Evaluation

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

- There are six (6) objectives under the Customer Pillar. 3 of the 6 objectives were Met, 2 Not Met and 1 Partially Met (Practitioner Survey)
- ECHO Survey - *Goal not Met*
  - The 2022 (look back) ECHO® survey, is underway, a preliminary report will be available in late April and a final report will be available in June 2023.
- National Core Indicator Survey - *Goal not Met*
  - The 2022 NCI survey is underway with the pre-survey background being completed for selected members, results will not be available until August or September of 2023.

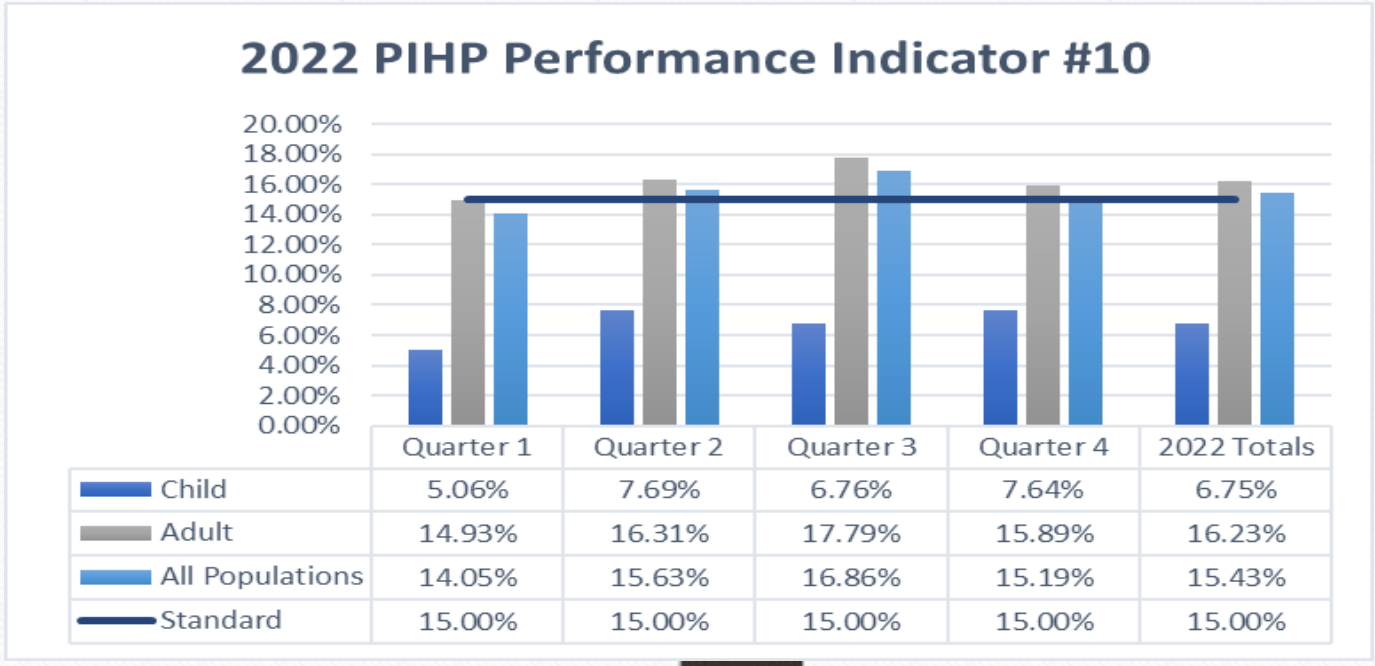
QAPIP Annual Evaluation

The goal of the **Access Pillar** is to 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. 5 of the 6 objectives were met and 1 not met.
  - PI#10 (Recidivism or Readmission within 30 days) from Q2 (16.31%), Q3 17.79%, Q4 15.89% for Adults, with an total population rate 15.43%. The standard is 15% or less. This remains an opportunity for ongoing improvement. We will continue with the efforts to meet the standard and will continue to evaluate the effectiveness of the interventions

QAPIP Annual Evaluation

The percentage of readmissions of children and adults during FY 2022 to an inpatient psychiatric unit within 30 calendar days of discharge from a psychiatric inpatient unit. **Goal**: The goal is to attain and maintain performance standards as set by the MDHHS contract. Standard 15% or below. **Results:** FY2022 standard met for the children population. Standard not met for the adult population for three out of four quarters Q2 (16.31%), Q3 (17.79%), Q4 (15.89%). Total population rate (15.43%).



	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2022 Totals
Child	5.06%	7.69%	6.76%	7.64%	6.75%
Adult	14.93%	16.31%	17.79%	15.89%	16.23%
All Populations	14.05%	15.63%	16.86%	15.19%	15.43%
Standard	15.00%	15.00%	15.00%	15.00%	15.00%

QAPIP Annual Evaluation

DWIHN met the standards for PI#1 (Children & Adults), PI#4a (Adult), 4b (SUD) and PI#10 (Children) during FY22. DWIHN provided access to treatment/services for 95% or more members receiving a pre-admission screening for psychiatric inpatient care within 3 hours of a request for service. DWIHN demonstrated an 6.75% performance rate for Children who were re-admitted within 30 days of being discharged from a psychiatric hospitalization. This was a significant improvement in performance from the previous reporting period.

Performance Indicators	Population	1st Quarter 21/22	2nd Quarter 21/22	3rd Quarter 21/22	4th Quarter 21/22
Indicator 1: Percentage who Received a Prescreen within 3 Hours of Request (95% Standard)	Children	97.78%	98.14%	98.91%	98.80%
	Adults	97.14%	98.81%	97.83%	97.69%
	Total	97.29%	98.65%	98.06%	97.89%
Indicator 4a & 4b: Percentage who had a Follow-Up within 7 Days of Discharge from a Psychiatric Unit/SUD Detox Unit (95% Standard)	Children	98.15%	93.75%	86.44%	100.00%
	Adults	94.80%	95.94%	96.81%	97.90%
	Total	95.09%	95.71%	95.83%	98.10%
	SUD	100%	99.37%	99.81%	98.97%
Indicator 10: Percentage who had a Re-Admission to Psychiatric Unit within 30 Days (<15% Standard)	Children	5.06%	7.69%	6.76%	6.80%
	Adults	14.93%	16.31%	17.79%	15.85%
	Total	14.05%	15.63%	16.86%	15.15%

QAPIP Annual Evaluation

- The goal of the **Quality Pillar** is to monitor clinical performance of provider services and programs to ensure system wide compliance with State, Federal regulations and the safety and wellness of the people we serve.
- There are (6) objectives under the quality pillar. 6 of the 6 objectives were met.
- Goals were to increase performance monitoring with CRSP, Residential, B3 Service, Autism, Waiver Programs SUD and Inpatient Hospital Settings by 25% or greater during FY2022. (Goal Met)
- Increase CRSP self-monitoring reviews were increased by 10% during FY2022. (Goal Met)
- MDHHS reporting requirements for CE/SE (Goal Met)
- BTAC reporting requirements (Goal Met)

Year End Monitoring Data FY 2022

Provider Monitoring Reviews
Total Number Reviews Conducted = 107
CRSP, SUD, Autism, B3, Waivers and Inpatient Hospital Settings

Staff Record Reviews
Total Number of Staff Records Audited = 114
Overall Score = 96%

Provider Self-Monitoring
22 CRSP
1st Q Case Records
Overall Score = 93%

Provider Self-Monitoring
25 CRSP
2nd Q Case Records
Overall Score = 92%

Provider Self-Monitoring
24 CRSP
3rd Q Case Records
Overall Score = 90%

Provider Self-Monitoring
14 CRSP
4th Q Case Records
Overall Score = 92%

Staff Qualification Reviews
Total Number of Staff Qualifications Audited = 114
Overall Score = 96%

Provider Network Trainings
Total Number Hosted = 6
Attendees = 800+

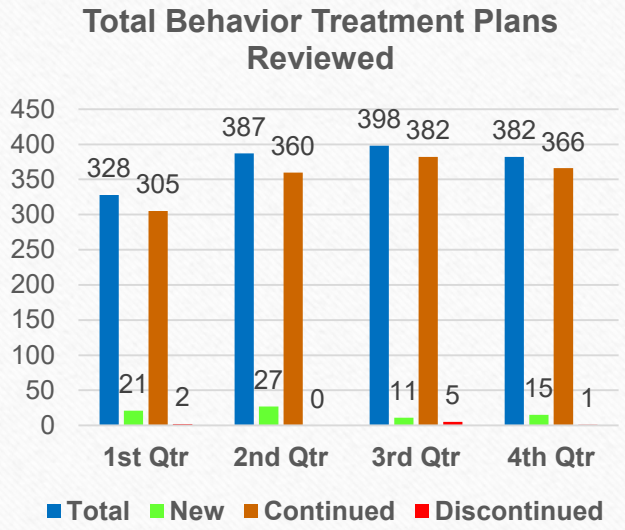
Critical/Sentinel, Unexpected Deaths and Risk Reporting

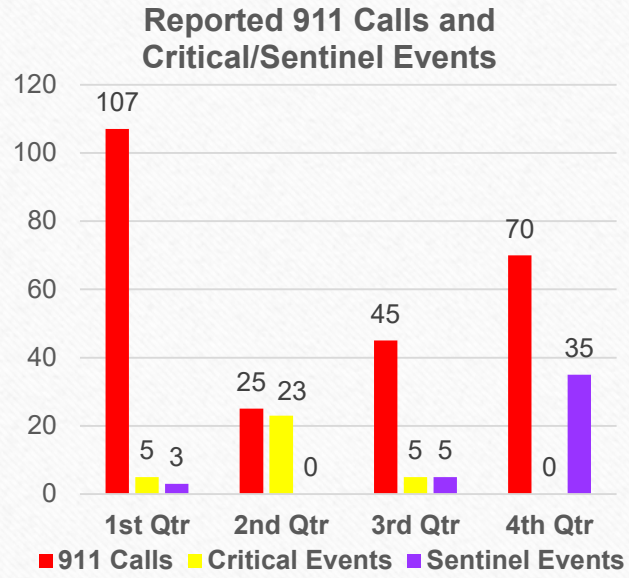
In FY2022, the Quality Performance Improvement Team processed 1,915 Critical/Sentinel Events, which is a decrease of (39.3%) from FY2021. This decrease is attributed ongoing training with the Provider Network on correct and accurate reporting. Of those incidents, the SERC reviewed and analyzed over eight-hundred and thirty (830) critical incidents. Critical Incidents include arrests, deaths, emergency medical treatment due to injuries or medication errors, and hospitalizations due to injuries or medication errors.

CATEGORY	FY 2021/2022	FY 2020/2021	FY 2019/2020	FY 2018/2019	FY 2017/2018
ARREST	64	72	83	161	153
BEHAVIOR TREATMENT (New 2020/2021)	88	61	0	0	0
DEATHS	492	551	731	480	444
ENVIRONMENTAL EMERGENCIES	57	79	38	65	205
Injuries Requiring ER	177	227	259	498	673
Injuries Requiring Hospitalization	35	47	203	88	83
Medication Errors	14	16	27	123	172
Physical Illness Requiring ER	216	975	634	1039	2188
Physical Illness Requiring Hospitalization	239	445	400	763	1107
Serious Challenging Behavior	437	609	815	1322	2199
OTHER/ADMINISTRATIVE	96	77	166	409	361
TOTAL	1915	3159	3356	4948	7585

Behavior Treatment Review

In FY22, through DWIHN's BTPRC provider network there were 1,495 member cases on Behavior Treatment Plans which is an increase of 334 (28.76%) from the previous year. The data below depicts all the use of intrusive and restrictive techniques, 911 calls/critical events and use of medication per Individual receiving the intervention. The charts below illustrate the BTAC Summary of Data Analysis FY22. During FY 2021-20222, DWIHN BTAC staff provided three system-wide trainings on Technical Requirements of Behavior Treatment Plan Review Committee (BTPRC) Processes with a total of 1,215 staff trained within our provider network.





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 (9) PIP's under the quality pillar. 8 of the 9 PIP's did not meet the target goal.
  - *Improving the availability of a follow up appointment with a Mental Health Professional after Hospitalization for Mental Illness - **Adult***
    - *(7 Day Follow-Up: Goal Not Met – 28.33%, Goal at 45% or higher).*
    - *(30 Day Follow-Up: Goal Not Met – 46.67%, Goal at 58% or higher).*
  - *Adherence to Antipsychotic Medications for Individuals with Schizophrenia (Goal Not Met – 46.92%, Goal at 68.00% or higher)*
  - *Antidepressant Medication Management for People with a New Episode of Major Depression (Goal not Met – 13.36%, Goal at 46.42%)*
  - *Improving Diabetes Monitoring for People with Schizophrenia and Bipolar Disorder (Goal not Met – 64.86%; Goal at 78.01%)*
  - *Coordination of Care (Goal Not Met – 68.86%, Goal at 95% or higher)*
  - *Case Finding for Opiate Treatment (Goal not Met –,60% Goal at 79% or higher)*
  - ***PHQ-9 Implementation (Goal Met – 99.1%,Goal at 95%)***
  - *PHQ-A Implementation (Goal Not Met – 99.2%, Goal at 100%)*
  - *Decreasing Wait for Autism Services (Goal Not Met – 67.5%, Goal at 100%)*

QAPIP Annual Evaluation

- The goal of the **Workforce Pillar** is to continue to focus on maintaining and expanding a centralized training program for health professionals.
- There was (1) objective under the workforce pillar. The target goal was met.
  - DWIHN met the objective by continuous quality monitoring of our workforce through credentialing and through Provider trainings on Detroit Wayne Connect, a continuing education platform for stakeholders of the behavioral health workforce. We strive to provide a variety of live and online courses. Log on at dwctraining.com. SUD Trainings are also available on Improving MI Practices posted at www.dwihn.org.

QAPIP Annual Evaluation

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

- Performance Improvement Project
  - Goal met/outcome (100%) Target goal (80%)
- Performance Measurement Validation
  - Goal met received (100%) with no POC required.
- Compliance Review
  - Goal partially met received a score of 83% with a corrective action plan.

QAPIP Annual Evaluation

The goal of the **Finance Pillar** is to ensure financial stewardship and provide monitoring and oversight of claims/encounters submitted within the Provider Network. DWIHN verifies the delivery of services billed through our Medicaid Claims Process.

- There was (1) objective under the finance pillar. The objective was met.
  - In FY2022, a total of 3,598 claims were randomly selected for verification. Of those claims, 3,524 were reviewed and validated for 98.03%, which is a 35.75% increase from the previous fiscal year 2021 (1260). 3,210 of the claims reviewed were compliant, having received scores of at least 95%, and 215 of the claims reviewed had scores ≤ 95%, of which 124 required a Plan of Correction during FY2022.

QAPIP Annual Evaluation

The goal of the **Advocacy Pillar** is to promote full integration in the community.

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

QAPIP Annual Evaluation

- Overall, most activities planned in the Work Plan FY22 2021-2022 is at approximately (70%) completion.

- The activities that were Not Met, Partially Met or opportunities for Continuous Quality Improvement will be continued during FY2022-2023.