Quality Improvement Steering Committee (QISC)
May 30, 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** • **Table**	**Dr. S. Faheem/Committee**
V.	**Follow-up Items** • **None**	
VI.	**QAPIP Effectiveness**	
	Integrated Health	
	• **CCM Program Description FY2023**	**A. Bond**
	• **Performance Improvement Projects**	**A. Oliver**
	○ **Follow-Up After Hospitalization (FUH)**	
	○ **Antidepressant Medication Management (AMM)**	
	○ **Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)**	
	○ **Improving Diabetes Monitoring for People with Schizophrenia or Bipolar Disorder (SSD)**	
	○ **Hepatitis C**	
	Quality Improvement	
	• **Accessibility of Services**	**T. Greason**
VII.	**Adjournment**	

Quality Improvement Steering Committee (QISC)
May 30, 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

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: The construction at the crisis center is going at the speed that is expected. There was a bit of a delay in terms of getting the generator that would give us the occupancy permit and for us to go live. We are working on overall improvement of our services, continuing to look at our HEDIS measures and performance indicator data and other quality measures, making sure that our HEDIS measure are going in the right direction. DWIHN was instructed by MDHHS to develop a performance improvement project (PIP) around racial disparity and to identify any existing racial disparities for any of the quality indicator. We are currently talking more about our efforts to narrow racial disparity as it relates to the 7-day follow up measurement after inpatient psychiatric admissions.

3) Item: Approval of Agenda: Agenda for May 30, 2023, Meeting Approved.

4) Item: Approval of Minutes: Tabled.

5) Item: Follow-up Items

Goal:

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

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

Discussion		
None.		
Provider Feedback	**Assigned To**	**Deadline**
No provider feedback.		
Action Items	**Assigned To**	**Deadline**
None		

6) Item: QAPIP Effectiveness – Integrated Health
Goal: CCM Program Description FY2023

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

Discussion		

Ashley Bond shared with the committee the Complex Case Management (CCM) Program Description FY22 including the following:
 	
• Who DWIHN's Complex Case Management Program is available to.
  ○ DWIHN's Complex Case Management Program is available to children and adults who are eligible for:
  ○ Medicaid and Medicare (Including MI Health Link, SED and/or Autism Waiver benefits)
• Members enrolled in CCM can carry the designations of:
  ○ ~Severely mentally ill (SMI)
  ○ ~Intellectually/developmentally disabled (I/DD)
  ○ ~Substance use disorder (SUD)
  ○ ~Severely emotionally disabled (SED)
 	
The reason to initiate CCM services is to support members to sustain/maintain optimum health and/or functional capacity in the most appropriate setting and in a cost-effective manner. Complex case management is a free voluntary, short-term program available to DWIHN members.
CCM is led by the clinical specialist and overseen by the director of integrated health. There are currently two complex case managers. Complex case management services will be delivered by licensed and limited licensed masters and bachelors' level social workers. The team is led by a licensed professional counselor.
 	
• The ultimate goals of DWMHA's/DWIHN's Complex Case Management (CCM) Program are to:
  ○ Improve medical and/or behavioral health concerns and increase overall functional status as well as improve overall quality of life as evidenced by a 10% improvement in PHQ scores and/or a 10% improvement in WHO-DAS scores at CCM closure.
  ○ To provide early intervention for members appropriate for Complex Case Management to prevent recurrent crisis or unnecessary hospitalizations as evidenced by 10% reduction in Emergency Department (ED) utilization and/or 10% reduction hospital admissions from 90 days prior to receiving CCM services to 90 days after receiving CCM services.		

○ Increased participation in out-patient treatment as evidenced by a 10% increase in out-patient behavioral health services from 90 days prior to receiving CCM services to 90 days after receiving CCM services. ○ Assist members to access community resources and obtain a better understanding of the physical and/or behavioral health conditions as evidenced by improved compliance with behavioral health and physical health appointments and decrease in ED visits and/or inpatient admissions. ○ 80% or greater member satisfaction scores for members who have received CCM services. For additional information please review the "Complex Case Management Program Description FY23(Revised).pptx"		
Provider Feedback	**Assigned To**	**Deadline**
Questions/ Concerns: • How many members do we have enrolled in the program? Answers: • Currently, I believe we have 15 or 16.		
Action Items	**Assigned To**	**Deadline**
Dr. S. Faheem and the QISC approved the Complex Case Management Program Description as written.	Dr. S. Faheem and QISC	May 30, 2023

6) Item: QAPIP Effectiveness – Integrated Health
Goal: Performance Improvement Projects
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems X **Quality** ☐ Workforce
NCQA Standard(s)/Element #: QI# 10 CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Discussion		

Alicia Oliver shared the following Performance Improvement Projects updates with the committee for Q1 2023 scores. DWIHN continue to work with providers to improve these numbers. Providers are given their scores on a quarterly bases and asked to provide a plan of correction. The following PIPs were reviewed:
 	
• SAA Adherence to Anti-Psychotic Medications for Individuals with Schizophrenia
• AMM Data Results/HEDIS Measurement-Medication Compliance for Members 18 years or older with a Diagnosis of Major Depression on Antidepressant Medication for at least 84 Days (12 weeks), Effective Acute Phase Treatment
• AMM Data Results/HEDIS Measurement-Medication Compliance for Members 18 years or older with a Diagnosis of Major Depression on Antidepressant Medication for at least 180 Days (6 months), Effective Continuation Phase Treatment
• SSD Improving Diabetes Monitoring for People with Schizophrenia or Bipolar Disorder Data Results/ Measurement
• Increasing Screening for Hepatitis C
• Follow-up after hospitalization for mental Illness (FUH)
  ○ FUH 30 Day
  ○ FUH 7 Day
For additional information, please review the "Quality Improvement Scores.pdf"		

Provider Feedback	**Assigned To**	**Deadline**
Questions/ Concerns: 1. Where were we at for fiscal year 22, overall? 2. When we get those results from 2022, and our goal is like 86.36% for this SSD PIP, but the state's benchmark is 80.09%, would we want to think about lowering our goal at least to the state, because we have a long way to get to the 80 percentiles as well. Answers: 1. I won't be able to report on that until our next IPLT meeting and then I'll be able to report the results to the QISC meeting. 2. The 95 percentile is a percentile from our quality compass, that's what we are striving for. But we can have the conversation in regards to being a more realistic with set goals.		

Action Items	Assigned To	Deadline
Dr. S. Faheem and the QISC approved the SAA, AMM, SDD, HEPC and FUH Performance Improvement Projects. Alicia Oliver will review with the IPLT the goals that are set with the Quality Compass for discussion of possibly lowering the goal expectations based off performance.	Dr. S. Faheem, QISC and Alicia Oliver	September 30, 2023

6) Item: QAPIP Effectiveness – Quality Improvement

Goal: NCQA QI # 4 (Accessibility of Services) Establishment of Goals for PI# 2, 3

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

NCQA Standard(s)/Element #: QI# 4 CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Discussion		
Tania Greason shared the NCQA QI# 4 requirement with the committee. As a part of DWIHN's NCQA requirement, QI# 4 aims to ensure that we are providing and maintaining appropriate access to services. Measurements used are MDHHS Michigan Mission Based Performance Indicators (MMBPI). Effective FY2020, MDHHS excluded exceptions for the following indicators. To date, a goal has not yet been established for the following Performance Indicators: ○ PI#2a-*The percentage of new persons during the Period receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.* ○ *PI#2b-Persons Requesting a Service who Received Treatment or Supports within 14 Days.* ○ PI#3-*Percentage of new persons during the Period starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment.* The request to QISC: ○ Seeking approval and feedback for goal based on 2021 MDHHS data. ○ Measurements ○ 2021 MDHHS PIHP PI#2a – **62.81%** ○ 2021 SUD – **74.82%** ○ 2021 MDHHS PIHP PI#3 – **77.78%**		
Provider Feedback	**Assigned To**	**Deadline**
None Provided		
Action Items	**Assigned To**	**Deadline**
Dr. S. Faheem and the QISC approved the goals for the PI# 2a, 2b and 3 as noted above.	Dr. S. Faheem and QISC	May 30, 2023

New Business Next Meeting: June 27, 2023

Adjournment: May 30, 2023

COMPLEX CASE MANAGEMENT PROGRAM DESCRIPTION FY23

ASHLEY BOND MA, LPC, NCC

DETROIT WAYNE INTEGRATED HEALTH NETWORK

- DWIHN'S COMPLEX CASE MANAGEMENT PROGRAM IS AVAILABLE TO CHILDREN AND ADULTS WHO ARE ELIGIBLE FOR:

MEDICAID AND MEDICARE (INCLUDING MI HEALTH LINK, SED AND/OR AUTISM WAIVER BENEFITS)

MEMBERS ENROLLED IN CCM CAN CARRY THE DESIGNATIONS OF:

~SEVERELY MENTALLY ILL (SMI)

~INTELLECTUALLY/DEVELOPMENTALLY DISABLED (I/DD)

~SUBSTANCE USE DISORDER (SUD)

~SEVERELY EMOTIONALLY DISABLED (SED)

- THE REASON TO INITIATE CCM SERVICES IS TO SUPPORT MEMBERS TO SUSTAIN/MAINTAIN OPTIMUM HEALTH AND/OR FUNCTIONAL CAPACITY IN THE MOST APPROPRIATE SETTING AND IN A COST-EFFECTIVE MANNER
- COMPLEX CASE MANAGEMENT IS A FREE VOLUNTARY, SHORT TERM PROGRAM AVAILABLE TO DWIHN MEMBERS
- CCM IS LEAD BY THE CLINICAL SPECIALIST AND OVERSEEN BY THE DIRECTOR OF INTEGRATED HEALTH. THERE ARE CURRENTLY TWO COMPLEX CASE MANAGERS
- COMPLEX CASE MANAGEMENT SERVICES WILL BE DELIVERED BY LICENSED AND LIMITED LICENSED MASTERS AND BACHELORS LEVEL SOCIAL WORKERS. THE TEAM IS LEAD BY A LICENSED PROFESSIONAL COUNSELOR.

EVIDENCE USED TO DEVELOP PROGRAM

- DWIHN'S CCM PROGRAM WAS DEVELOPED BASED ON EVIDENCE-BASED GUIDELINES FROM THE FOLLOWING VARIOUS SOURCES OF MEDICAL AND BEHAVIORAL HEALTHCARE ORGANIZATIONS:

1. AMERICAN HEART ASSOCIATION, AMERICAN DIABETES ASSOCIATION, NATIONAL ALLIANCE ON MENTAL ILLNESS, THE SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, THE AMERICAN PSYCHIATRIC ASSOCIATION, NATIONAL COMPREHENSIVE CANCER NETWORK AND NATIONAL HEART, LUNG AND BLOOD INSTITUTE.

2. THE MICHIGAN CENTER FOR CLINICAL SYSTEMS IMPROVEMENT'S COMPLEX CARE MANAGEMENT GUIDELINES

3. CASE MANAGEMENT SOCIETY OF AMERICA'S CASE MANAGEMENT ADHERENCE GUIDELINES FOR CHRONIC CONDITIONS

4. ROBERT WOOD JOHNSON FOUNDATION: THE SYNTHESIS PROJECT

5. INSTITUTE FOR HEALTHCARE IMPROVEMENT

6. CASE MANAGEMENT SOCIETY OF AMERICA'S STANDARDS OF PRACTICE FOR CASE MANAGEMENT

7. DWIHN'S CLINICAL GUIDELINES

GOALS OF COMPLEX CASE MANAGEMENT

- THE ULTIMATE GOALS OF DWMHA'S/DWIHN'S COMPLEX CASE MANAGEMENT (CCM) PROGRAM ARE TO:
- IMPROVE MEDICAL AND/OR BEHAVIORAL HEALTH CONCERNS AND INCREASE OVERALL FUNCTIONAL STATUS AS WELL AS IMPROVE OVERALL QUALITY OF LIFE AS EVIDENCED BY A 10% IMPROVEMENT IN PHQ SCORES AND/OR A 10% IMPROVEMENT IN WHO-DAS SCORES AT CCM CLOSURE.
- TO PROVIDE EARLY INTERVENTION FOR MEMBERS APPROPRIATE FOR COMPLEX CASE MANAGEMENT TO PREVENT RECURRENT CRISIS OR UNNECESSARY HOSPITALIZATIONS AS EVIDENCED BY 10% REDUCTION IN EMERGENCY DEPARTMENT (ED) UTILIZATION AND/OR 10% REDUCTION HOSPITAL ADMISSIONS FROM 90 DAYS PRIOR TO RECEIVING CCM SERVICES TO 90 DAYS AFTER RECEIVING CCM SERVICES.
- INCREASED PARTICIPATION IN OUT-PATIENT TREATMENT AS EVIDENCED BY A 10% INCREASE IN OUT-PATIENT BEHAVIORAL HEALTH SERVICES FROM 90 DAYS PRIOR TO RECEIVING CCM SERVICES TO 90 DAYS AFTER RECEIVING CCM SERVICES.
- ASSIST MEMBERS TO ACCESS COMMUNITY RESOURCES AND OBTAIN A BETTER UNDERSTANDING OF THE PHYSICAL AND/OR BEHAVIORAL HEALTH CONDITIONS AS EVIDENCED BY IMPROVED COMPLIANCE WITH BEHAVIORAL HEALTH AND PHYSICAL HEALTH APPOINTMENTS AND DECREASE IN ED VISITS AND/OR INPATIENT ADMISSIONS.
- 80% OR GREATER MEMBER SATISFACTION SCORES FOR MEMBERS WHO HAVE RECEIVED CCM SERVICES.

SERVICES OFFERED

SERVICES AVAILABLE TO MEMBERS IN CCM WILL INCLUDE:

~CARE COORDINATION TO SUPPORT/ASSIST MEMBER IN ARRANGING APPOINTMENTS

~COORDINATION OF CARE BETWEEN MEDICAL AND BEHAVIORAL HEALTH PROVIDERS

~REFERRALS TO APPROPRIATE MEDICAL, BEHAVIORAL, SOCIAL AND COMMUNITY RESOURCES

~EDUCATION AND PROMOTION OF SELF-MANAGEMENT TO EMPOWER MEMBERS TO TAKE A MORE ACTIVE ROLE IN THEIR HEALTH

~ASSISTANCE TO HELP MEMBERS BETTER UNDERSTAND THEIR BEHAVIORAL HEALTH AND MEDICAL BENEFITS

~SUPPORT MEMBER'S ADHERENCE TO THE CARE PLAN

~ADVOCACY TO ENSURE APPROPRIATE REFERRAL AND SERVICES ARE RECEIVED

~MEDICATION RECONCILIATION, INCLUDING MEDICATION EDUCATION WITH THE MEMBER

~SYSTEMATIC APPROACH TO ASSESSING, PLANNING AND PROVISION OF CASE MANAGEMENT SERVICES TO IMPROVE HEALTH OUTCOMES

- IT WILL BE IMPORTANT TO COORDINATE WITH MEDICAL HEALTH PLANS (MHP)/INTEGRATED CARE ORGANIZATIONS (ICO) TO ENSURE THAT THE MEMBERS/MEMBERS REFERRED TO DWIHN FOR CCM SERVICES ARE NOT RECEIVING THESE SAME SERVICES THROUGH THE MHP OR ICO. COMPLEX CASE MANAGERS MAY MAKE REFERRALS FOR MEMBERS IN THE PROGRAM TO APPROPRIATE RESOURCES BASED ON MEMBER ASSESSMENT OR NEED.
- DWIHN COMPLEX CASE MANAGERS WORK WITH STAFF AT CLINICAL RESPONSIBLE SERVICE PROVIDER (CRSP)ORGANIZATIONS TO COORDINATE CARE AND STRENGTHEN MEMBERS RELATIONSHIP WITH CURRENT CARE TEAM WHICH INCLUDES SHARING PLAN OF CARE, ATTENDING SOME MEETINGS WITH CARE TEAM, AND FREQUENT CONTACT WITH CASE MANAGER/SUPPORTS COORDINATOR.

ELIGIBILITY FOR COMPLEX CASE MANAGEMENT

THE DWIHN COMPLEX CASE MANAGEMENT PROGRAM HAS GENERAL ELIGIBILITY CRITERIA FOR ADULTS AND CHILDREN/YOUTH

FOR ADULTS, THESE INCLUDE ANY OF THE FOLLOWING:

MEMBER IS AN ACTIVE CONSUMER OF OUTPATIENT BEHAVIORAL HEALTH SERVICES WITH A DISABILITY DESIGNATION OF SMI, DD/IDD AND/OR SUD AS EVIDENCED BY AT LEAST ONE VISIT WITHIN THE LAST QUARTER WITH DWIHN PROVIDER

AND

1 OR MORE OF THE FOLLOWING CHRONIC MEDICAL HEALTH CONDITIONS: HYPERTENSION, DIABETES, ASTHMA, COPD, HEART DISEASE, OBESITY, AND CHRONIC PAIN

AND

10 OR MORE VISITS TO THE ED IN THE LAST 6 MONTHS

OR

EVIDENCE OF 1 OR MORE GAPS IN SERVICES, INCLUDING BUT NOT LIMITED TO: ABSENCE OF PRIMARY OR SPECIALTY MEDICAL CARE VISITS WITHIN THE LAST 12 MONTHS OR GAPS IN MEDICATION REFILLS FOR BEHAVIORAL HEALTH AND/OR MEDICAL CHRONIC CONDITIONS

AND

WILLINGNESS TO ACTIVELY PARTICIPATE IN THE PROGRAM FOR AT LEAST 90 DAYS

CRITERIA FOR CHILDREN/YOUTH ELIGIBILITY ARE AS FOLLOWS:

MUST BE DIAGNOSED WITH SERIOUS EMOTIONAL DISTURBANCE (SED) AND SEEN FOR SERVICES AT DWIHN PROVIDER AT LEAST ONCE IN LAST QUARTER

AND

SHOULD RANGE BETWEEN THE AGES OF 2-21 YEARS (THOSE MEMBERS IN THIS COHORT THAT ARE AGED 18-21 ARE TYPICALLY SPECIALLY DESIGNATED AS YOUTH WITH LEARNING DISABILITIES, COURT WARD STATUS, I/DD, ETC.)

AND

DIAGNOSED WITH CHRONIC ASTHMA, DIABETES, OBESITY AND/OR AUTISM

AND

4 OR MORE ED VISITS IN THE LAST 12 MONTHS

OR

GAPS IN SERVICES/CARE- INCLUDING BUT NOT LIMITED TO: ABSENCE OF PRIMARY CARE VISIT WITHIN THE LAST 6 MONTHS AND GAPS IN REFILLING PRESCRIPTIONS FOR MEDICAL AND/OR BEHAVIORAL HEALTH CONDITIONS

AND

WILLINGNESS OF MEMBER/MEMBER AND OR PARENTS/GUARDIAN TO ACTIVELY PARTICIPATE IN THE PROGRAM FOR AT LEAST 90 DAYS

ACCESS TO COMPLEX CASE MANAGEMENT

1. THE DWIHN PIHP CARE COORDINATION TEAM RECEIVE REFERRALS FOR SERVICES ELECTRONICALLY, TELEPHONICALLY OR BY WRITTEN COMMUNICATION. THE REFERRAL FORM IS ALSO AVAILABLE ON THE DWIHN WEBSITE

REFERRALS CAN BE MADE BY PRACTITIONERS/PROVIDERS, MEMBERS OR THEIR CAREGIVERS, UM STAFF, CUSTOMER SERVICE STAFF, ACCESS CENTER STAFF, HOSPITAL DISCHARGE PLANNERS, HEALTH PLAN CASE MANAGERS/DISEASE MANAGERS.

2. THE DWIHN PIHP CARE COORDINATION TEAM WILL PROVIDE EDUCATION AND WRITTEN COMMUNICATION TO PROVIDERS ON A REGULAR BASIS TO DISSEMINATE INFORMATION REGARDING COMPLEX CASE MANAGEMENT

3. THE MEMBER HANDBOOK, WHICH IS SENT TO EVERY MEMBER UPON INITIATION INTO DWIHN, INCLUDES A DESCRIPTION OF COMPLEX CASE MANAGEMENT AND INFORMATION ON HOW TO ACCESS THESE SERVICES.

4. THE PROVIDER MANUAL INCLUDES INFORMATION ABOUT COMPLEX CASE MANAGEMENT AND HOW TO MAKE A REFERRAL.

5. INFORMATION FOR MEMBERS AS WELL AS PRACTITIONERS/PROVIDERS IS AVAILABLE ON THE DWIHN WEBSITE AND CAN BE OBTAINED BY CALLING CUSTOMER SERVICE

6. MEMBERS ARE IDENTIFIED FROM DATA SHARING OR CARE COORDINATION MEETINGS IN CONJUNCTION WITH MEDICAL HEALTH PLAN (MHP) PARTNERS, COMMUNITY OUTREACH OF PSYCHIATRIC EMERGENCIES (COPE), COMMUNITY SERVICE PROVIDERS, GUARDIANS, AND MEMBERS. (MEDICAL MANAGEMENT PROGRAMS)

7. MEMBERS ARE IDENTIFIED BY INTERNAL DWIHN STAFF INCLUDING HOSPITAL LIAISON, UM, AND CLINICAL SPECIALIST STAFF.

CCM PROCESS

THE CCM PROGRAM WILL USE A STANDARDIZED CASE MANAGEMENT PROCESS FOR ALL OF ITS ASSIGNED MEMBERS AND CONSISTS OF SEVERAL KEY AREAS INCLUDING BUT NOT LIMITED TO:

~COMPREHENSIVE INITIAL ASSESSMENT

~DEVELOPMENT OF AN INDIVIDUALIZED CARE PLAN

~FACILITATION OF MEMBER REFERRALS TO RESOURCES

~SELF MANAGEMENT PLANS

~ASSESSMENT OF PROGRESS TOWARDS NEEDS IDENTIFIED IN THE PLAN OF CARE

THE NINE PHASES OF COMPLEX CASE MANAGEMENT

POPULATION ASSESSMENT (1)

REVIEWED ANNUALLY AND UTILIZED TO UPDATE CCM'S ACTIVITIES TO ADDRESS MEMBERS NEEDS, APPROPRIATE COMMUNITY RESOURCES AND ITS INTEGRATION INTO PROGRAMS OFFERINGS TO MAKE SURE MEMBER'S NEEDS ARE MET

MEMBER IDENTIFICATION AND SELECTION (2)

MEMBERS FOR CCM WILL BE IDENTIFIED FROM DATA SUPPLIED FROM MULTIPLE AVAILABLE SOURCES, INCLUDING:

MHWIN: THIS IS THE PRIMARY TRANSACTIONAL SYSTEM USED BY DWIHN FOR ANALYSIS OF REVENUE, COST AND UTILIZATION TRENDS FOR INDIVIDUALS SERVED BY THE DWIHN NETWORK. WITHIN THIS SYSTEM MEMBER DEMOGRAPHICS AND ENCOUNTERS ARE THE PRIMARY SOURCES OF DATA.

POPULATION HEALTH TOOL: POPULATION HEALTH TOOL THAT USES MEDICAID CLAIMS AND PHARMACY DATA PROVIDED BY MDHHS AND RUNS IT THROUGH COMPLEX ALGORITHMS TO IDENTIFY MEMBER/MEMBERS THAT FLAG HEDIS AND OTHER COMPLIANCE AND QUALITY METRICS SIGNALING A POTENTIAL NEED FOR CCM INTERVENTION.

VITAL DATA TECHNOLOGIES: HEALTH TOOL THAT USES MEDICAID CLAIMS AND INFORMATION PROVIDED BY MDHHS TO IDENTIFY AND FLAG MEMBERS BASED ON SET HEDIS MEASURES FOR COMPLIANCE SIGNALING A POTENTIAL NEED FOR CCM INTERVENTION.

INTERNAL REPORTS: POTENTIAL MEMBERS FOR CCM ARE IDENTIFIED FROM THE FOLLOWING REPORTS:

- *HOSPITAL RECIDIVISM*
- *INPATIENT REPORT*
- *TRANSITION OF CARE*
- *PATIENT HEALTH QUESTIONNAIRE (PHQ)*
- *EMERGENCY SERVICES (EMS)*

DWIHN INTERNAL STAFF: MEMBERS ARE IDENTIFIED BY INTERNAL DWIHN STAFF INCLUDING HOSPITAL LIAISON, UM, AND CLINICAL SPECIALIST STAFF.

COMPLEX CASE MANAGEMENT ASSESSMENT (3)

- IF A MEMBER MEETS CRITERIA AND AGREE TO PARTICIPATE IN THE CCM PROGRAM, THE DWIHN PIHP CARE COORDINATOR WILL SCHEDULE A FACE TO FACE MEETING TO COMPLETE CC ASSESSMENT FROM WHICH MEMBER NEEDS WILL BE DETERMINED.

- THE ASSESSMENT MUST BE COMPLETED WITHIN 30 CALENDAR DAYS OF THE DATE THE MEMBER WAS OPENED FOR CCM SERVICES, WITH THE MAXIMUM TIMEFRAME FOR COMPLETION BEING 60 CALENDAR DAYS FROM MEMBERS CASE OPENING.

PROCESS FOR OUTREACH

- IF EFFORTS TO CONTACT MEMBERS TO INTRODUCE CCM SERVICES, COMPLETE ASSESSMENT AND/OR PLAN OF CARE ARE NOT SUCCESSFUL, IT IS REQUIRED THAT THE PIHP CARE COORDINATOR WILL ATTEMPT THE FOLLOWING OUTREACH:

1. CONTACT MEMBER TELEPHONICALLY ONE TIME PER WEEK FOR 30 DAYS

2. SEND MEMBERS A UNABLE TO REACH LETTER INDICATING THAT EFFORTS ARE BEING MADE TO REACH THEM

~OUTREACH TO REFERRAL SOURCES, IDENTIFIED EMERGENCY CONTACTS AND/OR FAMILY MEMBERS WILL ALSO BE ATTEMPTED PRIOR TO CLOSING A CASE.

CCM ASSESSMENT ADDRESSES THE FOLLOWING

MEMBERS HEALTH STATUS	
PHYSICAL HEALTH HISTORY INCLUDING MEDICATIONS	VISUAL AND HEARING NEEDS
ACTIVITIES OF DAILY LIVING (WHO-DAS)	CAREGIVER RESOURCES
BEHAVIORAL HEALTH STATUS (PHQ-9, MSE, SUBSTANCE USE HISTORY)	AVAILABLE BENEFITS
SOCIAL DETERMINANTS OF HEALTH	INTELLECTUAL/DEVELOPMENTAL HISTORY
LIFE PLANNING ACTIVITIES	COMMUNITY RESOURCES (INCLUDES MENTAL HEALTH, DISEASE MANAGEMENT, WELLNESS ORGANIZATIONS, PALLIATIVE CARE PROGRAMS AND ETC)
CULTURAL AND LINGUISTIC NEEDS	DIAGNOSTIC SUMMARY

PLAN OF CARE DEVELOPMENT, UPDATE AND IMPLEMENTATION (4 &5)

- THE CCM ASSESSMENT IDENTIFIES MEMBERS NEEDS AND LEADS TO THE DEVELOPMENT OF THE PLAN OF CARE
- THE PLAN OF CARE WILL BE MEMBER-FOCUSED, AND THE MEMBER WILL PRIORITIZE GOALS TO BE ADDRESSED. MEMBER BARRIERS WILL ALSO BE IDENTIFIED TO BE ADDRESSED
- THE PLAN OF CARE WILL BE DEVELOPED UTILIZING PERSON-CENTERED PRINCIPLES. MEMBERS WILL BE ABLE TO IDENTIFY SUPPORTS, FAMILY, AND ADVOCATES THAT THEY WOULD LIKE TO ATTEND.
- THE PIHP CARE COORDINATOR, AS WELL AS THE SERVICE PROVIDER, BEHAVIORAL/MEDICAL HEALTH PERSONNEL WILL BE PART OF THIS MEETING WHEN AVAILABLE AND APPROPRIATE AND PART OF MEMBER'S SUPPORT TEAM.

PLAN OF CARE MONITORING AND EVALUATION (6)

- THE PLAN OF CARE WILL BE REVIEWED WITH MEMBER AND IDENTIFIED TEAM MEMBERS ON A MONTHLY BASIS TO ASSESS PROGRESS AND/OR MAKE ADJUSTMENTS

1. INDIVIDUAL CASE MANAGEMENT PLAN AND GOALS	4. FOLLOW UP SCHEDULE
2. IDENTIFICATION OF BARRIERS	5. DEVELOPMENT AND COMMUNICATION OF SELF-MANAGEMENT PLAN
3. REFERRALS TO AVAILABLE RESOURCES	6. ASSESSING PROGRESS

CASE DISCHARGE (7)

CCM CASES ARE CLOSED FOR THE FOLLWING REASONS AND IN THE FOLLOWING MANNER:

~MEMBER ACHIEVED GOALS

~MEMBER/GUARDIAN COULD NOT BE REACHED TO INTRODUCE CCM SERVICES DESPITE NUMEROUS OUTREACH ATTEMPTS

~MEMBER ACHIEVED MAXIMUM BENEFIT FROM CCM AND CONTINUE CARE WITH OUTPATIENT PROVIDERS

~MEMBER/GUARDIAN DISCONTINUED CCM SERVICES

~FOLLOWING COMPLETION OF CCM ASSESSMENT AND POC, MEMBER/GUARDIAN ARE UNABLE TO REACH

~MEMBER REQUIRES A HIGHER LEVEL OF CARE

~DEATH OF THE MEMBER

TRANSITION TO OTHER CARE (8)

- TRANSITION OF CARE NEEDS WILL BE ADDRESSED TO ENSURE CONTINUITY OF CARE INCLUDING CONNECTING MEMBERS WITH SERVICES THAT WILL CONTINUE TO SUPPORT AND ASSIST.
- PIHP COMPEX CASE MANAGERS WILL ALSO ASSIST MEMBERS WITH SCHEDULING APPOINTMENTS WITH PROVIDERS PRIOR TO CLOSURE TO INCREASE OUTPATIENT ATTENDANCE OUTCOMES.

MEASUREMENT OF EFFECTIVENES OF PROGRAM (9)

MONTHLY CCM MEMBER ASSESSMENT

~WHO-DAS

~PHQ-9

~ATTAINMENT OF GOALS IDENTIFIED IN CCM (% COMPLETE FOR EACH GOAL)

CCM WILL BE MEASURED ANNUALLY AGAINST THE FOLLOWING BENCHMARKS FOR PARTICIPATING MEMBERS

~AN OVERALL10% IMPROVEMENT IN PHQ-9 SCORES AT CCM CLOSURE OF THE COMBINED SCORES OF MEMBERS ENROLLED IN CCM FOR 90 DAYS OR MORE DURING THE FY

~AN OVERALL10% IMPROVEMENT IN WHO-DAS SCORES TO DECREASE THE LEVEL OF DISABILITY BARRIERS AT CCM CLOSURE OF THE COMBINED SCORES OF THE MEMBERS ENROLLED IN CCM FOR 90 DAYS OR MORE DURING THE FY

~COMPLETED AT LEAST 2 VISITS WITH BEHAVIORAL HEALTH PROVIDER WITHIN 60 DAYS OF STARTING CCM

~COMPLETED AT LEAST 1 VISIT WITH PRIMARY CARE PROVIDER IF NOT SEEN WITHIN THE LAST YEAR

~10% REDUCTION IN EMERGENCY DEPARTMENT USAGE COMPARING 90 DAYS PRIOR TO PARTICIPATING IN CCM SERVICES AND 90 DAYS AFTER STARTING CCM SERVICES

~10% REDUCTION IN INPATIENT HOSPITAL ADMISSIONS COMPARING 90 DAYS PRIOR TO PARTICIPATING IN CCM SERVICES AND 90 DAYS AFTER STARTING CCM SERVICES

~IMPROVED PARTICIPATION IN OUTPATIENT APPOINTMENTS BY A 10% INCREASE IN OUTPATIENT SERVICES WITHIN THE 90 DAY PERIOD FOLLOWING PARTICIPATON IN CCM SERVICES COMPARED TO THE 90 DAY PERIOD PRIOR TO STARTING CCM SERVICES

~80% OR GREATER IN RETURNS OF SATISFACTION SURVEYS FROM MEMBERS THAT HAVE PARTICIPATED IN CCM SERVICES

QUALITY IMPROVEMENT SCORES:

SAA

AMM

SDD

HEP C

FUH

Barriers

SOCIAL DETERMINANTS OF HEALTH, such as socioeconomic status, education, neighborhood, employment, social support, and access to healthcare, are linked to a person's lack of opportunity and resources to protect, improve, and maintain their health.

DWIHN continue to work with providers to improve these numbers. Providers are given their scores on a quarterly bases and asked to provide a plan of correction.

SAA Adherence to Anti-Psychotic Medications for Individuals with Schizophrenia

Data Results/HEDIS Measurement- The percentage of members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

Time Period	Measurement	Numerator	Denominator	Rate	Goal	Comparison to goal
3/2023		1130	1879	60.14%	85.09%	State of Michigan benchmark 66.28%
4/2023		878	2171	71.20%	85.09%	State of Michigan benchmark 66.28%

Numerator-The number of members who achieved a proportion of days covered of at least 80 percent for their antipsychotic medications during the measurement year.

Denominator-Medicaid members 18 and older as of January 1 of the measurement year with schizophrenia.

DWIHN 1st quarter results for 2023 60.14%.

DWIHN continues to work to be in the 95th percentile 85.09%.

State of Michigan rate of results for Medicaid Health Plan 66.28%.

April rate of results 71.20%

AMM Data Results/HEDIS Measurement-Medication Compliance for Members 18 years or Older with a Diagnosis of Major Depression on Antidepressant Medication for at least 84 Days (12 weeks). Effective Acute Phase Treatment

Time Period	Measurement	Numerator	Denominator	Rate	Goal	Comparison to goal
3/2023		1502	3402	44.15%	77.32%	State of Michigan benchmark 66.93%
4/2023		1746	3785	46.13%	77.32%	State of Michigan benchmark 66.93%

Numerator-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).

Denominator-Number of members 18 years of age or older with a diagnosis of major depression who were newly treated with an antidepressant medication.

DWIHN 1st quarter for 2023 is 44.15%.

DWIHN continues to work to be in the 95th percentile 77.32%.

State of Michigan rate of results for the Medicaid Health Plans 66.93%

DWIHN rate for April 2023 is 46.13%

AMM Data Results/HEDIS Measurement-Medication Compliance for Members 18 years or Older with a diagnosis of Major Depression on Antidepressant Medication for at least 180 Days (6 months)

Effective Continuation Phase Treatment

Time Period	Measurement	Numerator	Denominator	Rate	Goal	Comparison to goal
3/2023		711	3402	20.90%	63.41%	State of Michigan average 50.71%
4/2023		930	3785	24.57%	63.41%	State of Michigan average 50.71%

Numerator-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 or more.

Denominator-Number of members 18 years of age or older with a diagnosis of major depression who were newly treated with an antidepressant medication.

DWIHN 1st quarter for 2023 is 20.90%

DWIHN continues to work to be in the 95th percentile 63.41%.

State of Michigan average rate of results for Medicaid Health Plans 50.71%

DWIHN rate for April 2023 is 24.57%.

SSD Improving Diabetes Monitoring for People with Schizophrenia or Bipolar Disorder

NCQA's HEDIS measure Diabetes Screening for People with Schizophrenia or Bipolar Disorder measures the percentage of members 18-64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

Data Results/ Measurement – Diabetes Screening for Schizophrenia and Bipolar Members on Antipsychotic Medication

Time period	Measurement	Numerator	Denominator	Rate	Goal	Comparison to Goal
3/2023		1000	3739	26.75%	86.36%	State of Michigan Benchmark 80.09%
4/2023		1544	4605	33.53%	86.36%	State of Michigan Benchmark 80.09%

Numerator-Those enrollee/members who had an FBS or HbA1c who have a diagnosis of schizophrenia or bipolar disorder dispensed an antipsychotic medication that had diabetes screening during the measurement year meeting the eligibility criteria for the measure.

Denominator-All enrollee/members with a diagnosis of schizophrenia or bipolar disorder who have been dispensed an antipsychotic medication meeting the eligibility criteria for the measure.

DWIHN 1st quarter result for 2023 is 26.75%.

DWIHN continues to work to be in the 95th percentile 86.36%.

State of Michigan Benchmark 80.09%

DWIHN rate for April 2023 is 33.53%.

Increasing Screening for Hepatitis C

Percentage of members 18 to 79 years old with a SUD diagnosis who were tested for Hepatitis C

Time Period	Measurement	Numerator	Denominator	Rate	Goal	Comparison to Goal
2022 Q 4	HCV RNA Test	20	3423	0.58%	5%	0.55
2023 Q 1	HCV RNA Test	13	3354	0.38	5%	0.55

Numerator-DWIHN members that received HCV RNA testing and have a diagnosis of SUD

Denominator DWIHN members 18 to 79 with a SUD diagnosis

The State of Michigan 2020 rate for hep c is 0.55. (MDHHS 2020 Hepatitis B and C Annual Surveillance Report)

DWIHN has chosen a goal of 5%

FUH Follow-up after hospitalization for mental illness (FUH)

Two rates are reported:

1. The percentage of discharges for which the member received follow-up within 30 days after discharge.

2. The percentage of discharges for which the member received follow-up within 7 days after discharge.

Numerator: An outpatient visit within 7 or 30 days of discharge with a mental health provider within 30 days after discharge. Does not include visits that occur on the date of discharge.

Denominator: The eligible population

FUH 30 Day

Time period	Measurement	Numerator	Denominator	Rate	Goal	Comparison to Goal State of Michigan
3/2023	6-17 years	81	136	59.56%	70%	70%
3/2023	18-64 years	571	1439	39.68%	58%	58%
4/2023	6-17 years	124	199	62.31%	70%	70%
4/2023	18-64 years	837	1961	42.68%	58%	58%

DWIHN 1st quarter result for 2023 ages 6-17, 59.56%

The State of Michigan benchmark 70%.

DWIHN 1st quarter result for 2023 ages 18-64, 39.68%.

The State of Michigan benchmark 58%

DWIHN rate for April 2023, results for ages 6-17, 62.31%

Ages 18-64, 42.68%

FUH 7 Day

Time period	Measurement	Numerator	Denominator	Rate	Goal	Comparison to Goal State of Michigan
3/2023	6-17 years	56	136	41.18%	70%	70%
3/2023	18-64 years	571	1439	39.68%	58%	58%
4/2023	6-17 years	88	199	44.22%	70%	70%
4/2023	18-64 years	549	1961	28.00%	58%	58%

DWIHN 1st quarter result for 2023 ages 6-17 41.18%

The State of Michigan benchmark 70%.

DWIHN 1st quarter for 2023 ages 18-64, 39.68%

The State of Michigan benchmark 58%

DWIHN rate for April 2023, results for ages 6-17, 44.22%

Ages 18-64, 28.00%.

Provider Response

In the attempt to increase compliance with antidepressant medication for people with a new episode throughout the network, we will use our Supports Coordination department. This department will be responsible for identifying individuals with a new episode of Major Depression and the possible lack of medication adherence. Once identified, the assigned Supports Coordinator will meet monthly with the individual (in addition to regularly scheduled visits). This monthly meeting will be solely dedicated to meeting with the participant to discuss their medication adherence, discuss and confirm upcoming medical appointments for medication refills, administration of the PHQ 2 and PHQ 9 if needed, provide any needed referrals, and provide information regarding the importance of medication adherence (information sheet to be developed). There will be a progress note specifically dedicated to this visit that allows for tracking multiple data points within the Effective Acute Phase Treatment (Adults who remain on an antidepressant medication for at least 84 days (12 weeks). This process will be included in current SOPs and given to responsible staff.

QI4: Accessibility of Services

Quality Improvement Activity

- The standard aims to ensure DWIHN is providing and maintaining appropriate access to services.
- Measurements used are MDHHS Michigan Mission Based Performance Indicators (MMBPI)

Quality Improvement Activity

- PI#2a- *The percentage of new persons during the Period receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service*
- *PI#2b- Persons Requesting a Service who Received Treatment or Supports within 14 Days.*
- PI#3- *Percentage of new persons during the Period starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment*

Our Request to QISC

- Seeking approval for goal based on 2021 MDHHS data
- Approved by DWIHN IPLT Committee on 5/9/23.

Measurements

2021 MDHHS PIHP PI#2a			
All Populations	In-compliance	Total	
Quarter 1	8963	13710	
Quarter 2	9901	15501	
Quarter 3	9634	15449	
Quarter 4	9176	15323	
Total	37674	59983	62.81%

Measurements

SUD	In-compliance	Total	
Quarter 1	12496	16688	
Quarter 2	12321	16143	
Quarter 3	12180	16496	
Quarter 4	12579	16935	
Total	49576	66262	74.82%

Measurements

2021 MDHHS PIHP PI#3			
All Populations	In-compliance	Total	
Quarter 1	8306	10780	
Quarter 2	8986	11397	
Quarter 3	8795	11269	
Quarter 4	8940	11587	
Total	35027	45033	77.78%

Our Request to QISC

- Seeking approval for goal based on 2021 MDHHS data
- PI#2a- 63% Goal
- PI#2b- 75% Goal
- PI#3- 78% Goal
- Approved by DWIHN IPLT Committee on 5/9/23.