Quality Improvement Steering Committee (QISC)
February 28, 2023
10:30am – 12:00pm
Via Zoom Link Platform
Agenda

I.	**Welcome**	**T. Greason**
II.	**Authority Updates**	**Dr. S. Faheem**
III.	**Approval of Agenda**	**Dr. S. Faheem/Committee**
IV.	**Approval of Minutes** • **November 23, 2022**	**Dr. S. Faheem/Committee**
V.	**QAPIP Effectiveness**	
	Integrated Health Updates	
	• **Population Assessment FY21**	**A. Bond**
	• **Complex Case Management (CCM) FY21**	**A. Bond**
	• **HEDIS Data and Goals**	**A. Oliver**
	• **BTAC SFY2022 Analysis (Tabled)**	**F. Nadeem**
	Utilization Management	
	• **UM FY2022 Evaluation**	**L. Wayna**
	Clinical Practice Improvement Updates	
	• **Clinical Practice Guidelines**	**E. Reynolds**
VI.	**Adjournment**	

Quality Improvement Steering Committee (QISC)
February 28, 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, April Siebert, **Justin Zeller**, Alicia Oliver, John Rykert, Allison Smith, Angela Harris, , Cassandra Phipps, Vicky Politowski, Micah Lindsey, Ebony Reynolds, Sharon Matthews, Sinitra Applewhite, Leigh Wayna, Josephine Austin, Bonnie Herndon, Brandon Taylor, Cheryl Fregolle

Members Absent: Benjamin Jones, Carl Hardin, Carla Spright-Mackey, Carolyn Gaulden, Cherie Stangis, Daniel West, Dhannetta Brown, Donna Smith, Jacqueline Davis, Jennifer Smith, Judy Davis, Latoya Garcia-Henry, Maria Stanfield, Melissa Hallock, Mignon Strong, , Rachel Barnhart, Rakhari Boynton, Blackburn, Shana Norfolk, Shelley Meller, Shirley Hirsch, Dr. Sue Banks, Shelley Nelson, Starlit Smith, Melissa Moody, Robert Spruce, Lee Boynton, Cheryl Madeja, Michele Vasconcellos, Yvonne Bostic, Marianne Lyons, Michelle York

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:

Recently there was a legislation bill regarding the use of restrictions around the rules of use of restraint at a crisis center. The restraints would be limited to in-patient hospitals, only that's going to change because we were working off in a wrong door approach where police or anyone could drop off individuals. Definitely seclusion or restraints are what we do not desire in any case, but sometimes it might be needed for the members safety or the safety of others. We will review how the bill unfolds, and we'll continue our advocacy efforts in that regard.

Ebony Reynolds informed the committee of the following updates:

DWIHN will be converting MHWIN from the DSM-IV to the DSM-V. To begin this process CRSP providers will need to convert to DSM-V first in their PCE system. Once all CRSP providers are using DSM-V, then DWIHN will convert MHWIN to DSM-V (no multi-axial). By following this approach, there should not be a negative impact on HIE or claims. There will be some temporary coding done by PCE for mapping from provider systems to MHWIN related to HIE. Claims will not be impacted due to billing ICD-10. DWIHN is requesting that all CRSP providers work with their respective PCE Project Mangers to convert their PCE systems to DSM-V by **April 1, 2023**. DWIHN is requesting that all CRSP providers send a status update to the Director of IT Suzanne Henson shenson@dwihn.org by **March 1, 2023,** to ensure that all providers are on track to meet the April 1st deadline

3) Item: Approval of Agenda: Agenda for QISC February 28, 2023 meeting approved.

4) Item: Approval of Meeting Minutes: Meeting minutes for November 23, 2022 QISC meeting were approved by Dr. Faheem and the QISC Committee.

5) Item: Ashley Bond
Goal: Population Assessment FY21
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems **X Quality** ☐ Workforce
NCQA Standard(s)/Element #: QI # 8 ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Discussion		
Ashley Bond shared with the group the following Updates regarding the Population Assessment for SFY 2021. • Data has been added to include information in regard to LGBTQ+ members. • According to the UCLA Williams Institute 2020 data, there is an estimated 311,000 LGBTQ+ members in Michigan. Although the full range of LGBTQ+ identities is not commonly included in large-scale studies of mental health, there is strong evidence from recent research that members of this community are at a higher risk for experiencing mental health conditions — especially depression and anxiety disorders • More information was also added in regard to Hispanic and Latino members. Information includes traditional healthcare approaches, as well as some barriers and information in regards to different disparities, like the lack of health insurance & fewer healthcare visits in that population. • In response to the 2021 Population Assessment DWIHN plans to focus more on the subpopulation of LGBTQ+ members, Hispanic & Middle Eastern, and North African Cultures (MENA). Our goal is to also include more training to increase knowledge within the community. • In regards to DWIHN's language materials, we offer different language materials on our website. Materials include our member handbook which is listed in Arabic, English, and Spanish for members who speak those languages. Other languages are available per request. • More information was added to the Population Assessment for the inclusion of utilization of translation for services provided as well as adding the total number of calls and the top languages that were requested by our members. • The information that is gathered for Serious & Persistent Mental Illnesses, the top 5 SPMI Diagnosis includes:		

○ Major Depressive Disorder (9,503) ○ Anxiety Disorder (3,577) ○ Bipolar I Disorder (3,368) ○ Schizoaffective Disorder (1,886) ○ Post-Traumatic Disorder (1,858) • The top diagnosis is also utilized to adjust the eligibility criteria for Complex Case Management. Due to the prevalence of Autism in our population, DWIHN will be adding Autism to CMM eligibility criteria for children & Adolescents. Chronic pain will be added to the eligibility criteria for adults. • For Schizoaffective Disorder, some potential barriers that may create challenges for members to seek support were added to the population assessment. Those potential barriers include Stigma & Fear, Lack of awareness, Severe symptoms, Possible substance use, and Client Resistance. • The 2022 Population Assessment is currently in the process of being finalized and will be presented to the QISC for review and approval once the final draft is approved. • Please see the attached handout "Updates to DWIHN Population Assessment.pdf"		
Provider Feedback	**Assigned To**	**Deadline**
No provider feedback.		
Action Items	**Assigned To**	**Deadline**
Dr. Faheem and the QISC approved as written the noted updates to the FY2021 Population Assessment Report.	Dr. Faheem and QISC	Complete

6) Item: Ashley Bond

Goal: Complex Case Management (CCM) FY21

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

NCQA Standard(s)/Element #: QI 8 ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Discussion		
Ashley Bond provided the following CCM updates for FY21: • There has been an added goal to increase participation in a number of members who attend two or more behavioral health outpatient service businesses within 60 days of starting complex case management (CCM) services. • Timeframes were added to PHQ and WHO-DAS, and members who were open for at least 90 days were included. • Timeframes were also added to Emergency Room, Inpatient admits and Utilization of Out-Patient Services, members who were open for at least 60 days were included. • A Causal Analysis has also been added to the CCM Evaluation for FY21 that will explore goals, discuss interventions, discuss barriers, and goal evaluations for the upcoming fiscal year. Inclusive of the following: ○ PHQ ○ WHO-DAS ○ ED and Hospital Admits ○ Out-Patient Services ○ Satisfaction Surveys • It was noted, that for 42 members provided the Satisfaction Surveys, 16 were returned. In order to increase our return rate an electronic survey process has been added. Members will have the option to submit a paper survey or submit using the electronic version. • Changes were also implemented to the satisfaction survey's format for FY2023 to include the elimination of neutral responses in order to obtain negative and positive feedback from members.		
Provider Feedback	**Assigned To**	**Deadline**
No provider feedback.		
Action Items	**Assigned To**	**Deadline**
Dr. Faheem and the QISC approved as written the noted updates to the FY2021 CCM Evaluation Report.	Dr. Faheem and QISC	Complete

7) Item: Alicia Oliver

Goal: HEDIS Data and Goals

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

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

Discussion		

Alicia Oliver provided the following updates:
 	
• There are currently five (5) Quality Improvement Plans that will be discussed during the meeting.
• The discussion will include a review of the current rate of results and a comparison to the goal which was determined by the Quality Compass analysis, a tool that helps an agency compare its performance to Medicaid Health plans.
• Reported on the 2022 rate of results, the annual total number for 2022 will not be completed until March or April 2023 due to a 3-month reporting lag.
• What is HEDIS?
  ○ Healthcare
  ○ Effectiveness
  ○ Data and
  ○ Information
  ○ Set
• HEDIS is a Retrospect Review. A look backward at the year(s) prior. It is a review of the services and clinical care provided to our clients.
• HEDIS DATA is a combination of:
  ○ Administrative data: Data captured from Claims, Encounters, Pharmacies, and Labs.
  ○ Medical Record Review: A validation audit conducted by Quality.
• DWIHN is responsible for five (5) of the identified HEDIS measures:
  ○ Diabetes Screening
  ○ Adherence to Anti-psychotic Medication
  ○ Adherence to Anti-depressant Medication
  ○ Follow-up after Hospitalization
  ○ Screening for Hepatitis C
Please see handout "QISC Presentation HEDIS Data" for additional information.		

Provider Feedback	**Assigned To**	**Deadline**
No Provider Feedback		
Action Items	**Assigned To**	**Deadline**

None Required		

8) Item: Leigh Wayna, Director of Utilization Management
Goal: UM FY2022 Evaluation
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems ☐ Quality ☐ Workforce
NCQA Standard(s)/Element #: QI ☐ CC# ___ **X UM #1** ☐CR # ___ ☐ RR # ___

Discussion		

Leigh Wayna shared with the committee the results and analysis for the Utilization Management FY2022 Evaluation which included the following areas for discussion and review:
• Population served by disability designation FY2022:
  ○ Individuals with Serious Mental Illness (SMI)
  ○ Children with Serious Emotional Disturbances (SED)
  ○ Individuals with Substance Use Disorders (SUD)
  ○ Individuals with Intellectual and Developmental Disabilities (IDD)
  ○ Individuals with Mild to Moderate Mental Illness (MI)
• Funding Sources utilized to pay for an individual's services in FY2022.
  ○ Medicaid (General Medicaid 54%, Healthy Michigan 21%, Habilitation Waiver 1%) 76%
  ○ Block Grant and State Disability Assistance(SDA) 9%
  ○ General Funds 8%
• Utilization Management Program Description Goals and Strategic Plan Goals
• Evaluation is based on the six pillars that are identified in DWIHN Strategic Plan:
  ○ Customer Service
  ○ Access
  ○ Workforce
  ○ Finance
  ○ Quality
  ○ Advocacy
• Standardized IPOS Process:
  ○ Throughout the year, UM continued efforts to build the skill set of the network in the area of Person-Centered Planning. Person Centered Planning and IPOS Development training sessions were held in Quarter 3.
• Self Determination VS. Self-Directed Services		

○ The UM Department further demonstrated its commitment to supporting our members' ability to exercise autonomy over their life by developing the infrastructure so that all populations could Self-Direct their services if they choose to do so. • Opportunities for Improvement were reviewed for the following pillars: ○ Access ○ Workforce ○ Quality ○ Advocacy		
Provider Feedback	**Assigned To**	**Deadline**
None.		
Action Items	**Assigned To**	**Deadline**
Dr. Faheem and the QISC approved as written the UM FY2022 Evaluation Report.	Dr. Faheem and QISC	Complete

9) Item: Ebony Reynolds, Clinical Officer
Goal: Clinical Practice Guidelines

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

Discussion		
Ebony Reynolds provided the following updates for the Clinical Practice Guidelines review and approval: There has been a complete review of the Clinical Practice Guidelines (CPG). As DWIHN continues to review and update the CPG's it is necessary to make certain we have feedback from our provider partners with the development and updates of the clinical practice guidelines. We have shifted the use of the CPG to more of a tool, a resource of evidence based promises and practices that are available for common behavioral health disorders to individuals to whom we provide treatment and services. . Part of our HSAG compliance review is to show that we receive feedback from our Provider Network and the adopted guidelines were agreed upon. Intended guidelines were sent out in December and January to our Provider Network requesting feedback-did received some feedback which was helpful. DWIHN has received some feedback on adding more personality disorder information to our current guidelines this year, which we did, we also expanded on our LGBTQIA population guideline information and added some additional substance use disorder treatment guidelines as well. It is written within our Policy and Procedures that if throughout the year we have the ability to add additional sources to the CPG, for new and up-to-date information please email the information to Ebony Reynolds. Ebony will review the information and determine if needs to bring back to IPLT and QISC. It is recommended to have one annual period to update the CPG and present information to the provider network as required.		
Provider Feedback	**Assigned To**	**Deadline**
No provider feedback.		
Action Items	**Assigned To**	**Deadline**
Dr. Faheem and the QISC approved the Clinical Practice Guideline updates as written.	Dr. Faheem and QISC	Complete

New Business Next Meeting: March 28, 2023
Adjournment: February 28, 2023

UPDATES TO DWIHN POPULATION ASSESSMENT

Ashley Bond MA, LPC
Detroit Wayne Integrated Health Network

Member Populations

- Data has been added to include information in regards to LGBTQ+ members. This includes:
  - According to the UCLA Williams Institute 2020 data, there is an estimated 311,000 LGBTQ+ members in Michigan.
  - Although the full range of LGBTQ+ identities are not commonly included in large-scale studies of mental health, there is strong evidence from recent research that members of this community are at a higher risk for experiencing mental health conditions — especially depression and anxiety disorders.
  - Including LGBTQ+ identifiers in our demographic data to reflect the growing population of members that we serve (starting third quarter FY2022)

- Hispanic/Latino members represent 4.68% of our members served. Information has been added to include:
  - Traditional Healthcare approaches

~Many combine traditional approaches combined with Western Medicine

  - Barriers

~ Hispanic/Latino have the highest rates (32%) of any racial group within the United States to have a lack of health insurance which often results in fewer needed healthcare visits

Language Materials

- Currently DWIHN's website offers the Member handbook and other documents in Arabic, English and Spanish to support members who reported other Primary Languages spoken other than English.

- During FY21, a total of 835 member calls utilized translation services. The languages requested were Arabic, Spanish, Bengali, Bosnian, Persian, Mandarin, Punjabi, Dari, Vietnamese, Hindi, Urdu, Cantonese and Albanian. The top two languages requested were Arabic and Spanish.

SPMI

- The Top 5 Serious and Persistent Mental Illnesses were added for FY21 for Adult Members age 18 and older. These Diagnosis were derived from Member charts in MHWIN. The top 5 SPMI Diagnosis includes:

1. Major Depressive Disorder (9,503)
2. Anxiety Disorder (3,577)
3. Bipolar I Disorder (3,368)
4. Schizoaffective Disorder (1,886)
5. Post-Traumatic Disorder (1,858)

* The SPMI Diagnosis for adults will be compared in FY22.

Analysis of Complex Case Management Activities and Resources

- For the last two years Autism has been in the top five conditions for children and youth. In FY 2021 it ranked number six with 914 members served. Due to the prevalence of Autism in our population, DWIHN will be adding Autism to CCM eligibility criteria for children and adolescents.

- Chronic pain has been in the top five medical conditions for adults for the last 2 years and thus chronic pain will be added to the eligibility criteria for adults.

- Schizoaffective Disorder was the 3rd most common Behavioral Health diagnosis for DWIHN adults in FY 2021 .
- We added some potential barriers to accepting treatment/mental health support for individuals diagnosed with Schizoaffective Disorder which could include:

~stigma and fear

~lack of awareness

~severe symptoms

~possible substance use

~client resistance

In response to the 2021 Population Assessment

- We plan to focus more on the subpopulations of LGBTQ+ members, Hispanic and Middle East and North African Cultures (MENA).
- This includes more trainings to increase our knowledge base in working with members within these subgroups, and partnering with different organizations to better serve our members (such as Ruth Ellis, Affirmations and etc)
- The Complex Case Management team participated in a series of SOGIE (Sexual Orientation Gender Identity and Expression) trainings offered by the Ruth Ellis Center to expand knowledge base and better work with LGBTQ+ members.
- We will also participate in trainings to learn more about barriers and different approaches that is better received from members of different cultures with the focus primarily being on Hispanic and MENA cultures as they are the second and third highest reported groups of our member populations.

FUH and African American Members

- Another population that has been identified as needing more supports/interventions are African American Members and attendance with Follow Up after Hospitalization appointments (FUH).
- The Integrated Care Department under which the Care Coordinators function has partnered with the Quality Improvement Department on an initiative the Michigan Department of Health and Human Services has asked to see an improvement on. The Quality Improvement project is titled "Reducing ethnic disparity with African Americans for the percentage of discharges from a psychiatric inpatient unit that were seen in follow-up in seven days.

- As part of their job responsibilities, the Care Coordinators perform transition of care activities and will incorporate interventions specific for this population.
- Prior to discharge, Care Coordinators contact hospital Social Workers to discuss discharge planning.
- Members are contacted post discharge and receive verbal reminders of their scheduled FUH appointments. During these contacts, Care Coordinators also try to address barriers to increase attendance for aftercare appointments. Care Coordinators will continue to make a conscious effort to address barriers for our members, with additional focus on our African American members to increase FUH outcomes.

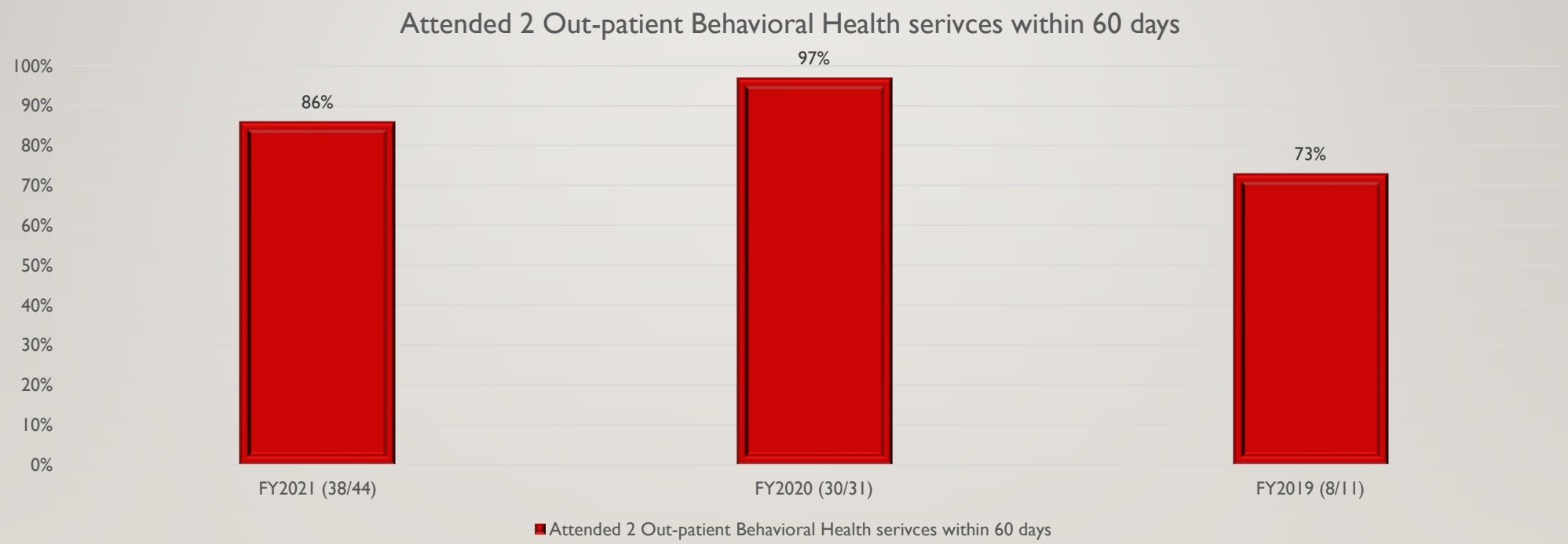
UPDATES TO COMPLEX CASE MANAGEMENT PROGRAM EVALUATION FY21

ASHLEY BOND MA, LPC

DETROIT WAYNE INTEGRATED HEALTH NETWORK

GOALS

- New goal: Improve participation in the number of members who attended two out patient Behavioral Health service visits within 60 days starting CCM services who were open for at least 60 days and closed as of October 2021 as evidenced by an overall 10% increase in participation (86%)


Attended 2 Out-patient Behavioral Health serivces within 60 days
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
86%
97%
73%
FY2021 (38/44)
FY2020 (30/31)
FY2019 (8/11)
Attended 2 Out-patient Behavioral Health serivces within 60 days

TIMEFRAMES

- PHQ and WHO-DAS

~Members were included who were open for at least 90 days

- Emergency Room, Inpatient admit and Utilization of Out-Patient Services

~Members were included who were open for at least 60 days

CAUSAL ANALYSIS

- Although we met our program goals for FY21, we added a Causal Analysis to explore goals, discuss interventions, discuss barriers, and goal evaluations for the upcoming fiscal year.
- A Causal Analysis was added for the following:
  - PHQ
  - WHO-DAS
  - ED and Hospital Admits
  - Out-Patient Services
  - Satisfaction Surveys

SATISFACTION SURVEYS

- Out of 42 members, 16 returned Satisfaction Surveys (38%)

- Elimination of neutral responses starting in FY23 to obtain members true opinions for negative and/or positive feedback
- Electronic Satisfaction Surveys

I will reintroduce 5 of our Quality Improvement Plans

I will review our current rate of result and compare it to our goal which was determined by quality compass. A tool that helps an agency compare their performance to Medicaid health plans.

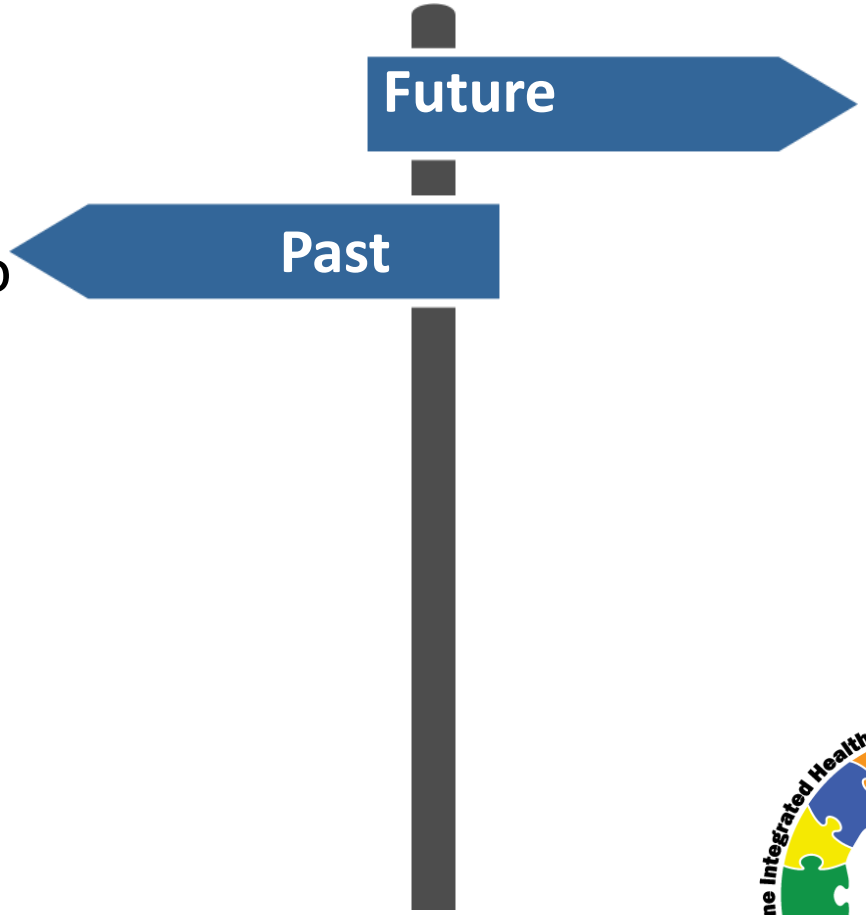
I will be reporting on the 2022 rate of results, keep in mind the annual total number for 2022 will not be completed until March or April 2023 due to a 3-month reporting lag.

What is HEDIS?

- Healthcare
- Effectiveness
- Data and
- Information
- Set

HEDIS is a Retrospective Review

- HEDIS® is a look backwards at the year or year(s) prior
- It is a review of the services and clinical care provided to our clients



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What is HEDIS DATA

HEDIS is a combination of:

1. **Administrative data**: Data captured from Claims, Encounters, Pharmacy, and Labs
2. **Medical Record review**: A validation audit conducted by Quality

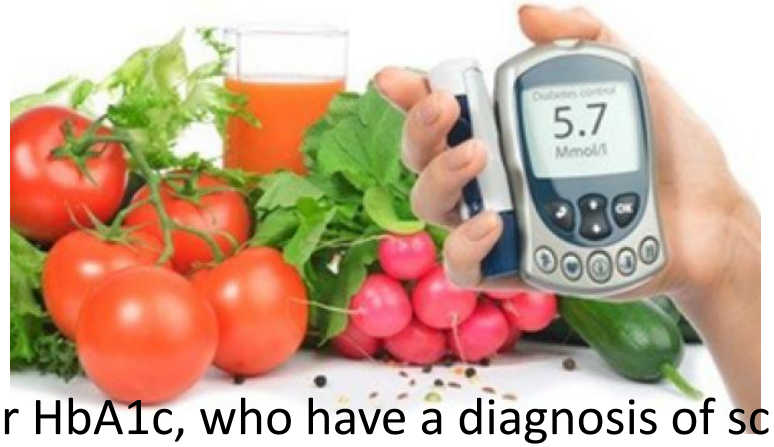
What is your role in HEDIS ?

- Ensure preventative healthcare screening is done
- Ensure screening is completed within the right time frame
- Ensure all screenings are documented.

Identified HEDIS Measures

Diabetes Screening
Adherence to Anti-psychotic Medication
Adherence to Anti-depressant Medication
Follow up after Hospitalization
Screening for Hepatitis C

SSD Diabetes Monitoring for People with Schizophrenia and Bipolar Disorder



Targeted population

Ages 18-64

Members who have a FBS or HbA1c, who have a diagnosis of schizophrenia or bipolar.

Members dispensed an antipsychotic medication that had diabetes screening during the measurement year.

Documentation must have:

Hemoglobin A1C or Fasting blood sugar results

DWIHN goal for this measure: 86.36%

2020 rate of results:64.38%

2021 rate of results:64.86%

0.48 percentage point increase

2022 current rate of results for 3rd quarter 64.19%

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Diabetes Monitoring for People with Schizophrenia and Bipolar Disorder

Why it Matters

Heart disease and diabetes are among the top 10 leading causes of death in the United States.[1] Because persons with serious mental illness who use antipsychotics are at increased risk of cardiovascular diseases and diabetes, screening and monitoring of these conditions is important. Lack of appropriate care for diabetes and cardiovascular disease for people with schizophrenia or bipolar disorder who use antipsychotic medications can lead to worsening health and death. Addressing these physical health needs is an important way to improve health, quality of life and economic outcomes.

SAA Adherence to Antipsychotic Medication for Individuals with Schizophrenia

Targeted Population:

Ages 18 to 64

Members during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.

Documentation must have:

Evidence of medication refill as prescribed.

DWIHN goal for this measure: 85.09%

2020 rate of results: 79.34%

2021 rate of results: 46.42%

2022 3rd quarter rate of results: 54.67%

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Adherence to Antipsychotic Medication for Individuals with Schizophrenia

Why it matters

Schizophrenia is a chronic and disabling psychiatric disorder that requires ongoing treatment and monitoring. Symptoms include hallucinations, illogical thinking, memory impairment, and incoherent speech.[1] Medication non-adherence is common and a major concern in the treatment of schizophrenia. Using antipsychotic medications as prescribed reduces the risk of relapse or hospitalization

AMM Adherence to Antidepressant Medication

Targeted population:
Age 18 years and older
2 phases are measured:
Effective Acute Phase Treatment: Number of members 18years of age or older with a diagnosis of major depression who were newly treated with an antidepressant medication and remained on an antidepressant medication for 84 days (12 weeks).
Effective Continuation Phase Treatment: Number of members 18years of age or older with a diagnosis of major depression who were newly treated with an antidepressant medication and remained on an antidepressant medication for 180 days.(6months)
Documentation must have:
Evidence of medication refill as prescribed
DWIHN goal for this measure:
Acute Phase: 77.32%
Continuation Phase 64.41%
Current results:

Acute Phase:	2020 26.94%	2021 41.28%	2022 3rd quarter rate of results 39.73%
Continuation Phase:	2020 21.66%	2021 13.36%	2022 3rd quarter rate of results 13.95%

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Adherence to Antidepressant Medication

Why it matters

Major depression can lead to serious impairment in daily functioning, including change in sleep patterns, appetite, concentration, energy and self-esteem, and can lead to suicide, the 10th leading cause of death in the United States each year. Clinical guidelines for depression emphasize the importance of effective clinical management in increasing patients' medication compliance, monitoring treatment effectiveness and identifying and managing side effects.

Effective medication treatment of major depression can improve a person's daily functioning and well-being and can reduce the risk of suicide. With proper management of depression, the overall economic burden on society can be alleviated, as well.

Follow up after Hospitalization

Targeted population:

Ages 6-and older

With a follow-up visit with a mental health practitioner (psychiatrist, psychologist, nurse practitioner) within 7-30 days after discharge

Documentation must have:

Evidence of a follow up appointment with a mental health practitioner within 7-30 days after discharge.

DWIHN goal for this measure:

7 day-ages 6 -17: 70%

7 day-ages 18-64: 58%

30 day-age 6-17: 70%

30 day-age 18-64: 58%

Current results:

7 day-ages 6 -17: 2020 41.33% 2021 44.14% 2022 3rd quarter rate of results 43.73%

7 day-ages 18-64: 2020 29.14% 2021 28.33% 2022 3rd quarter rate of results 29.96%

30 day-age 6-17: 2020 62.96% 202166.32% 2022 3rd quarter rate of results 65.42%

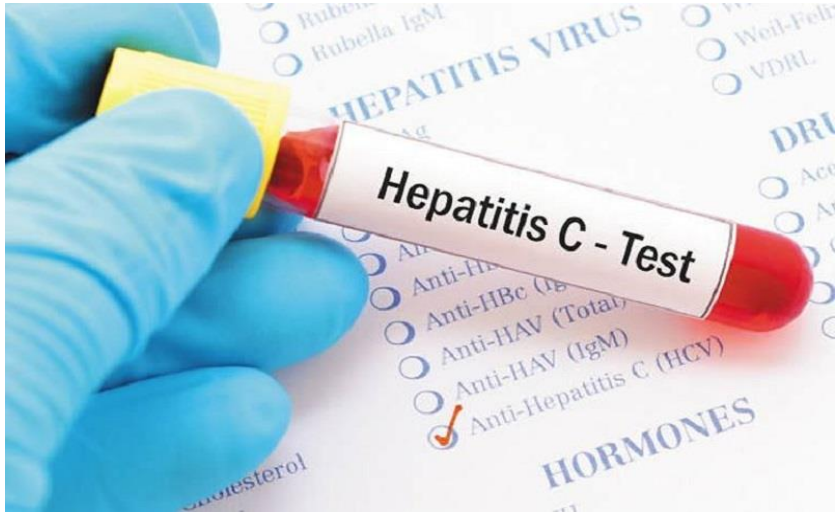
30 day-age 18-64: 2020 48.74% 2021 46.67% 2022 3rd quarter rate of results 48.39%

Follow up after Hospitalization

Why it matters

In 2019, nearly one in five adults aged 18 and older in the U.S. had a diagnosed mental health disorder. Despite this, individuals hospitalized for mental health disorders often do not receive adequate follow-up care. Providing follow-up care to patients after psychiatric hospitalization can improve patient outcomes, decrease the likelihood of re-hospitalization and the overall cost of outpatient care.

Screening for Hepatitis C



Targeted population:

Ages 18 to 79

Percentage of members with a substance use disorder diagnosis who were tested for Hepatitis C.

Documentation must have:

Hepatitis RNA testing results

DWIHN goal for this measure: 5%

Current results: 0.05%

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Screening for Hepatitis C

Why it matters

Screening for hepatitis C leads to the appropriate evaluation and treatment of individuals chronically infected with the hepatitis C virus and prevents the progression of liver disease, cancer, and death. Screening for hepatitis C is also cost effective.

The following barriers were identified by a clinical literature search:

- Relationship with physician
- Lack of a consistent treatment approach by physicians
- Stigma of the disease
- Disorganized thinking/cognitive impairment
- Enrollee/member's lack of insight regarding presence of illness or need to take medication.
- Lack of family and social support
- Medication side effects and/or lack of treatment benefits
- Patient forgets to take medications
- Patient forgets to re-fill medications.
- Lack of follow-up
- Financial Problems

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From the barriers above the following opportunities for improvement were identified

- Improve the relationships with physician by helping the member identify pre-appointment questions
- Improve the treatment approach by physician's, by sending memo's to providers chief medical officers quarterly with current HEDIS score.
- Improve members adherence with medication by educating member of the importance of taking their medication
- Improve patient adherence to medication refill by educating member of the importance of having their medications refilled
- Improve member follow up by telephone calls, texting and letters to members addressing the importance of follow up care. Case managers are also instructed to provide a follow up appointment for the member.

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Barrier regarding treatment

Covid continues to be a barrier. The State of Michigan did not allow in person face to face visits with our population until July 2021. Some remote workers did not have equipment to work from home at the onset of Covid.

Telehealth continues to be a preferred form of contact. Not all members are computer literate or have the equipment needed to perform the service. Some members that have government issued phones are preferring to use their phone minutes for emergencies. Transportation continues to be a barrier for those that chose to attend their appointments face to face. The state continues to work on this issue.

Telehealth has caused non-adherence to medication refill possibly due to members not having a prescription in hand.

Post Covid there is a shortage of mental health staff. Caseloads continue to be over 100 for case managers which causes difficulty in assisting member with care. Social workers are needed at many of the provider agencies. Providers are struggling with a large client population with very little staff to take on the numbers causing a gap in care.

Staffs fears of exposure to COVID

Private companies are paying higher salaries causing a shortages within our agency. Educational requirement has changed from a BA to BSW for case manager positions which lowered our pool for staffing.

Shortage of nursing staff causing a decrease in the number of prescribed injections.

Insurance limits covering new antipsychotic medications.

Post Covid, agencies are trying to reorganize.

MDHHS service back log.

Restructuring of DWIHN Access Center caused a lag in timely access to care.

The Covid vaccine is a requirement at some of DWIHN provider site with few exceptions.

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Plans Moving Forward

In an effort to maintain staff, provider rates were increased. Stability payments provided to CRSP. Updated integrated biopsychosocial can be completed by a LBSW as long as the clients treating facility has not changed.

DWIHN registered nurse will conduct quarterly lunch and learns, focusing on interventions that will help improve the HEDIS score.

In an effort to improve clients understanding of the importance of medication adherence, DWIHN's registered nurse will call members identified in complex case management that are identified as non-adherent to care. The nurse will educate the client regarding the importance of adherence. The nurse will help clients identify barriers to care and provide resources that will help the client achieve their medical goal.

DWIHN's registered nurse will serve as mentor to several nursing students. This internship will address the shortage of nurses in the mental health field. The nurse interns will assist in educating the clients on the importance to medication adherence and follow up care. Nurse interns will conduct integrated health education classes that address chronic conditions such as, diabetes, heart failure, hypertension, and asthma.

Laboratory blood draw reminders automatically built into providers system.

Developing a HEDIS tool kit on our website.

HEDIS score cards data review presented to providers every 45 days.

Continue to hire staff to access center and update infrastructure.

Resources at Your Fingertips

dwihn.org

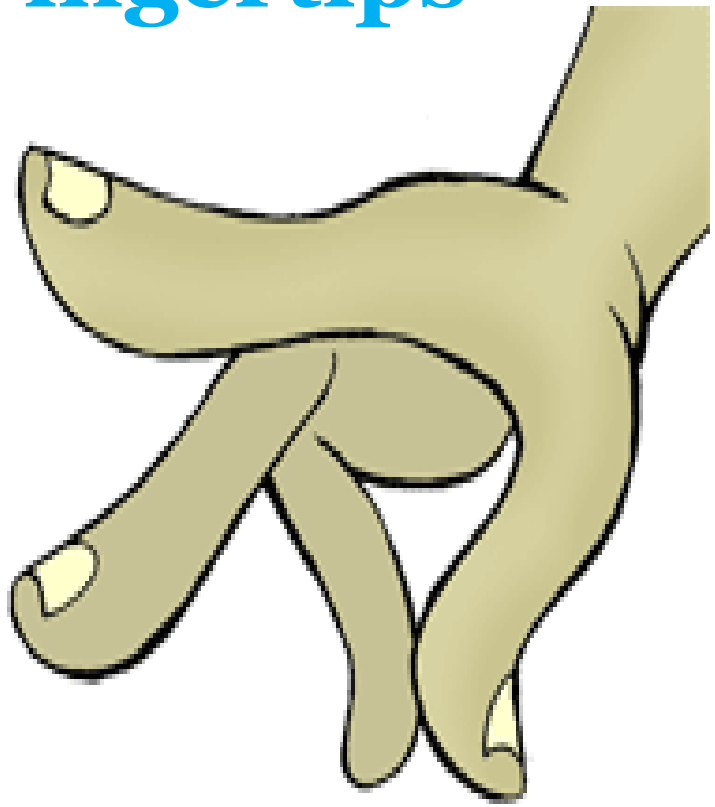
- Clinical Guidelines
- CRSP Guidelines
- Educational Material
- MyStrength mental health tool

Presentation and Trainings:

- HEDIS® Overview Presentation
- HEDIS® Made Easy

Guidance Documents:

- HEDIS® at a Glance
- HEDIS® Measures Handout
- HEDIS® Measures Poster
- HEDIS® Office Manager's Guide
- Provider Opportunity Report
- HEDIS® Value Set Directory



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Question and Answer Period

Utilization Management Department Annual Evaluation FY 2021-2022

DETROIT WAYNE

INTEGRATED HEALTH NETWORK

POPULATION SERVED

Disability Designation

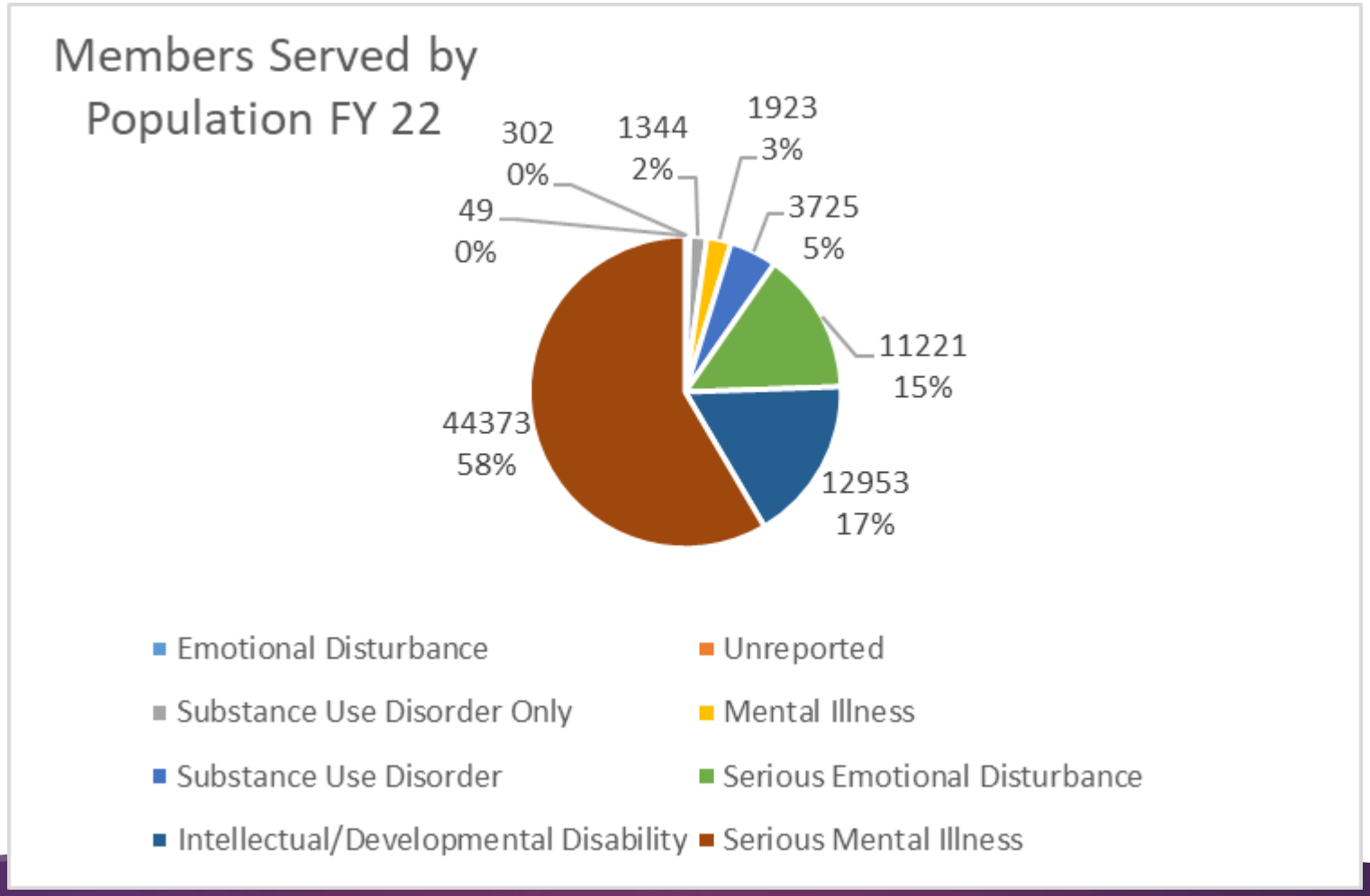
The pie chart details members served by disability designation. DWIHN oversees and monitors services provided to:

- Individuals with Serious Mental Illness (SMI)
- Children with Serious Emotional Disturbances (SED)
- Individuals with Substance Use Disorders (SUD)
- Individuals with Intellectual and Developmental Disabilities (IDD)

With the federal demonstration program, MI Health Link, DWIHN also serves

- Individuals with Mild to Moderate Mental Illness (MI).

***Individuals with Substance Use Disorders may also be reflected in multiple categories due to co-occurring diagnoses. The unreported designation is either due to consumers being admitted to the system in unconventional pathways (not via the Access Center) or consumers that do not have an updated disability designation.*



Members Served by Disability Designation FY 22

SMI – 54% IDD – 17% SED -- 15%

SUD – 5% MiHealthLink – 2%

Funding Source

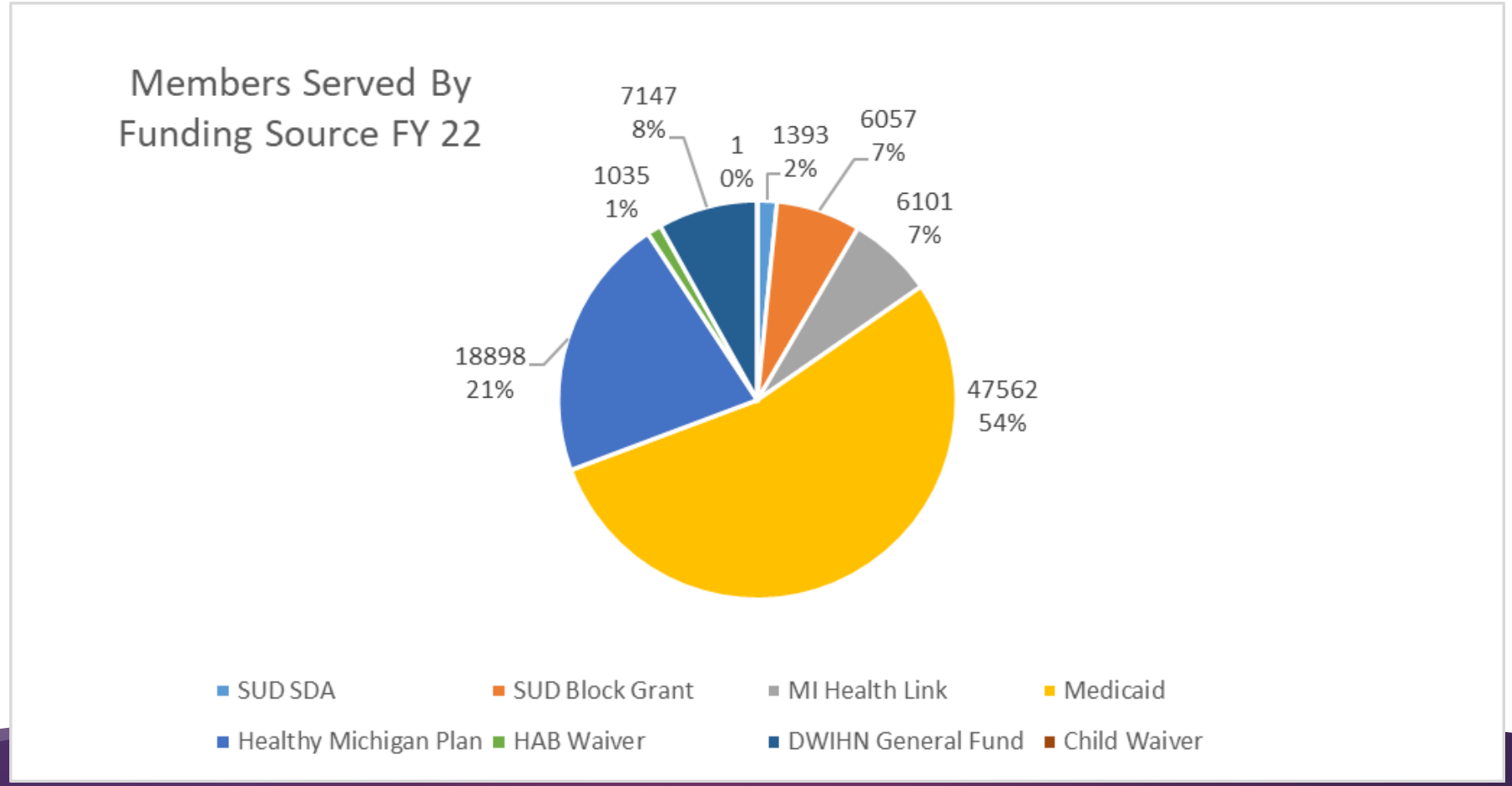
The chart indicates funding sources utilized to pay for an individual's services in FY 22.

When combining general Medicaid (54%), Healthy Michigan (21%), Habilitation Waiver (1%) which are all Medicaid, this accounts for 76% of the funding sources utilized.

Block Grant and State Disability Assistance (SDA) which is used to pay for SUD and Room and Board with Substance Use Disorders is reflected as funding sources totaling 9%,

General Fund is reflected at 8%,

MI Health Link is at 8% which is a 2% increase from FY 20. These are all consistent with the forecasting model.


Members Served By Funding Source FY 22
7147
8%
1
0%
1393
2%
6057
7%
1035
1%
6101
7%
18898
21%
47562
54%
SUD SDA
SUD Block Grant
MI Health Link
Medicaid
Healthy Michigan Plan
HAB Waiver
DWIHN General Fund
Child Waiver

Utilization Management Program Description Goals and Strategic Plan Goals

THE UM EVALUATION IS BASED ON SIX (6) PILLARS THAT ARE IDENTIFIED IN DWIHN'S STRATEGIC PLAN. THESE INCLUDE THE:

CUSTOMER SERVICES PILLAR

ACCESS PILLAR

WORKFORCE PILLAR

FINANCE PILLAR

QUALITY PILLAR

ADVOCACY PILLAR

Customer Services Pillar

THE CUSTOMER SERVICES PILLAR ENCOMPASSES THREE SURVEYS CONDUCTED THROUGHOUT THE YEAR WHICH THE UM DEPARTMENT COLLABORATES WITH VARIOUS OTHER DEPARTMENTS TO COMPLETE:

- ENROLLEE MEMBER SATISFACTION SURVEY
- DWIHN MEMBER SATISFACTION SURVEY
- DWIHN REPORT ON PRACTITIONER NETWORK EXPERIENCE SURVEY

IT ALSO INCLUDES THREE (3) AREAS IN WHICH THE UM DEPARTMENT HAS IDENTIFIED GOALS SPECIFIC TO OUR WORK AND OUR QUALITY IMPROVEMENT:

- CUSTOMER INVOLVEMENT
- STANDARDIZED IPOS
- SELF DETERMINATION AND SELF DIRECTION

Consumer Involvement

The Consumer Voice (Persons Points of View) is a quarterly newsletter, edited and written by consumers, that is distributed throughout the provider network. Each of the FY 2021-2022 editions contained language regarding the UM "Affirmative Statement."

Here, members are advised that UM decision making is based only on appropriateness of care and no rewards or financial incentives influence those decisions.

DWIHN'S CUSTOMER SERVICE DEPARTMENT INSTITUTED A RAPID RESPONSE PROCESS FOR INQUIRES COMING FROM CONSUMERS AND OTHER STAKEHOLDERS VIA THE DWIHN WEBSITE. QUESTIONS ARE FORWARDED BY IT TO CUSTOMER SERVICE STAFF AND THEN DIRECTED TO THE APPROPRIATE DEPARTMENT FOR A RAPID RESPONSE. THE GOAL IS TO PROVIDE A PROMPT, POSITIVE, PRODUCTIVE EXPERIENCE FOR ANYONE REGARDING DWIHN PROCESSES, CLINICAL PROGRAMS OR PROCEDURES, OR OTHER PRACTICES IMPACTING THE COMMUNITY.

CUSTOMER SERVICE REPORTED THAT TWO INQUIRIES WERE DIRECTED TO UM FOR FY 22 AND RESOLVED SATISFACTORILY.

Standardized IPOS

Throughout the year, UM continued efforts to build the skillset of the network in the area of Person-Centered Planning. Person Centered Planning and IPOS Development training sessions were held in Quarter 3.

Service Utilization Guidelines (SUG) were used throughout the year to offer a transparent and consistent guideline for service delivery.

Services that did not fall within the guidelines, required an additional review for medical necessity prior to being authorized by the UM Department.

In the prior SUG training sessions, there were additional instructions on the Golden Thread which details the process of weaving relevant clinical information throughout the Assessment, IPOS, and Progress Notes.

April 1, 2022, HSAG identified a PIHP Corrective Action Plan for Standard V—Coordination and Continuity of Care Requirement: Home and Community-Based Settings.

The UM Department collaborated with several other DWIHN departments to modify the standardized IPOS. A comprehensive training was developed and presented to the network. A total of 854 individuals attended one of the three trainings.

Self Determination Vs. Self Directed Services

Self-Determination (SD) is the right of all people to have the power to make decisions for themselves; to have free will.

On an individual basis, the goals of SD are to promote full inclusion in community life, to have self-worth and increase belonging while reducing the isolation and segregation of people who receive services. Self-Determination builds upon choice, autonomy, competence and relatedness which are building blocks of psychological wellbeing.

SELF DETERMINATION

SELF DIRECTED SERVICES

Self-Direction (Self-Directing Services) is a method for moving away from professionally managed models of supports and services. It is the act of selecting, directing, and managing ones services and supports using an individual budget.

People who self-direct their services can decide how to use their CMH dollars on authorized services to meet the outcomes identified in their Individual Plan of Service.

Self Determination
Vs.
Self Directed Services

The UM Department further demonstrated its commitment to support our members' ability to exercise autonomy over their life by developing the infrastructure so that all populations could Self-Direct their services if they choose to do so. Individual budgets were developed in MHWIN and standardized agreements were developed.

By October 2022, DWIHN had transitioned the oversight of all Self-Directed services from a contractual provider to direct oversight. Between January 2022 and October 2022, the UM Department transitioned and began direct oversight for 690 Self-Directed arrangements which were previously had oversight by a contractual provider. This year DWIHN supported a total of 1029 individuals, primarily with IDD, in Self-Directed Arrangements.

Opportunities For Improvement

Strategic Pillar	Goal and Timeline for Completion	Brief Description	2021 Status	2022 Plan	2022 Status	2023 Plan/Assignment
Customer	80% satisfaction standard for Member Experience Surveys Member satisfaction	Member Experience Surveys to improve member satisfaction	Report from Customer Services not yet available	Continue to practice the principals of the Affirmative Statement and implement additional steps in accordance with 2021 findings	Report from Customer Services not yet available	Continue to practice the principals of the Affirmative Statement and implement additional steps in accordance with 2022 findings
Customer	80% satisfaction standard for Provider Experience Survey	Provider Experience Surveys to improve provider satisfaction	Not Met- Aggregate scores for each FY: 66% - FY 21 65.5% - FY 20 67% - FY 19 76% - FY 17	Specific interventions to be developed in collaborative effort, inclusive of UM department staff, Crisis Services, network practitioners and the Utilization Management Committee (UMC).	Report from Customer Services not yet available	Continue to practice the principals of the Affirmative Statement and implement additional steps in accordance with 2022 findings

Access Pillar Goals

Evaluate DWIHN's UM Program Description to assure effective and efficient utilization of behavioral health services identifying any barriers, analyzing metrics, utilization trends and quality of care concerns.

Monitor use of specialty behavioral health waiver programs:

Autism-Spectrum-Disorder (ASD) benefit

Habilitation and Supports Waiver (HAB)

Children's Waiver Program (CWP)

Serious Emotional Disturbances Waiver (SED)

Analyze other populations served, examining services received and services available to identify any gaps.

Opportunities For Improvement

Strategic Pillar	Goal and Timeline for Completion	Brief Description	2021 Status	2022 Plan	2022 Status	2023 Plan/Assignment
Access	UM will monitor timely written notification of ABA eligibility	Delegated functions	Timely notification of eligibility continues to be monitored. In FY 21, notification of ineligibility is no longer a delegated function.	Ongoing Monitoring	ABA Eligibility is no longer a delegated function. Policies and procedures have been updated to reflect same.	Ongoing Monitoring
Access	Identify the impact of telehealth on access to behavioral health services	UM Performance Improvement Project		To be Determined	Not done.	To be determined

Workforce Pillar Goal

Assure fair and consistent UM/review decisions based on MCG, Local Coverage Determination (LCD), National Coverage Determination (NCD) and/or American Society of Addition Medicine (ASAM) medical necessity criteria by monitoring the application of the applied criteria and service authorizations for behavioral health services (including substance use disorders) using a standard inter rater reliability process system wide.

Demonstrate consistent guideline application & Identify staff improvement opportunities

All staff who make UM decisions are tested with the IRR module to ensure consistent application of the guidelines and medical necessity criteria.

During 2022, a total of 932 case studies were completed. Of those case studies, staff received and passed cases studies score of 90% or above 55% of the time.

Opportunities For Improvement

Strategic Pillar	Goal and Timeline for Completion	Brief Description	2021 Status	2022 Plan	2022 Status	2023 Plan/Assignment
Workforce (Jackie)	Fall 2023 opening of DWHIN Milwaukee Clinical Care Center	UM role, policies, technology and staffing			Ongoing	Fall 2023 opening of Milwauke Clinical Care Center

Quality Pillar Goals

Monitor the effectiveness of processes that promote clinical review procedures established from accrediting and regulatory agencies by evaluating the efficiency of targeted metrics during UM activities through interdepartmental collaboration.

Provide oversight of delegated UM functions through use of policies that reflect current practices, standardized/inter-rater reliability procedures and tools, pre-service, concurrent and post-service (retrospective) reviews, data reporting (ie. timeliness of UM decisions and notifications), outcome measurements and remedial activities.

Opportunities For Improvement

Strategic Pillar	Goal and Timeline for Completion	Brief Description	2021 Status	2022 Plan	2022 Status	2023 Plan/Assignment
Quality	Fulfill terms of HSAG Plan of Correction	Standards VI, VII, VIII and X	Plan of correction	April 1, 2022	Continued Monitoring	April 1, 2023
Quality	Ensure 2 provider trainings per year regarding Service Utilization Guidelines (SUGs) by end of FY 21	Ongoing collaboration and improvement of service utilization guidelines	The Provider Network was trained on at least one occasion during the FY and provided ongoing technical assistance with the SUGs.	Ongoing collaboration and improvement of service utilization guidelines	The Provider network has been trained on SUGs at all provider and CRSP meetings during FY 22.	Ongoing collaboration and improvement of service utilization guidelines

Opportunities For Improvement

Strategic Pillar	Goal and Timeline for Completion	Brief Description	2021 Status	2022 Plan	2022 Status	2023 Plan/Assignment
Quality	Achieve MMBPI 15% or less hospital recidivism quarterly standard for adults and children	Recidivism Source: MHWIN Performance Indicators	Recidivism rate for *children* consistently meeting standard, with quarterly rates of 8.94%, 12.03%, 6.76% & 8.22%.	Ongoing	Recidivism rate for *children*	
Quality	Ensure 2 provider trainings per year regarding Service Utilization Guidelines (SUGs) by end of FY 21	Ongoing collaboration and improvement of service utilization guidelines	Recidivism rate for *adults* consistently did not meet 15% standard until 4th quarter with quarterly rates of 17.94%, 17.34%, 17.03% & 15.01%	Ongoing collaboration and improvement of service utilization guidelines	Recidivism rate for *children*	Ongoing collaboration and improvement of service utilization guidelines

Opportunities For Improvement

Strategic Pillar	Goal and Timeline for Completion	Brief Description	2021 Status	2022 Plan	2022 Status	2023 Plan/Assignment
Quality Quality	DWIHN UM department to have an approved 2022-2024 UM Program Description Quarterly PAR Audits for UM Delegated Entities	UM Program Description policy PAR Audits tool completion for 25 PARs monthly (75 per quarter)	Completed	UM Program description. PAR Audits tool completion for 25 PARs monthly (75 per quarter)	UM Program Description was approved by the Board of Directors, June 2022	Review status throughout the year with UMC, UM staff, delegated entities, etc.
			Not completed		Completed for February 2023.	Implement quarterly audit process. Report findings to QMC, UM staff, delegated entities.

Advocacy Pillar Goal

Promote need for enhanced use of Social Determinants of Health in making clinical decisions within standardized guidelines as part of the clinical review process.

Opportunities For Improvement

Strategic Pillar	Goal and Timeline for Completion	Brief Description	2021 Status	2022 Plan	2022 Status	2023 Plan/Assignment
Advocacy	Continue bi-monthly meetings and contribution to Michigan Consortium for Healthcare excellence in ensuring access, parity, and uniform application of benefits for Michigan consumers	MCG Behavioral Health Guidelines, Interrater Reliability	Met: New three-year contract signed by MCHE; meetings moved to quarterly for FY 22	Ongoing; MDHHS to begin reviewing use of MCG behavioral health guidelines during audit	Ongoing	MDHHS to begin reviewing use of MCG behavioral health guidelines during audit

THANK YOU

DETROIT WAYNE

INTEGRATED HEALTH NETWORK