DETROIT WAYNE INTEGRATED HEALTH NETWORK QUALITY ASSURANCE PERFORMANCE IMPROVEMENT PLAN

(QAPIP) DESCRIPTION

FISCAL YEAR 2023-2025

AND

WORK PLAN FISCAL YEAR 2025

Approved:

Approved by Quality Improvement Steering Committee (QISC)	**1/30/2024**
Approved by Program Compliance Committee (PCC)	**2/14/2024**
Approved by Full Board of Directors	**2/21/2024**
Annual Review by QISC	**1/28/2025**
Annual Review by PPC	**2/12/2025**
Annual Review by Full Board of Directors	**2/19/2025**

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Introduction

The Detroit Wayne Integrated Health Network (DWIHN) is an esteemed Managed Behavioral Health Organization (MBHO) that has received accreditation from the National Committee for Quality Assurance (NCQA). In its pivotal role, DWIHN functions as both the Pre-Paid Inpatient Health Plan (PIHP) and the Community Mental Health Service Provider (CMHSP) for the regions of Detroit and Wayne County. This designation positions DWIHN as the largest provider of community mental health services in the state of Michigan, thereby playing a critical role in the mental health landscape of the region. To ensure high standards of care and service delivery, DWIHN has developed a comprehensive Quality Assurance Performance Improvement Plan (QAPIP). This plan outlines the necessary structural and governance frameworks that are essential for systematically evaluating and enhancing the quality and appropriateness of healthcare services. Additionally, it addresses the overall health status of the populations served by DWIHN. As mandated by state and federal regulations, the PIHP is required to implement and maintain an extensive, ongoing quality assessment and performance improvement program. This program will guide the evaluation of services provided to its members and highlight any areas that require improvement, adaptation, or innovation.

The QAPIP delineates specific quality initiatives that DWIHN actively undertakes, aimed at fostering excellence in all operational areas through a commitment to continuous quality improvement. By implementing evidence-based practices and strategies, DWIHN seeks to demonstrate to its members, advocates, community organizations, and healthcare providers that it is a high-performing, member-centric organization focused on delivering quality-driven and evidence-based behavioral health and substance use disorder services. This commitment not only enhances the services provided but also supports broader initiatives in healthcare reform. DWIHN is equipped with a robust infrastructure designed to improve the quality and safety of clinical care and services for its members. This includes overseeing the Quality Improvement (QI) program, which plays a significant role in identifying opportunities for enhancement based on data-driven insights and feedback from stakeholders. The effective term of the QAPIP is established to commence on October 1, 2023, and to conclude on September 30, 2025. During this period, the Board of Directors will undertake an annual review of the QAPIP to ensure that it remains relevant and effective, incorporating any necessary changes or updates. This review process will also confirm that the Governing Body has approved both the plan and its annual review. After the initial term expires, the current QAPIP will remain in effect until the DWIHN Board of Directors formally approves a new version. The plan encompasses all policies and procedures required for DWIHN to operate effectively as a Prepaid Inpatient Health Plan and Community Mental Health Services Program. Furthermore, the DWIHN Board of Directors will maintain oversight by approving all existing and future policies and procedures as part of the QAPIP, ensuring a consistent commitment to quality and effectiveness in service delivery.

Mission, Vision, and Values

The Mission and Vision Statement provides inspiration for DWIHN and describes what we aim to achieve mid-to-long term. Values are the core principles and define DWIHN culture and identity.

Mission

We are a healthcare safety net organization that provides access to a full array of integrated services that facilitate individuals to maximize their level of function and create opportunities for quality of life.

Vision

To be recognized as a national leader that improves the behavioral and physical health status of those we serve, through partnerships that provide programs promoting integrative holistic health and wellness.

Values

- We are an advocate, person-centered, family and community focused organization.
- We are an innovative, outcome, data-driven, and evidence-based organization.
- We respect the dignity and diversity of individuals, providers, staff, and communities.
- We are inclusive, culturally sensitive, and competent.
- We are fiscally responsible and accountable with the highest standards of integrity.
- We achieve our mission and vision through partnerships and collaboration.

Quality Assurance Performance Improvement Plan (QAPIP) Description

The QAPIP is a comprehensive framework designed to significantly enhance the quality, safety, and efficiency of clinical care within our organization. This crucial plan establishes a clear structure and governance model that facilitates systematic evaluation and ongoing enhancement of healthcare services, thereby improving health outcomes for the diverse populations we serve. The QAPIP outlines the authority and responsibilities associated with the Quality Improvement (QI) program, detailing the specific roles and responsibilities of committees and individuals engaged in its implementation. This clarity in roles ensures that each participant knows their contributions are vital to the success of the initiative. To foster a culture of improvement, active participation and engagement from all members in both the development and continuous monitoring of DWIHN's QAPIP is essential. The QAPIP is intricately linked to the core functions of DWIHN's Board-approved Strategic Plan. It is built upon six foundational pillars that collectively demonstrate DWIHN's unwavering commitment to the continuous improvement of the quality and safety of clinical care and services we provide.

These functions are not carried out in isolation; they are implemented by DWIHN in conjunction with our extensive network of contracted service providers, ensuring a collaborative approach to quality assurance. Furthermore, DWIHN is tasked with the crucial responsibility of ensuring that the QAPIP complies with relevant regulations, including the Balanced Budget Act (BBA) of 1997 (Public Law 105-33) and the provisions outlined in 42 Code of Federal Regulations (CFR) 438.358 (2002). This adherence to federal guidelines is critical to maintaining the integrity and effectiveness of our services. In addition, the QAPIP incorporates key concepts and standards that are specifically tailored to meet the needs of the population served under the Managed Specialty Supports and Services Waiver Program. This ensures that the strategies we implement are not only effective but also appropriate and responsive to the unique challenges faced by our community. Through this comprehensive approach, the QAPIP positions DWIHN to achieve its goals of enhanced quality and safety in all aspects of clinical care provided.

Scope of the QAPIP

The QAPIP at DWIHN is a comprehensive framework designed to enhance the quality of care and services provided across the network. This framework is organized through a set of designated Standing Committees, each tasked with specific roles in overseeing and implementing various quality improvement activities. The Compliance Committee is a vital component of this structure, focusing on regulatory and corporate compliance issues. Its primary aim is to ensure that all services delivered within the network adhere to applicable laws, regulations, and organizational standards. The committee actively reviews compliance metrics and implements corrective actions when necessary to uphold service integrity. The Improving Practices Leadership Team (IPLT) plays a crucial role in the development and monitoring of clinical service areas. It creates and evaluates clinical practice guidelines and evidence-based practices while overseeing care integration processes. Additionally, the IPLT is responsible for planning transitions to Home and Community-Based Services, ensuring that members receive safe and effective care even as their needs evolve.

The overarching goal of this team is to guarantee that clinical care remains both high quality and safe while simultaneously enhancing the overall experience of members who utilize these services. The Credentialing Committee is another essential body within the QAPIP structure. This committee ensures that all network practitioners and healthcare providers maintain the appropriate qualifications, licenses, and credentials necessary to deliver safe and quality clinical care. By rigorously vetting practitioners, the committee helps to safeguard member wellbeing and confidence in the care they receive. The Quality Improvement Steering Committee (QISC) is tasked with the analysis of performance indicator data and member satisfaction survey results. Through ongoing oversight of performance improvement projects, the QISC monitors and evaluates quality improvement plans to ensure that service delivery meets the highest possible standards. The committee's efforts are integral to assessing member experiences, identifying areas for improvement, and implementing necessary interventions. The Critical Sentinel Events Committee (CSEC) is dedicated to reviewing and monitoring critical and sentinel events—unusual occurrences that may indicate potential safety issues in clinical care. By analyzing these events, the CSEC aims to identify root causes and develop strategies that enhance safety and improve care quality.

Furthermore, the Utilization Management (UM) Committee addresses issues related to the utilization of services within the network. This committee conducts thorough assessments to identify patterns of underutilization, aiming to ensure that members have access to the care they need in a timely manner. By analyzing service usage data, the committee works to uphold the quality and safety of the clinical services provided. The quality improvement initiatives at DWIHN are supported by a complex and well-defined infrastructure that involves key stakeholders, process owners, and cross-functional teams and committees. This structure is crucial for identifying ger, clinical, and non-clinical processes necessary for delivering high-quality support and services to individuals within the system. To ensure a comprehensive approach, DWIHN requires all contracted Clinically Responsible Service Providers (CRSP) and substance use disorder service providers to develop quality improvement plans tailored to their specific services. The QAPIP is designed to be inclusive, engaging all demographic groups, various care settings, and a wide range of service types. This is achieved by actively involving members, advocates, contracted service providers, and community groups throughout the quality improvement process, all guided by a Continuous Quality Improvement (CQI) perspective.

DWIHN's organized structure is key to facilitating effective administration and evaluation of the QAPIP. The QISC operates as the principal decision-making body for the QAPIP and is responsible for reporting evaluations to the Program Compliance Committee (PCC) and the full Board of Directors. This reporting provides essential oversight and ensures that all quality improvement efforts receive the necessary review and approval from leadership. A designated senior official oversees the QAPIP, working alongside the Chief Medical Officer (CMO), who ensures its effective implementation. Both the participation of providers and the input from individuals receiving services are critical to the success of QAPIP processes. Additionally, external practitioners within the network actively contribute to process improvement, program planning, and overall evaluation through systematic data collection and analysis. To further support quality improvement, the QAPIP includes mechanisms designed to assess both the underutilization and overutilization of services, ensuring that all members have access to the appropriate level of care based on their unique needs. By fostering an environment of continuous improvement, DWIHN aims to enhance the overall quality of care and service delivery within its network

Quality Improvement Program (QIP)

The QAPIP encompasses a comprehensive set of mechanisms designed to systematically evaluate the quality and appropriateness of healthcare services provided to members with special healthcare needs. These needs are identified in alignment with the state's quality strategy, ensuring that care delivery is tailored to individuals requiring specialized attention. The DWIHN Quality Improvement Program is grounded in the principles of Continuous Performance Improvement (CPI), and this philosophy permeates all levels of the organization, promoting a culture of ongoing improvement and high standards of care. In accordance with federal regulations, the Centers for Medicare and Medicaid Services (CMS) Medicaid Bureau mandates that each Pre-Paid Inpatient Health Plan integrate a detailed Quality Improvement Plan (QIP). This requirement ensures that quality improvement efforts are not only documented but actively pursued to enhance service delivery to members.

DWIHN maintains multiple contracts with the Michigan Department of Health and Human Services (MDHHS) to provide a range of services including Managed Specialty Supports and Services (Medicaid), General Fund resources, and waiver services aimed at addressing mental health and substance abuse needs. DWIHN is obliged to comply with specific guidelines and frameworks such as the Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program for fiscal year 2019, as stipulated in Attachment P7.9.1. Furthermore, the CMHSP Managed Mental Health Supports and Services Contract for FY19, outlined in Attachment C6.8.1.1, details the requirements for Quality Assessment and Performance Improvement Programs specifically tailored for Specialty Pre-Paid Inpatient Health Plans. DWIHN also adheres to various indicators established by the Department of Community Health Michigan Mission-Based Performance Indicators, the Balanced Budget Act, mandates for External Quality Reviews, and the Application for Renewal and Recommitment, ensuring comprehensive compliance with state and federal guidelines. DWIHN is wholeheartedly committed to fostering a network-wide emphasis on quality service delivery and continuous improvement. This commitment involves upholding stringent industry best practices and meeting or exceeding the standards set by both state and federal regulations, along with those outlined by accrediting organizations. By partnering with the Network for Regional Healthcare Improvement (NRHI), DWIHN is establishing itself as a national leader in enhancing the behavioral and physical health of the communities it serves.

This is accomplished through strategic partnerships that develop and implement programs aimed at promoting integrative, holistic health and wellness. In addition to its other initiatives, DWIHN has recently introduced a Certified Care Coordination platform, which is explicitly aligned with HEDIS (Healthcare Effectiveness Data and Information Set) quality measures. This platform enhances the capabilities of the provider network working alongside various health plans, facilitating improved care coordination and interoperability among providers. To ensure effective collaboration and information sharing, DWIHN Integrated Care staff participate in monthly meetings with state officials and Health Plans. These meetings provide a platform for discussing updates and best practices. Moreover, DWIHN organizes separate meetings with various Medicaid Health Plans to explore collaborative efforts and identify opportunities for improvement. Currently, DWIHN is engaged in two significant quality improvement projects with Medicaid Health Plans: one project focuses on improving diabetes screening rates for members diagnosed with bipolar disorder or schizophrenia who are prescribed antipsychotic medications, while the other aims to enhance compliance with prescribed antidepressant medications for affected individuals. These projects underscore DWIHN's dedication to advancing the quality of care for its members through targeted interventions and collaborative efforts.

The Quality Improvement (QI) staff at DWIHN is composed of a team of highly skilled and experienced professionals dedicated to enhancing the quality of services provided. Each staff member is required to participate in ongoing training to stay updated on best practices and emerging trends in the field. Additionally, the QI team engages in regularly scheduled case consultations with the Chief Medical Officer of DWIHN. These consultations promote collaborative discussions regarding complex cases, allowing for shared insights and strategies that enhance overall service delivery. DWIHN is firmly committed to fostering competency through continuous professional development activities. This includes various training workshops, seminars, and courses that not only enhance the skills of the staff but also align with the organization's mission to provide top-notch services to the community. The following outlines the specific assigned activities and professional qualifications required of QI staff members, highlighting their roles and contributions to the organization's ongoing efforts to improve service quality.

1. Board of Directors (BOD):
    - The BOD primary responsibility is to provide leadership, governance, and oversight of the region. The Board is a policy setting body, the fiduciary of the Medicaid funds.
2. Chief Medical Officer (CMO):
    - 5 years of experience working in a state or community psychiatric hospital or outpatient setting, as a direct provider of mental health services.
    - At least 5 years of administrative experience as CMO in a Mental Health Program with experience in: policy writing; accreditation activities, staff development; peer review management of direct report staff (i.e., nurses, social workers, etc.).
    - Prior experience working with State and Community Hospitals.
    - Prior Managed Care experience, and with the implementation of Evidence-Based Practices in psychiatry.
    - Completed medical school at an accredited university.
    - Completed an internship and psychiatric residency at an accredited program.
    - Thorough and up to date knowledge of psychiatric and medical practice.
    - At least three years' experience with peer and utilization review in a community mental health setting.
    - Active participation in professional organizations such as the American Psychiatric Association, the Michigan Psychiatric Society, and the American Association of Community Psychiatrists, Wayne County Medical Society, Michigan State Medical Society, Detroit Medical Society.
    - Must have a valid Michigan License to practice as a physician, and Michigan.
      controlled substance license. Additionally, the candidate must have a valid and current Drug Enforcement Authority Registration. Board certification by American Board of Psychiatry and Neurology as an adult psychiatrist is preferred not required.

Responsibilities include:

- Chairing the Quality Improvement Steering Committee.
- Chairing the Peer Review Committee & Improving practice Leadership Team (IPLT).
- Active Participation in the Sentinel Events Committee Activities.
- Active Participation in the Review of Death Committee.
- Active Participation in the Executive Leadership Team (as needed).
- Review policies, procedures, and protocols for the delivery of psychiatric and medical services.
- Co-facilitate advisory committees of Chief Medical Officers of Providers to meet on a regular basis and provide input into psychiatric and medical standards, policies, procedures, and protocols.
- Provide technical assistance and psychiatric input where needed regarding development of services, policies, and procedures.
- Provides leadership, support, and direction for development of clinical and cost-effective programs which improve member access, reduce gaps in care, enhance customer satisfaction, lower costs, and maximize positive health outcomes.

- Serve as clinical consultant to contractors and their sub-contractors on difficult cases.
- Work collaboratively with other agency areas to increase effectiveness of medical administration programs and promote the integration of all clinical programs.
- Provide consultation on the activities of DWIHN to advance workforce development, best, promising and evidence-based practices and integration of physical and mental health care.
- Function as a liaison with local, state, and national psychiatric and medical organizations for the purpose of information and networking to keep the Board of Directors and staff aware of trends in psychiatric and medical practice, research, training, and issues.
- Present to the Board of Directors and board subcommittee meetings (as needed).

3. **Psychiatrist**
   - Must have a valid Michigan License to practice as a physician, and Michigan controlled substance license. Additionally, they must have a valid and current Drug Enforcement Authority Registration. Board certification by the American Board of Psychiatry and Neurology as an adult psychiatrist is preferred but not require.
   - Must have completed a Psychiatric Residency approved by Accreditation Council for Graduate Medical Education (ACGME).
   - Five (5) years of experience working in a state or community psychiatric hospital or outpatient setting, as a direct provider of mental health services.
   - At least five (5) years of administrative experience as Medical Director in a Mental Health Program with experience in: policy writing; accreditation activities, staff development; peer review management of direct report staff (i.e., nurses, social workers, etc.).
   - Reviews Behavior Treatment cases including consultation on Behavior Treatment services to the network providers.
   - Participates in Behavior Treatment Review Advisory Committees.

4. **Director of Quality Improvement**
   - Master's Degree in a social work, psychology, counseling, or human service field.
   - Minimum of 10 (ten) years full-time paid experience in the areas of Quality with ongoing responsibility for supervising ten or more staff and managing projects within a health care environment.
   - Responsible for the development and continual updating of all UM processes, policies, and procedures within department.
   - Provides supervision and implements development plans for all QI staff.
   - Makes recommendations regarding staffing, hiring, training and allocation of resources.
   - Oversees the monitoring activities of services across all covered populations.
   - Develops quality improvement processes and ensures accreditation and regulatory requirements are met.
   - Leads multidisciplinary case reviews, to recommend/develop alternative treatment plans for complicated consumer cases.
   - Conducts analysis of internal and external reports to ensure compliance with contract, accreditation, and regulatory requirements.
   - Collaborates with other departments and agencies.
   - Sets yearly QI goals for department.
   - Represents DWIHN as assigned, in collaborative meetings or presentations with DCH, Board Association, and contracted entities.
   - Responsible for Agency reporting requirements.
   - Prepares annual QI program evaluation and Work Plan.

5. **Quality Administrator – Performance Monitoring**
   - Master's degree in social work, Psychology, Counseling, Nursing (a bachelor's degree will be accepted), Quality Management, Business Administration, the Human Services, the Social Services or a related field with clinical licensure and credentials, if applicable.
   - A Valid State of Michigan clinical licensure: RN, LMSW, LMHC, LPC, LLP or PhD.
   - Credentialing qualification in at least one of the following: Qualified Mental Health Professional (QMHP), Qualified Intellectual Disabilities Professional (QIDP), Qualified Children Mental Health Professional (QCMHP); Substance Abuse Treatment Specialist (SATS).
   - Minimum of five (5) years' experience working in mental health services.
   - Provides supervision and implements development plans for all QI staff.
   - Oversees the on-going performance monitoring activities to monitor usage of services across all covered populations.
   - Knowledge and skills in community based behavioral health care and case management preferred.
   - Works collaboratively with other DWIHN departments to implement and improve the utilization management program at DWIHN.
   - Participates in meetings, committees, and collaboration internally and externally.
   - Develops written and timely reports as requested.
   - Provides timely reporting of pertinent observations and system challenges which may directly impact the achievement of expected outcomes.

6. **Provider Network Quality Improvement Administrator**
   - Bachelor's degree social work or human service fields, valid Michigan license required.
   - Minimum of five (5) years' experience working in mental health services.
   - Co-chair of QISC committee.
   - Provides supervision and implements development plans for all QI staff.
   - Oversees the on-going performance improvement activities to monitor usage of services across all covered populations.
   - Knowledge and skills in community based behavioral health care and case management preferred.
   - Works collaboratively with other DWIHN departments to implement and improve the utilization management program at DWIHN.
   - Participates in meetings, committees, and collaboration internally and externally.
   - Develops written and timely reports as requested.
   - Provides timely reporting of pertinent observations and system challenges which may directly impact the achievement of expected outcomes.

7. **Clinical Specialist Psychologist (Behavior Treatment)**
   - Master's degree in psychology with license as Psychologist in the State of Michigan.
   - Conduct quarterly reviews analyses of data from the Behavior Treatment Review Committee where intrusive or restrictive techniques have been approved for use with members and where physical management or 911 calls to law enforcement have been used in an emergency behavioral crisis.
   - Review techniques permitted by the Technical Requirement for Behavior Treatment Plans and have been approved during person-centered planning by the member or his/her guardian, may be used with members.
   - Review data numbers of interventions and length of time the interventions were used per individual.
   - Chairing the Quality Improvement Steering Committee Worked with MDHHS BTPRC on MDHHS BTPRC FAQ document.

- Preparing for the systemwide upcoming Behavior Treatment Training for DWIHN CAP for MDHHS HSW Review.
- Ongoing Individual consultations with DWIHN departments (UM, ORR, Residential, Children's).
- Review the referred cases for the SEC/PRC meeting.

8. **Clinical Specialist Performance Monitor**
   - Master's degree in nursing or social work preferred. Bachelor's degree in psychology, social work, or related human services required. Certification as an addiction drug counselor (CADC) or certification as advanced addiction drug counselor (CAADC) or an approved development plan by the Michigan Certification Board for addiction professional (MCBAP) required.
   - Oversees and monitors the development and implementation of the quality improvement program.
   - Develops and implements the quality improvement plan in accordance with the QAPIP of the organization, federal and state laws/regulations, and accreditation standards.
   - Performs analytical monitoring of contractors and providers.
   - Monitors Medicaid and contractual agreements.
   - Monitors Medicaid Verification Claims and Michigan Mission Based Performance Indictors (MMBPI) data.
   - Develops performance improvement targets for quality, service, and the efficiency of the organization.
   - Implements changes targeted at system improvement.
   - Measures and evaluates attainment of results.
   - Provides consulting, technical, and clinical assistance.
   - Implements systematic improvements.
   - Ensures assigned service providers maintain quality services.
   - Assures improvement activities are documented and reported.
   - Analyzes, updates, and modifies standard operating procedures and processes to continually improve QI services.
   - Plans, organizes, manages, and leads work processes of the quality improvement program.
   - Performs statistical analysis and data analysis.
   - Monitors systems and procedures.
   - Conducts work simplification and measurement studies.
   - Prepares operations and procedures manuals.
   - Monitors compliance of SUD Treatment and Prevention providers within the DWIHN provider network.
   - Works with providers to improve the quality of care and services.
   - Assists with the NCQA accreditation process.
   - Sets standards, conducts performance assessments, and conducts remote and on-site monitoring of providers in the network.
   - Participates in MDHHS audits and site visits.
   - Develops and implements corrective action and improvement plans.
   - Oversees new program and Medicaid Enrollment reviews which involves site visits to ensure that new programs or programs requiring Medicaid enrollment meet the minimum requirements for participation in the DWIHN network.
   - Creates reports regarding - initial communication, review findings, Plans of Correction (POC) and POC monitoring and follow-up for DWIHN providers.
   - Completes or assists co-workers with reviews i.e. (Clinical Reviews, Investigations and Claims Reviews).
   - Attends SUD and other provider meetings.
   - Reviews data for trends and creates monthly reporting including reporting data into the Cascade software database.

- Communicates with providers by responding to phone calls and e-mail requests, providing training, and providing technical assistance.
- Performs related duties as assigned.

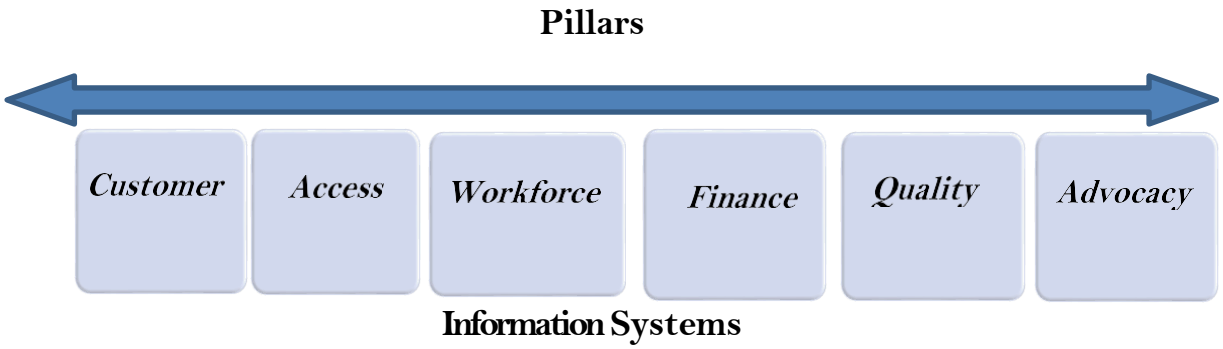
9. **Clinical Specialist Performance Improvement (Critical/Sentinel Event)**
   - Master's degree in nursing or social work preferred. Bachelor's degree in psychology, social work, or related human services required. Review of Critical/Sentinel Events to determine if the incident meets the criteria and definitions for a critical event, critical incidents, risk events, sentinel event, or media events and is related to a practice or standard of care.
   - Review to classify a critical event or incident as either a) sentinel event, or b) non-sentinel event.
   - Develop and update the "MH-WIN Procedural Guidance Manual for Reporting Critical Incidents/Events, Sentinel Events and Death Reporting Process".
   - Documentation and reporting of high profile, media-reported and urgent incidents that meet the critical incident criteria.
   - Develop Critical/Sentinel event face-to-face training for the provider network for accessing the Critical/Sentinel Event Module.
   - Reporting of ALL deaths (expected and unexpected) along with the appropriate information to MDHSS within 24 hours of knowledge.
   - Responsible for closure of assigned deaths in the MH-WIN Module.
   - Review of investigations of records and information concerning the member including, but not limited to, the review of Individual Plans of Service (IPOS), progress notes, psychiatric evaluations, Behavior Management Plans, records of dispute resolutions, grievances and appeals, and recipient rights complaints.
   - Maintain all materials as confidential and distribute only as necessary to perform the peer review function.
   - Ensure that all information related to the Critical Event be uploaded in MH-WIN using the Critical Event/Sentinel Event Module into the "All Scanned Documents" tab.
   - Review Critical and Sentinel Events to include analysis and reporting of member experience and satisfaction with services provided allowing for integration with the Customer Experience process.

10. **Clinical Specialist Performance Improvement (Registered Nurse)**
    - Bachelor's degree in nursing with certification as Registered Nurse in the State of Michigan.
    - Must meet credentialing qualification in at least one of the following: Qualified Mental Health Professional (QMHP), Qualified Intellectual Disabilities Professional (QIDP), Qualified Children Mental Health Professional (QCMHP).
    - Three (3) years of work experience in behavioral healthcare, two years of progressively responsible experience in a community mental health setting, two years in clinical practice.
    - Review of Critical/Sentinel Events to determine if the incident meets the criteria and definitions for a critical event, critical incidents, risk events, sentinel event, or media events and is related to a practice or standard of care.
    - Review to classify a critical event or incident as either a) sentinel event, or b) non-sentinel event.
    - Develop and update the "MH-WIN Procedural Guidance Manual for Reporting Critical Incidents/Events, Sentinel Events and Death Reporting Process".
    - Documentation and reporting of high profile, media-reported and urgent incidents that meet the critical incident criteria.
    - Develop Critical/Sentinel event face-to-face training for the provider network for accessing the Critical/Sentinel Event Module.
    - Reporting of ALL deaths (expected and unexpected) along with the appropriate information to MDHSS within 24 hours of knowledge.
    - Responsible for closure of assigned deaths in the MH-WIN Module.

- Review of investigations of records and information concerning the member including, but not limited to, the review of Individual Plans of Service (IPOS), progress notes, psychiatric evaluations, Behavior Management Plans, records of dispute resolutions, grievances and appeals, and recipient rights complaints.
- Follow-up with providers for completion of root cause analysis or investigation, a) the findings shall include actions that will minimize the further occurrence of the sentinel event (per CMS approval and MDHHS current contractual requirement); or b) a written explanation providing the rational for not pursuing an intervention. A corrective action plan or intervention must identify objective, measurable actions; who will implement the plan of action; a timeframe for the implementation; and how the implementation of the plan will be monitored or evaluated and submitted to DWIHN.
- Completes appropriate documentation in clinical systems (MHWIN) in compliance with regulatory and accreditation standards.
- Participates on committees or special projects as needed.

Quality Improvement Program (QIP) Governance

The DWIHN Strategic Plan serves as a detailed and comprehensive framework geared towards achieving shared objectives within the organization. This plan not only establishes clear agreements on the intended outcomes but also enables the ongoing evaluation and adjustment of the organization's strategic direction in response to a dynamic and evolving environment. Complementing this framework is the Quality Improvement Plan (QIP), which outlines a systematic methodology for assessing various services and determining key areas for improvement. Through regular evaluations, the QIP ensures that DWIHN maintains and enhances the quality of its offerings. At the core of DWIHN's commitment to quality improvement are six essential pillars. These pillars represent critical focus areas that guide the organization in realizing its overall vision of excellence and effectiveness in service delivery. Each pillar is designed to address specific aspects of quality and performance, allowing DWIHN to methodically target improvements and achieve tangible results. To support the successful implementation and integration of these pillars, robust Information Systems are essential. These systems provide the necessary technological infrastructure and data management capabilities that enable informed decision-making, enhance communication, and facilitate collaboration across all levels of the organization. By leveraging Information Systems, DWIHN can effectively track progress, measure outcomes, and refine its strategies to ensure continued success in fulfilling its mission.



DWIHN’s ability to understand and address the diverse health needs of our members is greatly enhanced by our sophisticated framework for accessing, integrating, and analyzing data from various sources. We have made substantial investments in advanced technology and in understanding our members' requirements, paving the way for our industry-leading data analytics capabilities. Our team consists of experts in healthcare analytics and statistics who are dedicated to developing and refining standardized methodologies. These methodologies are designed to deliver precise and targeted results that cater to the specific health issues faced by our members. By leveraging comprehensive data analysis, we can identify trends, facilitate informed decision-making, and implement tailored interventions that improve health outcomes for our members. This holistic approach not only enhances our understanding of individual health needs but also empowers us to create more effective programs and services that ultimately contribute to the overall well-being of the communities we serve.

Cultural and Linguistic Needs

DWIHN is deeply committed to serving a membership that is both culturally and linguistically diverse, emphasizing the following key objectives: fostering innovation in service delivery, ensuring affordability for all members, maintaining professional competence among staff, promoting continuous learning opportunities, encouraging teamwork, and supporting collaboration across all levels of the organization. The presence of racial and ethnic disparities in behavioral health care is well established, and thorough data analyses indicate that these disparities significantly contribute to lower HEDIS (Healthcare Effectiveness Data and Information Set) scores related to the effectiveness of care. To enhance the overall quality of care for its members, DWIHN is actively committed to identifying and understanding the racial and ethnic compositions within its membership. This endeavor aims to uncover potential healthcare disparities that may exist. DWIHN achieves this goal through systematic monitoring and evaluation of the services provided, along with a proactive approach to identifying and implementing opportunities for improvement. DWIHN incorporates several essential principles into its Quality Improvement Plan (QIP):

- The Importance of Culture. Recognizing that cultural factors play a crucial role in the effectiveness of health care delivery.
- Assessment of Cross-Cultural Relations. Engaging in ongoing assessments of how cultural differences impact interactions between service providers and members.
- Expansion of Cultural Knowledge. Committing to the continuous education of staff about diverse cultural practices and perspectives, which informs better service delivery.
- Adaptation of Services. Customizing services to address the specific and unique needs of each member, ensuring that care is relevant and appropriate. DWIHN and its Provider Network are fully dedicated to achieving linguistic and cultural competence, ensuring that all individuals receiving behavioral health services have both access to and meaningful participation in their care.

This commitment entails a deep respect for the cultural values, beliefs, and practices of the community. DWIHN recognizes that the intersection of language and culture significantly influences the delivery of support and services. Professional competence within the organization means maintaining a general awareness of the rich cultural diversity that exists within the service area. This awareness encompasses a range of factors, including but not limited to race, culture, religious beliefs, and regional influences. Additionally, social determinants such as gender, gender identity, sexual orientation, marital status, education level, employment status, and economic conditions are considered integral to understanding the individual needs of members. By addressing these various dimensions, DWIHN aims to provide more equitable and effective behavioral health services to all individuals in its care.

Credentialing and Re-Credentialing

DWIHN has established comprehensive Credentialing and Re-Credentialing procedures designed to assess and verify the qualifications of physicians and other licensed healthcare professionals who are either employees or contracted providers within the network. This process ensures that all healthcare professionals engaged with DWIHN are fully equipped to deliver high-quality services to the community. In addition to licensed professionals, the QAPIP includes specific written policies aimed at ensuring that non-licensed care providers and support staff are also appropriately qualified for their respective roles. Ensuring a well-trained workforce is crucial for maintaining the integrity of the services provided. DWIHN's credentialing procedures are aligned with the guidelines set forth by the Michigan Department of Health and Human Services (MDHHS). This compliance encompasses all aspects of credentialing, including initial credentialing, re-credentialing, re-certification, and reappointment of healthcare practitioners. DWIHN applies stringent assessment criteria to evaluate the qualifications of both employed and contracted physicians as well as licensed behavioral healthcare practitioners, all following the established Credentialing and Re-Credentialing Policy.

In practice, DWIHN guarantees that all organizational providers who have direct contracts with the network, alongside practitioners associated with the Community Mental Health Services Program (CMHSP), meet the necessary professional and ethical standards. Both the Credentialing and Re-Credentialing Policy and the Organization Credentialing Policy govern these practitioners to ensure consistency and accountability. Furthermore, DWIHN actively conducts quarterly and annual audits of the Credentialing Verification Organization (CVO). These audits are designed to rigorously evaluate the system controls implemented by the CVO and to review their adherence to established policies. As part of this quality assurance process, DWIHN samples 5% of the files deemed "clean" for the Virtual Review Committee while thoroughly reviewing 100% of files categorized as "unclean," ensuring any discrepancies or issues are addressed comprehensively. Importantly, practitioners are afforded the right to correct any erroneous information that may appear in their credentialing applications. This provision is clearly delineated in the Credentialing and Re-Credentialing Policy, empowering practitioners to maintain the accuracy and fairness of their professional records. By implementing these detailed policies and procedures, DWIHN is committed to fostering a qualified and capable workforce dedicated to enhancing the health and well-being of the communities it serves.

Framework for Quality Improvement

1. **F**ind a Process to Improve
2. **O**rganize to Improve
3. **C**larify Current Knowledge of the Process
4. **U**ncover Causes of Process Variation or Poor Quality
5. **S**tate Plan Do Study Act (PDSA)
    i. **P**lan the Improvement Process
    ii. **D**o the Improvement, Data Collection, and Analysis
    iii. **S**tudy the Results and Lessons Learned
    iv. **A**ct by Adopting, Adjusting, or Abandoning the Change

To ensure compliance with the QAPIP methodology, the quality improvement process will consistently incorporate management tools and techniques following these four steps:

1. Identify - Determine what needs improvement.
2. Analyze - Understand the problem.
3. Develop - Formulate hypotheses about what changes will improve the situation.
4. Test/Improve - Test the proposed solution to see if it leads to improvement. Based on the results, decide whether to abandon, modify, or implement the solution.

Key cultural components are vital for the success of improvement efforts within organizations. These components encompass several critical elements: active involvement from leadership, implementation of data-informed practices, the deployment of statistical tools for analysis, a proactive focus on prevention instead of merely corrective measures, and a steadfast commitment to continuous quality improvement. Active involvement from leadership is particularly crucial. Support from the governing body and the Chief Executive Officer (CEO) helps to create a culture that prioritizes quality improvement initiatives. This commitment ensures that any efforts to enhance performance and prepare for audits are strategically aligned with the broader mission, vision, values, and strategic plan of the organization, such as the Detroit Wayne Integrated Health Network (DWIHN). In addition, successful quality improvement processes establish feedback loops that leverage data to inform practice and evaluate outcomes. By consistently analyzing data, organizations can make informed decisions that are based on reality rather than assumptions.

This reliance on information increases the likelihood of accurate decision-making, thereby promoting a cycle of ongoing improvement in the quality of care provided. Moreover, it is crucial that the processes involved in quality improvement are not static; they require ongoing review and refinement. Regular assessments help to identify what is working well and what may need adjustment, allowing for a responsive approach to quality improvement. It is also important to recognize that small, incremental changes, when implemented thoughtfully, can lead to substantial positive impacts. Providers and teams within the organization are encouraged to consistently seek out and explore opportunities for enhancement in their practices, fostering an environment of continual growth and better service delivery.

Continuous Quality Improvement Activities

The Quality Program at DWIHN is designed to ensure comprehensive care and optimal service delivery across all aspects of its operations. The program is structured around several key components:

- Clinical Components. This aspect covers the entire continuum of care provided to members, beginning with acute hospitalization and extending through to various outpatient services. By monitoring clinical practices, DWIHN aims to promote best practices and improve health outcomes through seamless transitions and coordination between different levels of care.
- Organizational Components. The organizational framework addresses significant service delivery factors that directly influence patient care. This includes, but is not limited to, effective case management procedures, thorough discharge planning processes, timely prior authorizations, and various additional processes that impact overall care access and delivery. These elements are critical in ensuring that members receive timely and appropriate services.
- Processes Affecting Members and Care Providers. A range of operational processes also plays a vital role in the quality of care provided. These include claims processing, which ensures that members have their services reimbursed promptly; interpreter services that facilitate communication for non-English speaking members; enrollment processes that help members access necessary care; customer service functions that provide support and address concerns; as well as the credentialing and recredentialing processes necessary to ensure that providers meet the required standards. Furthermore, utilization management processes monitor the appropriateness of services accessed by members.
- Member Satisfaction. Measuring member satisfaction is crucial to understanding the effectiveness of the services provided. DWIHN actively seeks feedback from members to inform improvements and ensure their experiences align with expectations.
- Member Safety. Prioritizing member safety is at the core of DWIHN's quality initiatives. Continuous monitoring and improvement of safety protocols are essential to prevent harm and enhance the overall health care experience.

Quality improvement activities are carried out within a structured, organized framework aimed at continuous enhancement of care and service delivery. This framework has been embraced by DWIHN's leadership and is communicated effectively throughout the organization. Continuous education programs and active engagement from staff at all levels ensure that performance improvement efforts are well understood and executed. Quality improvement encompasses two primary activities:

- Measuring and Assessing Performance. This involves systematically collecting and analyzing data to evaluate the performance of various processes and services. The assessment helps DWIHN identify areas of success and opportunities for improvement.
- Conducting Quality Improvement Initiatives. Based on performance assessments, DWIHN implements targeted initiatives to foster improvement. These changes may involve redesigning existing processes, developing new services to meet identified needs, or enhancing the quality of services already in place.

The MDHHS mandates DWIHN to submit a written description of its Quality Assessment and Performance Improvement Plan (QAPIP) for approval by the Board of Directors. The contract stipulates that DWIHN must conduct an annual review to assess the effectiveness of its QAPIP. This review examines whether the quality assessment and improvement activities have resulted in meaningful enhancements in the quality of healthcare and services provided to members. It includes a thorough analysis of service delivery trends and health outcomes over time, while also monitoring progress toward achieving established performance goals and objectives. The QAPIP is subject to quarterly evaluations to determine the effectiveness of the implemented methods for monitoring and assessing quality improvement processes. These evaluations incorporate feedback from a wide array of stakeholders, including members, healthcare providers, the Quality Improvement Steering Committee (QISC), and the Program Compliance Committee (PCC) of DWIHN's Board of Directors, along with other relevant parties. In addition to ongoing evaluations, DWIHN is required to submit an annual report by February 28th to MDHHS. This report outlines the effectiveness of DWIHN's QAPIP, highlights the progress made under the quality improvement work plan, and includes a comprehensive list of members of the governing body, ensuring transparency and accountability in its operations.

At a minimum, the QAPIP specifies the following elements:

a. An adequate organizational structure which allows for clear and appropriate administration and evaluation the of QAPIP.
b. The components and activities of the QAPIP including those as required by the Quality Assessment and Performance Improvement Program Technical Requirement. These requirements specify the measurable criteria that a healthcare organization must meet to demonstrate the effectiveness of its quality improvement processes. Key elements include methods for data collection, performance metrics, analysis techniques, and the development of action plans. All these efforts are aimed at identifying and addressing areas where patient care can be improved.
c. The role of recipients of services and other stakeholders in the QAPIP plan
d. The mechanisms or procedures to be used for adopting and communicating process and outcome improvements.
e. Responsibilities of the governing body for monitoring, evaluation and making improvements to care.
f. Objectives and timelines for implementation and achievement.
g. Description of a designated senior official responsible for QAPIP implementation.
h. Performance improvement projects that address clinical and non-clinical aspects of care that are directed as the state and the DWIHN established aspects of care. Clinical areas include high volume services, high-risk services and continuity and coordination of care. Non-clinical areas include grievances and appeals, complaints and access to and availability of services.
i. Process from the review and follow-up of Critical/ Sentinel Events and events that place members at risk of harm.
j. Periodic quantitative (i.e., survey) and qualitative (i.e., focus group) assessments of member experiences with services. These assessments must address issues of quality, availability, and accessibility of care.
k. Process for the incorporation of members receiving services into the review and analysis of the information obtained from quantitative and qualitative reviews.
l. Written procedures to determine whether physicians and other licensed health care professionals are qualified to perform their services.
m. Written procedures to ensure non-licensed providers of care or support are qualified to perform their jobs.

n. The organization's process for the initial credentialing and re-credentialing of providers.
o. Identification of staff training needs and provision of in-service training, continuing education, and staff development activities.
p. DWIHN process to verify whether services reimbursed by Medicaid were provided to enrollees by affiliates and service providers.

The Quality Improvement (QI) Unit plays a crucial role in evaluating and analyzing the feedback received concerning the effectiveness of various methods used to implement, monitor, and assess quality improvement processes within the organization. This evaluation not only looks at individual responses but also considers broader trends and insights that emerge over time. The findings, along with any recommendations for enhancement, are systematically incorporated into the Quality Assurance and Performance Improvement Plan (QAPIP) for the upcoming fiscal year. This plan serves as a strategic framework to guide quality assurance initiatives and improvements. DWIHN is committed to embedding quality improvement goals throughout the organization. These goals are effectively communicated and integrated via structured work plans, clear objectives, and measurable goals that are managed at the departmental level. Regular meetings and training sessions are conducted to ensure that all staff members understand their role in achieving these goals. Our organizational monitoring activities include comprehensive reports that are generated and reviewed throughout the year. These reviews are crucial for identifying areas where changes are necessary or where improvements can be made. We emphasize a proactive approach to monitoring, utilizing both quantitative and qualitative data to inform our strategies. Furthermore, ongoing improvement projects are continuously assessed to ensure they align with our quality goals. Together, these monitoring activities and projects form the foundation of our organization's work plan, reinforcing our commitment to providing high-quality services and ensuring that all aspects of DWIHN's offerings meet the evolving needs of the communities we serve.

Governing Body

The QAPIP is a critical component of DWIHN's commitment to delivering high-quality care, and it is under the oversight of the Governing Body. This body is tasked with the vital responsibilities of monitoring, evaluating, and enhancing the quality of care provided to clients. Specifically, the Program Compliance Committee (PCC) of DWIHN functions as the governing body for the QAPIP, ensuring that all processes align with the organization's objectives and standards of care. The PCC receives regular written reports that provide an in-depth overview of the various quality improvement projects that have been initiated within the organization. These reports outline the specific actions taken in response to identified areas for enhancement and include detailed results regarding the effectiveness of these actions. This systematic approach to documentation enables the PCC to maintain a clear understanding of progress and challenges in quality improvement efforts. In addition to ongoing reports, the PCC conducts a comprehensive annual review of the QAPIP. During this review, the committee examines a detailed written report that encompasses all facets of the QAPIP, allowing for a thorough evaluation of its effectiveness and alignment with DWIHN's broader goals. Each year, the PCC engages in a thorough analysis of the specific goals and objectives set forth by DWIHN, which includes a complete overview of the services offered, a detailed assessment of the QAPIP's implementation, the Year-End Evaluation, and periodic reviews of quality improvement progress reports. To further facilitate this process, the Director of Quality Improvement plays a pivotal role by providing the PCC with monthly and quarterly updates on ongoing QI activities. This consistent flow of information is essential for effective decision-making and ensures that the PCC remains informed about emerging issues, trends, and opportunities for enhancement. As the governing body, the PCC is responsible for making informed decisions on all major contracts and agreements that directly influence healthcare service delivery. The committee incorporates input from appropriate clinical personnel to ensure that diverse perspectives are considered and that decisions align with clinical best practices. The PCC's active support of the Quality Improvement Program is underscored by its continuous involvement in the organization's policy-making process. By engaging with various stakeholders and contributing to policymaking, the PCC ensures that quality improvement initiatives remain at the forefront of organizational priorities. Ultimately, the final approval of the QAPIP is reserved for DWIHN's full Board of Directors, emphasizing the importance of comprehensive oversight and accountability in the continuous pursuit of excellence in care delivery.

Director of Quality Improvement

The Director of Quality Improvement is a pivotal figure in the effective implementation of the Quality Assurance and Performance Improvement Plan (QAPIP). This position involves working closely with diverse divisions within DWIHN to enhance the overall quality of services provided to clients and streamline operational systems to improve efficiency and effectiveness. Key responsibilities of the Director of Quality Improvement include, but are not limited to, the following:

- Developing Quality Improvement Strategies. Designing and implementing comprehensive quality improvement initiatives that align with the goals of the QAPIP and adhere to best practices in health care quality assurance.
- Collaboration with Cross-Functional Teams. Facilitating collaboration between various departments, including clinical services, administrative support, and data analysis teams, to identify areas for improvement and deploy necessary changes.
- Monitoring Performance Metrics. Establishing, tracking, and analyzing performance metrics to assess the effectiveness of implemented strategies and ensure they meet organizational standards and client needs.
- Conducting Training and Workshops. Organizing training sessions and workshops for staff to promote a culture of quality improvement and ensure that all team members are equipped with the necessary skills and knowledge.

- Reporting and Compliance. Preparing detailed reports on quality improvement activities and outcomes for stakeholders and ensuring compliance with relevant regulations and standards set by governing bodies.
- Engaging Stakeholders. Engaging with stakeholders, including clients and community partners, to gather feedback and incorporate their perspectives into the quality improvement process.
- Continuous Evaluation. Regularly assessing and refining quality improvement processes to ensure ongoing enhancement of services and alignment with the organization's mission and strategic objectives.

Through these responsibilities, the Director of Quality Improvement plays a vital role in fostering a culture of excellence and accountability within DWIHN, ultimately leading to improved outcomes for the individuals served by the organization.

Quality Improvement (QI) Unit

The QI Unit plays a crucial role in overseeing and facilitating the implementation of program enhancements within the Pre-Paid Inpatient Health Program (PIHP) and the Community Mental Health Services Program (CMHSP). By working collaboratively across all departments within the organization, the QI Unit engages in a wide array of quality improvement projects that aim to enhance service delivery and outcomes for clients. In its efforts, the QI Unit engages with various stakeholders, including program members, advocates, contracted service providers, and staff from the Detroit Wayne Integrated Health Network (DWIHN). This collaboration is essential for gathering diverse perspectives and ensuring that improvements are aligned with the needs of the community. The primary objective of the QI Unit is to foster a culture of continuous quality improvement, which is achieved through three fundamental functions:

- Performance Monitoring. This involves regularly tracking and assessing the effectiveness of programs and services to ensure they meet established standards and identify areas for improvement.
- Performance Measurement. The unit utilizes various metrics and data analysis techniques to quantify the quality of care provided. This process helps identify trends, gaps, and opportunities for enhancement.
- Performance Improvement. Based on monitoring and measurement findings, the QI Unit initiates targeted strategies and action plans to enhance program efficacy, enhance client satisfaction, and ensure regulatory compliance. Through these comprehensive efforts, the QI Unit is dedicated to maintaining high-quality services that promote the well-being of individuals served within these vital health programs.

Performance Improvement

Performance Improvement is a comprehensive and systematic approach designed to analyze performance metrics, identify issues, and implement strategies to prevent, reduce, or eliminate waste. This process is essential for enhancing the overall quality of services provided to individuals. To achieve this, a set of policy directives is established, which applies uniformly across the entire system, including both DWIHN and its network of affiliated service providers. It is imperative that all service providers adhere to specific policies that align with DWIHN’s overarching directives. These policies are meticulously crafted to address various areas mandated by the contractual obligations with MDHHS. Additionally, they outline detailed processes and procedures aimed at ensuring compliance with state and federal regulations. Before any policy is finalized, it undergoes a thorough public comment period. This period allows stakeholders including service providers, beneficiaries, and community members to review and provide valuable feedback on proposed changes. Once the feedback is considered, each policy is approved and subsequently reviewed in Quality and Provider meetings with the DWIHN service provider network. Furthermore, once finalized, these policies are made publicly accessible on DWIHN’s website to ensure transparency and accountability.

To effectively meet the regulatory requirements set forth by MDHHS and NCQA, DWIHN undertakes Performance Improvement Projects (PIPs), which are strategically focused on both clinical and non-clinical areas of service. Each PIP is rigorously approved by the Improving Practices Leadership Team (IPLT) and is monitored by the Quality Improvement Steering Committee (QISC). The goal of each PIP is to achieve measurable and sustained improvements in both clinical outcomes and non-clinical services. This is accomplished through continuous evaluations of the projects, which assess their effectiveness and impact. By focusing on these areas, DWIHN aims to enhance overall health outcomes and increase member satisfaction, ensuring that services are not only effective but also aligned with the needs and expectations of the community they serve.

Performance Improvement Projects (PIP) Clinical/Non-Clinical PIPs

During the waiver renewal period, the Detroit Wayne Integrated Health Network (DWIHN) is committed to undertaking at least two comprehensive projects. The primary clinical focus of these projects will encompass several key areas, including high-volume services that affect many individuals, high-risk services targeting populations with significant health challenges, and the essential continuity and coordination of care to ensure that individuals receive seamless and holistic support throughout their treatment journeys. In addition to clinical concerns, the projects will also address important non-clinical topics. These will include the examination of appeals and grievances lodged by individuals, an analysis of trends and patterns stemming from substantiated Recipient Rights complaints, as well as a critical evaluation of the accessibility and overall availability of mental health services. This multifaceted approach aims to improve both the quality and accessibility of care provided to the community. When selecting the specific topics for these projects, DWIHN will engage in a thoughtful and data-driven decision-making process. This will involve a careful consideration of the prevalence of health conditions among the populations served by DWIHN, as well as a detailed analysis of the demographic characteristics and health risks faced by consumers. In addition, the organization will consider the expressed interests and preferences of individuals regarding the services that are planned to be addressed, ensuring that their voices are integral to the decision-making process. Upon completion of performance measurements for the selected processes, each measure will undergo thorough assessment and analysis.

The insights gained from these evaluations will be instrumental in identifying DWIHN's defined initiatives for continuous quality improvement (CQI). The decision to pursue these initiatives will be anchored in DWIHN's priorities, reflecting a commitment to enhancing service delivery and promoting better outcomes for individuals served. The overarching goals of these initiatives will be to both improve the performance of existing services and to innovate the design of new service offerings that meet the evolving needs of the community. The analytic models that DWIHN will utilize in these endeavors include the Focus-Plan-Do-Study-Act (PDSA) cycle, which encourages iterative testing and learning, and the Ishikawa Fishbone Diagram, which helps identify potential causes of issues within complex systems. Such structured methodologies will facilitate a systematic approach to performance improvement. Additionally, DWIHN requires all members of its provider network to engage actively in Performance Improvement Projects (PIPs) that align with their specific programs and services. This involvement is particularly essential for Substance Use Disorder Providers and Clinical Responsible Service Providers (CRSP), who are expected to participate in DWIHN's PIPs that are applicable to their service areas.

The Quality Improvement (QI) unit at DWIHN plays a pivotal role in overseeing and monitoring all functions within the quality improvement framework. Importantly, all quality improvement activities are managed internally, with no portions delegated to external entities.

Nevertheless, DWIHN expects providers to independently conduct PIPs informed by their own self-assessment processes, which evaluate needs, risks, frequency, and performance within their settings. Moreover, DWIHN's contractual agreement with the Michigan Department of Health and Human Services (MDHHS) explicitly mandates engagement in state-required performance improvement activities. These activities may also include tasks determined by the Integrated Planning and Leadership Team (IPLT) and the Quality Improvement Steering Committee (QISC). Oversight of the quality improvement infrastructure is established through collaboration with a diverse array of stakeholders, including members, advocates, service providers, DWIHN's Chief Medical Officer, and other relevant parties.

This collaborative effort ensures a comprehensive approach to quality assurance. Planned and systematic activities are implemented to guarantee that the quality standards for community mental health services are consistently met by DWIHN and its contracted service providers, ultimately aiming to enhance the well-being of individuals in the community.

Each Performance Improvement Project (PIP) must be carefully designed to achieve significant and sustained enhancements in health outcomes for members, as well as improvements in overall member satisfaction. A well-structured PIP should encompass several critical elements and is required to report on its status and results to the state authorities upon request, with a minimum frequency of once a year.

- Measurement of Performance. The PIP should utilize objective quality indicators to systematically measure performance. These indicators may encompass various aspects of health care delivery, such as patient outcomes, service accessibility, and patient safety metrics. Collecting and analyzing this data enables stakeholders to understand current performance levels and identify areas that require improvement.
- Implementation of Interventions. The project must include the design and implementation of targeted interventions aimed at improving both access to care and the quality of the services provided. This may involve strategies such as enhancing staff training, streamlining processes, deploying new technologies, or extending hours of operation to better accommodate members' needs.
- Evaluation of Effectiveness. An ongoing evaluation of the interventions' effectiveness is essential. This evaluation should rely on the performance measures established by the state, enabling project leaders to assess how well the interventions are meeting their intended goals. Techniques for evaluation may include comparing pre- and post-intervention data, gathering feedback from members, and conducting follow-up surveys to gauge satisfaction and outcomes.
- Planning and Maintenance. It is crucial to not only plan interventions but also to establish activities aimed at maintaining or enhancing improvements over time. This may involve continuous monitoring, regular revisits of performance data, and adapting strategies as needed based on feedback and assessment results. Sustainable improvements require a commitment to ongoing evaluation and adjustment. Various tools and methodologies can be utilized throughout the continuous quality improvement (QI) process. Some of these tools include:
- Problem Solving Methodology. Structured approaches for identifying and addressing specific issues within care processes.
- Process Mapping. Visual representation of workflow processes to identify bottlenecks and opportunities for streamlining operations.
- Force Field Analysis. Assessment of driving and restraining forces that affect change, helping to strategize around overcoming barriers.
- Cause and Effect Diagrams. Visual tools that help identify the root causes of problems in care delivery.
- Brainstorming Sessions. Collaborative meetings aimed at generating ideas for potential solutions.
- Pareto Analysis. A technique for prioritizing problems based on their significance, usually highlighting the most impactful issues.
- Control Charts. Graphical tools for monitoring process behavior over time to identify trends and variations.
- Check Sheets. Simple data collection forms for tracking occurrences or outcomes.
- Bar Charts and Scatter Diagrams. Visual tools for representing data trends and distributions.
- Matrix Analysis. A technique for evaluating multiple factors simultaneously.
- Tally Charts. Tools for counting frequencies of occurrences.
- Ishikawa Fishbone Diagram. A structured method to identify potential causes of a problem, promoting deeper analysis. In addition, quality assurance and improvement functions play a vital role in the overall process. This includes proactively informing practitioners, providers, members, and governing bodies about the results of assessments conducted. This comprehensive approach facilitates not only the evaluation of effectiveness but also the identification of systematic actions required to address any findings or discrepancies. Leadership's involvement is crucial in supporting QI activities. Leaders facilitate the coordination and communication of measurement activities related to QI initiatives while fostering an organizational culture focused on

continuous improvement. Sharing data and information about QI efforts is a key responsibility for leadership. Through a well-planned and collaborative communication strategy, leaders ensure that the Board of Directors, staff, members, and their families remain informed about ongoing QI initiatives and have opportunities to provide input. Various methods can be employed for this planned communication, such as:

- Storyboards and Posters. Utilizing visual displays in common areas to share the progress and outcomes of QI initiatives, promoting transparency and engagement.
- Participant Involvement. Encouraging recipients to actively participate in QI Committee discussions and report back to their respective groups, fostering a two-way communication channel.
- Annual QI Plan Evaluation Sharing. Distributing summaries of the annual evaluation of the QI Plan, highlighting successes and areas for further improvement.
- Newsletters and Informational Handouts. Providing regular updates and educational materials to keep all stakeholders informed and engaged.
- Dashboards. Using data dashboards to visually present key performance indicators and outcomes in an easily digestible format for stakeholders.
- Maintaining an accessible online platform where stakeholders can access QI information, reports, and updates on performance improvement initiatives. This comprehensive approach ensures that all parties involved are well-informed and engaged in the continuous journey of quality improvement, ultimately leading to better health outcomes and enhanced member satisfaction.

Sentinel Events and Critical Incidents

The DWIHN Reporting Policy for Consumer Critical Events, Sentinel Events, and Death provides comprehensive guidelines for the reporting and thorough review of potential Sentinel Events and Critical Incidents involving individuals. DWIHN actively participates in statewide initiatives and collaborations focused on the prevention, detection, and resolution of critical incidents, and it ensures compliance with state and federal mandates—at a minimum—related to home and community-based waiver programs. The QAPIP establishes a structured framework for the systematic review and follow-up of sentinel events and other critical incidents that could pose risks to the safety and well-being of individuals. DWIHN commits to frequently analyzing and reviewing incidents, incorporating a variety of data sources and stakeholder feedback to identify necessary corrective actions and preventive measures. This ongoing analysis is essential in recognizing patterns, mitigating risks, and improving overall service delivery. DWIHN has implemented a robust and systematic procedure for analyzing various critical events that may present risks to individuals receiving care. This procedure includes detailed documentation, investigation protocols, and multidisciplinary team reviews to ensure that all relevant factors are thoroughly considered. The insights gained from these analyses are crucial for determining the most effective interventions and strategies needed to address identified challenges and prevent future occurrences. The types of critical incidents under consideration include, but are not limited to, serious injuries, unexpected deaths, incidents of abuse or neglect, medication errors, and other significant events that could adversely affect the well-being of individuals. By meticulously identifying, reporting, and analyzing these events, DWIHN aims to foster a culture of safety, accountability, and continuous improvement within its services. The identified events include, but are not limited to:

- Actions taken by individuals receiving services that result in harm to themselves.
- Actions taken by individuals receiving services that result in harm to others.
- Two or more unscheduled admissions to a medical hospital within a 12-month period (not due to planned surgery or the natural progression of a chronic illness, such as terminal illness).
- Calls to the police made by staff of specialized residential treatment providers or other provider agency staff during a behavioral crisis, regardless of whether contacting the police is part of a behavioral treatment plan.
- Emergency use of physical management by staff in response to a behavioral crisis (refer to the Critical Sentinel Event Flow Chart in Appendix 1, pg. 58).

DWIHN is responsible for promptly assessing critical incidents to determine if they qualify as sentinel events. This assessment must be completed within three business days from the time the incident is reported. If the incident is determined to be a sentinel event, DWIHN has an additional two business days to initiate a comprehensive root cause analysis. This analysis aims to identify the underlying factors contributing to the incident and to implement strategies for improvement. To ensure a thorough and credible evaluation of sentinel events, DWIHN mandates that all individuals involved in the review process possess the appropriate credentials and expertise. This requirement is especially crucial for incidents that involve client deaths or other serious medical conditions, where the review must include the insights of qualified professionals such as physicians or nurses. Their involvement is essential for accurately assessing the scope of care and understanding the implications of the incident. DWIHN has identified seven specific types of incidents that must be reported through the Critical Incident Reporting System. These categories are designed to capture a wide range of sentinel events, ensuring that all significant occurrences are documented and addressed appropriately. The identified reportable categories include:

- Suicide
- Non-suicide deaths
- Arrest of the individual
- Emergency Medical Treatment due to Injury or medication Errors
- Hospitalization due to injury or medication error
- Crisis Stabilization refers to the physical management of injuries, which may include physical restraints, emergency police response, and transporting the individual to an emergency room.
- Substance Abuse Disorder Events

DWIHN conducts comprehensive quarterly analyses of critical incidents, sentinel events, and risk events to identify necessary remediation actions and implement preventive measures against similar occurrences in the future. The Sentinel Event Committee/Peer Review Committee (SEC/PRC) plays a crucial role in this process by reporting its findings on sentinel events to ensure in-depth evaluation and analysis. This committee is responsible for thoroughly documenting follow-up actions taken and outlining efforts to improve systems, all in accordance with the guidelines laid out by the Michigan Department of Health and Human Services (MDHHS). The SEC/PRC systematically reviews and analyzes sentinel event reports submitted by providers within the Crisis Response Services/Substance Use Disorder (CRSP/SUD) framework. As part of their responsibilities, they compile and present a detailed periodic summary along with well-informed recommendations for action and disposition to the Governing Body at least once a year. Moreover, the SEC/PRC holds the authority to require follow-up actions from providers as needed. These follow-up actions may encompass a Corrective Action Plan designed to address specific deficiencies, an Improvement Plan aimed at enhancing overall service delivery, or a Root Cause Analysis (RCA) to identify underlying causes of incidents. In the case of unexpected deaths involving Medicaid members who were receiving specialty support and services at the time of their passing, a thorough and meticulous review will be carried out. "Unexpected deaths" are characterized as those resulting from various causes, including suicide, homicide, undiagnosed medical conditions, accidental incidents, or circumstances that raise suspicions of potential abuse or neglect. Each review will encompass an array of elements, which may include but are not limited to data collection regarding the context of the death, discussions with relevant stakeholders, investigation of the care received prior to the incident, and assessments of any potential systemic failures that may have contributed to the situation. This careful examination is crucial for understanding the circumstances surrounding these tragic events and for developing strategies to prevent them in the future.

The review will include the following elements:

- A screening of individual deaths, incorporating standard information such as the coroner's report and death certificate.
- The involvement of medical personnel in the mortality review process.
- Documentation of the mortality review process, including findings and recommendations.
- The use of mortality information to improve quality of care.
- The aggregation of mortality data over time to identify potential trends.

Upon immediate notification of an event to MDHHS, DWIHN takes prompt action by submitting detailed information through the DWIHN Critical Incident Reporting System. Each type of event has its own set of reporting requirements, ensuring thorough documentation. The SEC/PEC Committee plays a vital role in analyzing all critical incidents, sentinel events, and risk events, guaranteeing that effective measures are implemented to resolve issues and prevent similar incidents in the future. This proactive approach underscores our commitment to safety and quality care.

Each Clinically Responsible Service Provider (CRSP) is responsible for entering Critical Events, Critical Incidents, Sentinel Events, and Risk Events into the Critical/Sentinel Event Module in MH-WIN within 24 hours of becoming aware of the event for members actively receiving services in their organization. Residential Treatment Providers must promptly submit events involving members to the CRSP and provide relevant hospital documentation or police reports when applicable.

DWIHN has expanded its reporting to include data for each Crisis Response and Support Program (CRSP), as well as trends and patterns identified by the Sentinel Event Committee (SEC) and the Performance Review Committee (PRC), along with accompanying recommendations. The SEC/PRC is composed of the Chief Medical Officer, clinicians, and administrative staff members of DWIHN. The expanded reporting now includes:

- Quantitative and qualitative analyses
- A review of the details and commonalities among events
- Member-specific, provider-specific, and systemic trends
- Incorporation of events related to substance use disorder (SUD) providers and members receiving SUD services
- A review of data by event type across Community Mental Health Service Providers (CMHSPs) and other providers
- An in-depth review of CMHSPs and providers that consistently report minimal or no critical incidents, sentinel events, or risk events
- Standardization of reporting requirements between CMHSPs and providers to enable the PIHP to easily aggregate the data.

DWIHN mandates that all contracted Clinically Responsible Service Providers (CRSP) establish a Behavior Treatment Plan Review Committee (BTPRC) to ensure the thorough evaluation and oversight of Behavior Treatment Plans (BTP). Providers have the option to collaborate with network providers and Mental Health CRSP to create and operate a unified BTPRC. It is DWIHN's expectation that all providers participating as partners in the BTPRC are committed to ensuring the timely review of proposed Behavior Treatment Plans. This process is critical for addressing such plans in real-time or during emergencies, thus enabling prompt and effective responses to behavioral health needs. The DWIHN-contracted Mental Health CRSP hold the responsibility for overseeing the compliance and implementation of policies and procedures related to Behavior Treatment. This oversight includes ensuring that all treatment interventions adhere to established guidelines and are delivered in a manner that respects the rights and needs of the individuals served. The QAPIP is tasked with conducting comprehensive quarterly reviews.

These reviews focus on analyzing data extracted from the Behavior Treatment Review Committee regarding the application of intrusive or restrictive techniques authorized for use with program members. This analysis encompasses any instances where physical management techniques were necessary, as well as situations that required intervention by law enforcement through 911 calls during emergency behavioral crises. It is essential that only those techniques which have been clearly outlined in the Technical Requirements for Behavior Treatment Plans and explicitly approved during the person-centered planning process—either by the member themselves or their legal guardian—are implemented. The data gathered during these reviews will specifically include metrics such as the total number of interventions applied and the duration of each intervention for individual members. This information is crucial for assessing the effectiveness of treatment strategies and ensuring that they align with the best practices in behavioral health care.

Assessment of Member Experience

The QAPIP is a comprehensive initiative aimed at enhancing the overall quality of care and services provided to members within the community. This program employs a systematic approach that includes both periodic assessments and ongoing evaluations of member experiences. These assessments utilize a combination of quantitative methods, such as structured surveys that collect numerical data, and qualitative methods, such as focus groups that gather in-depth opinions and insights from participants. The primary goal of these assessments is to ensure that they accurately reflect the experiences of the individuals being served, as well as the range and effectiveness of the services and supports available to them. Key areas of focus include evaluating the quality, availability, and accessibility of care, ensuring that each member's unique needs are addressed in a timely and efficient manner. To facilitate these evaluations, the program employs the Experience of Care and Health Outcomes (ECHO) survey, which is specifically designed to be applicable for both adults and children. The ECHO survey captures various aspects of members' experiences, including their satisfaction with services received and perceived health outcomes. As a direct result of the insights gained from these assessments, the Detroit Wayne Integrated Health Network (DWIHN) is committed to taking targeted actions to address individual cases that may require intervention. This includes identifying and investigating sources of dissatisfaction reported by members, understanding the underlying issues, and outlining systematic steps to resolve any identified concerns. Moreover, DWIHN prioritizes transparency by communicating the results of the assessments to various stakeholders, including practitioners, service providers, recipients of care, and the Governing Body. This open line of communication ensures that all parties are informed about findings and can collaborate on strategies for improvement. Importantly, the program ensures that individuals receiving long-term supports or services—such as those engaged in case management or support coordination—are actively included in the review and analysis of the data gathered through both quantitative and qualitative methods. This inclusive approach not only enriches the evaluation process but also gives voice to those directly affected by the services provided. Ultimately, DWIHN rigorously evaluates the effectiveness of the activities and interventions that are implemented in response to the assessments. By continually monitoring and assessing member satisfaction, the organization seeks to foster an environment of ongoing improvement in the quality of care and services delivered to its members.

Long-Term Services and Supports (LTSS)

DWIHN plays a vital role in monitoring the long-term care services and supports available to individuals through the Home and Community-Based Services (HCBS) framework, addressing a variety of needs. This comprehensive monitoring system is designed to include all members receiving long-term services and supports (LTSS), ensuring that the quality and accessibility of care meet established standards. To effectively assess the needs of each member identified by the Michigan Department of Health and Human Services (MDHHS) as requiring long-term services or having special healthcare needs, DWIHN has implemented a systematic approach. This involves using a detailed assessment template aimed at identifying ongoing special conditions that may necessitate specific treatment options or monitoring protocols tailored to each member's unique circumstances.

The assessment process is conducted by trained and qualified professionals who possess the necessary experience and credentials for LTSS service coordination. Whenever possible, members actively participate in the person-centered planning process, ensuring that their preferences and choices remain central to their care plan. Additionally, a member's representative—such as a family member, friend, or advocate—is engaged throughout the process to assist the member in expressing their needs. However, in certain situations, state law may grant decision-making authority to a legal representative, which can affect who is involved in the process. The resulting person-centered service plan is a crucial document that reflects the member's individual choices regarding their preferred living arrangements. DWIHN is committed to ensuring that the selected residential setting is integrated into the community and provides the member with full access to Medicaid HCBS.

This access includes various opportunities, such as employment in competitive integrated settings, participation in community activities, control over personal resources, and receiving services comparable to those not receiving Medicaid HCBS. Members are offered a variety of living arrangement options, allowing them the freedom to choose between different settings, including non-disability-specific residences and private units in residential facilities. Each option is thoroughly evaluated and documented within the person-centered service plan, considering the member's specific needs, personal preferences, and available resources for room and board. For those requiring LTSS, DWIHN also develops a detailed treatment or service plan, which MDHHS may mandate for members with identified special healthcare needs who require a specific course of treatment or ongoing care monitoring. This treatment or service plan is a dynamic document that requires regular updates. It undergoes a systematic review and revision process during reassessments of the member's functional needs.
These reassessments occur at least once every twelve months, whenever significant changes in the member's circumstances arise, or at the member's request. The treatment or service plan includes several essential elements:

- Development by a qualified individual adhering to LTSS service coordination requirements, with collaboration from the healthcare providers involved in the member's care and active participation from the member.
- Creation by an individual specifically trained in person-centered planning, facilitating a process defined in 42 CFR for LTSS treatment or service plans.
- Timely approval from the PIHP, contingent upon the requirements established by the PIHP.
- Compliance with applicable quality assurance standards and utilization review protocols set by MDHHS, ensuring high-quality service delivery and care outcomes for every member receiving LTSS.

Through these detailed processes and proactive measures, DWIHN strives to provide comprehensive, personalized care that promotes the well-being and autonomy of its members.

Clinical Practice Guidelines

The criteria for prioritizing the adoption of Clinical Practice Guidelines (CPGs) that are relevant to our membership involve a thorough evaluation of several key factors. These factors include the incidence or prevalence of the specific diagnosis or condition among the population we serve, the extent of variation observed in treatment methods or outcomes related to that diagnosis or condition, and the availability of robust scientific and medical literature that assesses the effectiveness of various treatment approaches. Once these guidelines are developed and finalized, they are made accessible by being posted on the DWIHN website, ensuring that all providers can easily access them. It is crucial for all providers to refer to these practice guidelines to enhance the quality of care they deliver and to support their ongoing treatment decisions and methodologies within the realm of behavioral health care. An integral component of the guideline development process is public review and comment.

After conducting comprehensive clinical training sessions and posting relevant updates concerning the latest clinical protocols and practice guidelines on the DWIHN website, we transition into the implementation phase, which is executed through the proposed policies process. During this phase, DWIHN may distribute the draft version of the clinical practice guidelines to contracted providers who are engaged in treating the specific condition under review, inviting their feedback and suggestions for improvements. This collaborative input is invaluable, as it ensures that the guidelines reflect real-world clinical practices and address the needs of providers. Ultimately, the Integrated Practice Leadership Team (IPLT) has the responsibility for guaranteeing that effective, evidence-based practices are in place, achieved through the development or adoption of comprehensive clinical guidelines. It is essential for all clinical practice guidelines to receive formal approval from DWIHN's IPLT before they are enacted. Under the strategic direction of the Chief Medical Officer, the DWIHN staff undertakes the ongoing responsibility of continuously monitoring, evaluating, and updating all practice guidelines and clinical protocols.

This process is guided by the latest research findings as well as compliance with state and federal regulations, all while aligning with the most effective standards of care in the field. The review and update process for clinical practice guidelines occurs at a minimum of every two years; however, adjustments may be made more frequently if there are significant changes in national guidelines or emerging best practices that necessitate immediate attention. DWIHN maintains a strong expectation that all contracted practitioners will adhere rigorously to these guidelines within their clinical practices. Furthermore, we actively encourage the adoption and implementation of evidence-based practices among our providers. Nonetheless, we recognize that the guidelines may not encompass every individual circumstance or unique patient need. To ensure compliance with clinical guidelines, DWIHN employs a variety of monitoring mechanisms, including detailed reports, thorough treatment chart reviews, and various process indicators. In addition, DWIHN is committed to supporting its members in effectively managing their conditions by providing easy access to practice guidelines through its website and by engaging in specific quality improveme

nt initiatives and activities designed to enhance overall care delivery.

Service Verification

The QAPIP outlines the comprehensive process by which the Detroit Wayne Integrated Health Network (DWIHN) verifies that services reimbursed by Medicaid have been provided to members by affiliated providers and, where applicable, by subcontractors. This verification process is crucial to ensuring accountability and quality in service delivery. It commences with the Individual Plan of Services (IPOS), which serves as a foundational document outlining the specific services a member is to receive. DWIHN engages in a systematic approach to claims verification by conducting thorough reviews of claims submitted by a randomized selection of contracted providers. These providers are drawn from various funding streams, including MI-HEALTH LINK, Medicaid, Substance Use Disorder (SUD) services, Autism services, grants, and the General Fund.

The reviews are multifaceted and consist of several components: desk audits to examine the documentation associated with claims, compliance investigations to assess adherence to regulations and standards, and on-site evaluations of providers to observe operations and service delivery in real-time. Every six months, DWIHN generates a statistically valid random sample from a comprehensive pool of "Paid Encounters/Claims." The size of this sample is carefully determined to meet the minimum sampling standards established by the Office of Inspector General (OIG), ensuring that the process is both rigorous and credible. It is imperative that all program and clinical case records conform to DWIHN's established policies and procedures, as well as the existing requirements and state guidelines mandated by the Michigan Department of Health and Human Services (MDHHS). Each year, DWIHN submits its methodology for claims verification to the State for formal approval. This process not only ensures alignment with state policies but also enhances transparency and accountability. Furthermore, DWIHN produces an annual report that details the outcomes of the verification process, including any issues identified during reviews and the corresponding follow-up actions that were taken in response. This thorough reporting mechanism serves to strengthen the integrity of the service provision framework and fosters continuous improvement within the network.

Provider Network

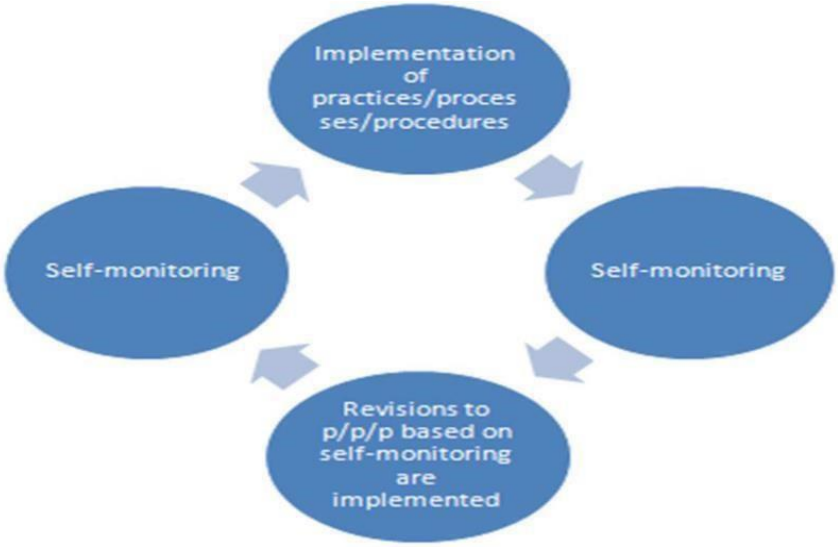
DWIHN conducts a comprehensive annual review of its provider network, which not only encompasses its directly employed staff but also includes affiliated organizations and subcontractors to whom it has delegated various managed care functions, such as the provision of services and support to clients. This thorough evaluation process adheres to established written procedures designed to assess the qualifications and competencies of healthcare professionals. During the review, special attention is given to physicians and other licensed healthcare providers who are either employed by DWIHN or contracted through the Prepaid Inpatient Health Plan (PIHP). The assessment ensures that these professionals meet the necessary licensure requirements and possess the expertise and credentials required to deliver high-quality care. Furthermore, the staff members at DWIHN are required to have the specific qualifications detailed in their job descriptions. This includes relevant education, training, and experience pertinent to their roles. In addition to licensed professionals, DWIHN places a strong emphasis on ensuring that non-licensed care and support providers are adequately qualified to perform their responsibilities. This involves a thorough review of their skills and training to guarantee they can effectively meet the needs of the individuals they serve. Overall, DWIHN is dedicated to maintaining a high standard of care through rigorous evaluation and continuous monitoring of its provider network. This includes meeting the following criteria:

- Educational background
- Relevant work experience
- Cultural competence
- Certification, registration, and licensure as required by law

Performance Monitoring

DWIHN has established a comprehensive performance monitoring process designed to enhance its Continuous Quality Improvement (CQI) practice. This initiative aims to systematically evaluate the effectiveness of services provided, ensuring that they meet the highest standards of quality and efficiency. Through regular and thorough assessments, the organization identifies areas for improvement, leading to informed refinements in processes, procedures, and programs. This commitment to ongoing monitoring allows DWIHN to adapt and evolve its practices based on real-time data and feedback, fostering a culture of continuous improvement. The benefits of this process are visually represented in Figure 1, highlighting key insights and improvements achieved through sustained evaluation efforts.

Figure 1.

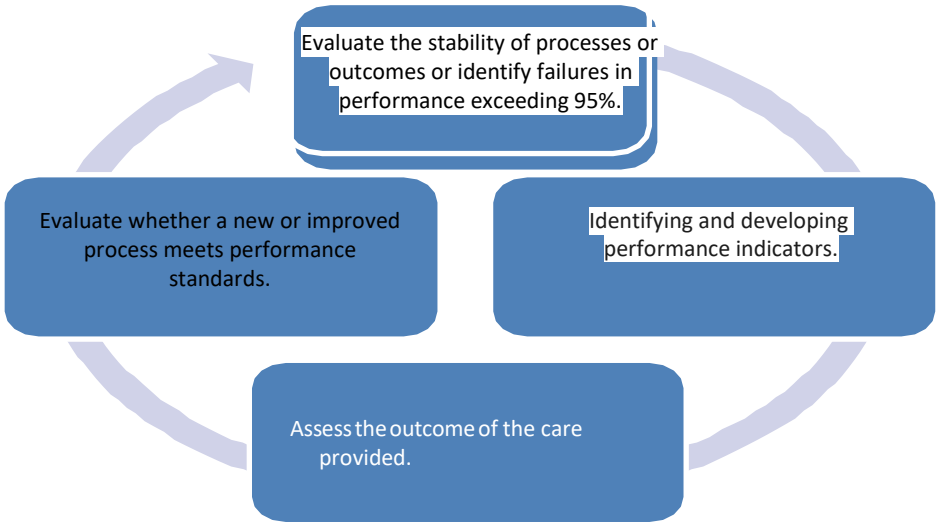


The Performance Monitoring Plan is specifically designed to enhance the quality of services provided and to systematically evaluate our performance in both service delivery and adherence to established standards. This comprehensive plan necessitates active participation and collaboration from various stakeholders, including DWIHN's Service Provider Network and our internal staff members. It emphasizes the importance of self-regulation and continuous monitoring by all partners involved, which include DWIHN, contracted providers, practitioners, and the members we serve. To ensure thorough oversight, DWIHN has implemented a multi-tiered monitoring approach that utilizes standardized self-monitoring and self-regulating techniques. This method begins at the individual service provider level, where frontline staff members engage in self-assessment and tracking of their performance against defined benchmarks. This data is then elevated through various levels of oversight, ultimately reaching DWIHN's Quality Improvement Team. As part of this monitoring strategy, we have developed standardized tools and protocols that facilitate accurate documentation and reporting. These tools are critical to ensuring accountability and transparency in the monitoring process. By employing this comprehensive monitoring approach, we aim to maintain the highest quality of service provision and ensure that all partners are aligned in their efforts to achieve excellence in care delivery.

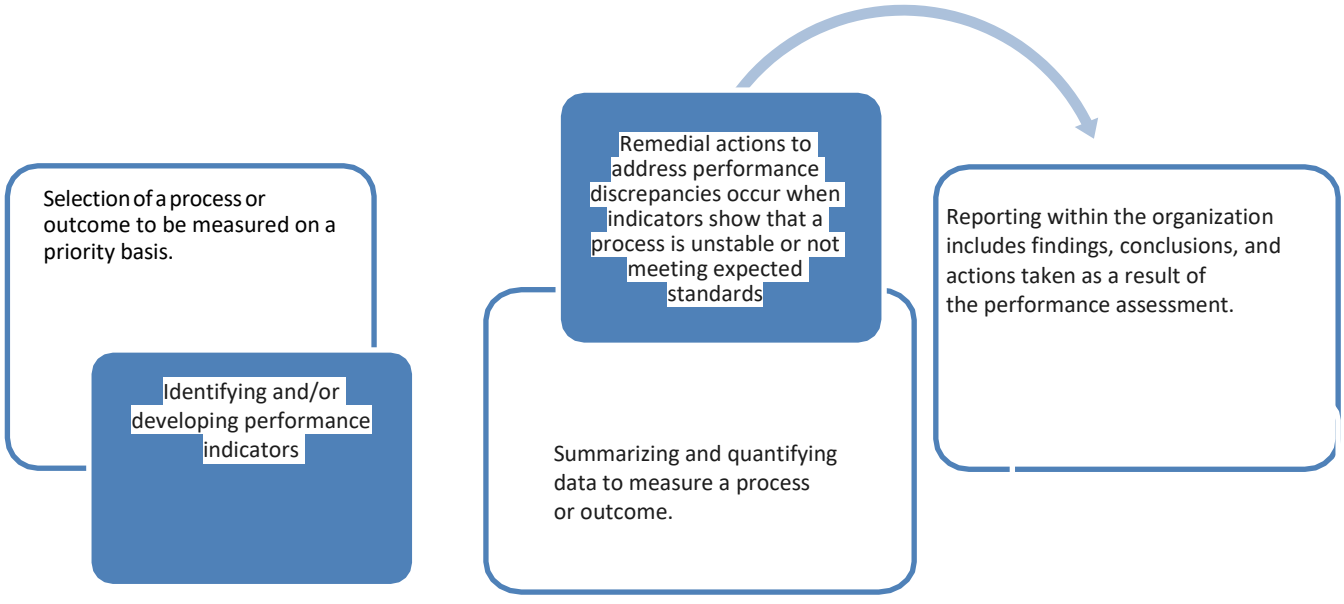
- Actions and/or process requirements are not open to different interpretations.
- The process is made easier to understand.
- Non-value-added steps are eliminated.
- Effectiveness and efficiency are increased.
- The process can be benchmarked to determine if it is excellent or to set new performance goals.
- DWIHN and Contracted Provider staff can collect evidence relying on process conformity to increase validity and reliability in findings.

Performance Measures

Performance measures play a vital role in the Plan-Do-Study-Act (PDSA) cycle, serving as a systematic method for evaluating the outcomes generated by a program. These measures involve the continuous collection and analysis of data, which allows organizations to monitor performance over time. The primary objectives of measurement and assessment include identifying areas for improvement, making informed decisions based on empirical evidence, and ensuring that the program is meeting its intended goals. By regularly reviewing performance data, teams can recognize trends, assess the effectiveness of interventions, and implement necessary adjustments to enhance overall program success.



Measurement and assessment ***involve***:



The collection and submission of performance measurement data must occur on an annual basis, ensuring that we maintain a consistent schedule for monitoring and reporting our performance. At the end of each year, we are required to produce a comprehensive report that outlines our achievements and challenges, which will be submitted to the State. This report must adhere to the standard measures that have been mandated by the State, ensuring that our performance is evaluated using the criteria that they have established. In addition to the annual report, we are obligated to submit specific data as requested by the State. This data is crucial for enabling the State to effectively assess the performance of the Prepaid Inpatient Health Plan (PIHP) based on the identified standard measures. Furthermore, we have the option to implement a combination of the activities mentioned previously. This means that we can gather and analyze data in conjunction with preparing our report, allowing for a more comprehensive overview of our performance throughout the year. This approach can enhance our ability to address any areas for improvement and demonstrate our commitment to meeting the State's expectations.

Measure of Service	
Name	***Michigan Mission Based Performance Indicators (MMBPI)***
Definition	*This includes the indicators found in the MDHHS Code Book***.**
Data Collection	*Data is collected through MH-WIN, while the remaining information is calculated by MDHHS.*
Assessment Frequency	*The Quality Improvement Steering Committee will review the data related to the indicator on a monthly basis and submit it to MDHHS quarterly.*
Measure of Service	
Name	***Member Grievances***
Definition	*An expression of dissatisfaction regarding any aspect of operations or activities by the Service Provider or DWIHN.*
Data Collection	*Primarily collected through MHWIN.*
Assessment Frequency	*The Customer Service Committee will review grievances, appeals, and other customer service-related issues on a quarterly basis.*
Measure of Service	
Name	***Member Satisfaction***
Definition	*Assessment of how well services meet or exceed members' expectations.*
Data Collection	*MH-WIN, Survey, Member Questionnaire*
Assessment Frequency	*The Customer Service Committee will review grievances, appeals, and other customer service-related issues on a quarterly basis.*

Measure of Service	
Name	***Clinical Practice Improvement (CPI)***
Definition	*CPI uses evidence-based, nationally recognized clinical practice guidelines tailored to the needs of the individuals we serve.*
Assessment Frequency	*CPI guidelines are reviewed and approved each year by the Chief Medical Officer and Clinical Officer. The Improving Practices Leadership Team (IPLT) meets regularly to discuss, approve, and disseminate these guidelines.*
Measure of Service	
Name	***Finance***
Definition	*Ensure the financial stability of DWIHN and its network providers.*
Data Collection	*Site Reviews, Audits, Financial Reports*
Assessment Frequency	*The Cost Utilization Committee will analyze spending and trends, making recommendations for the system based on Strategic Initiatives, Market Forecasts, and historical data on a quarterly basis or as needed.*
Measure of Service	
Name	***Crisis Services (CS)***
Definition	*CS facilitates member access to DWIHN's comprehensive services within the Crisis Continuum Service System.*
Data Collection	*MMBPI, Performance Monitoring, MH-WIN*
Assessment Frequency	*The Quality Improvement Steering Committee will review service requests and recidivism data on a monthly and quarterly basis.*
Measure of Service	
Name	***7 Day Follow-up***
Definition	*Make sure that all appointments are scheduled and attended by the members.*
Data Collection	*Performance Indicator Module in MH-WIN*

Assessment Frequency	*The Quality Improvement Steering Committee will review data related to this indicator on a monthly and quarterly basis.*
Measure of Service	
Name	***30 Day Follow-up***
Definition	*Make sure to schedule appointments with mental health professionals and ensure that members attend them.*
Data Collection	*MH-WIN, Performance Monitoring*
Assessment Frequency	*The Quality Improvement Steering Committee will review data related to this measure on a monthly and quarterly basis.*
Measure of Service	
Name	***Sentinel Events and Critical Incidents***
Definition	*The reporting of any actual or alleged incidents or situations that pose a significant risk or substantial harm to the physical or mental health, safety, or well-being of individuals within DWIHN's service delivery area.*
Data Collection	*MH-WIN*
Assessment Frequency	*The Sentinel Event Committee and Peer Review Committees will review data using a three-tiered system of peer review activity information associated with this measure on a monthly and quarterly basis.*
Measure of Service	
Name	***Advocacy***
Definition	*Identify strategies to enhance community inclusion and integration.*
Data Collection	*MH-WIN, Site Review, Performance Monitoring, HCBS*
Assessment Frequency	*The Quality Improvement Steering Committee and the Constituents' Voice will review data related to this measure on a monthly and quarterly basis.*

Performance Indicators Assessment

The Assessment of the Performance Indicators is accomplished by comparing actual performance on an indicator with:

- Self over time
- Pre-established standards, goals or expected levels of performance.
- Information concerning evidence-based practices.
- Other systems or similar service providers

Specific, measurable, actionable, relevant, and timely data are essential components of effective Quality Improvement (QI) operations within the organization. The dedicated staff of the Quality Improvement unit is actively involved in continuous processes aimed at identifying weaknesses and deficiencies in current data management practices. They work tirelessly to uncover opportunities to enhance both the accuracy and completeness of the datasets maintained by the Detroit Wayne Integrated Health Network (DWIHN) in the MH-WIN system and within the state's data warehouse. The Quality Improvement Unit holds the crucial responsibility of supervising the data related to the Michigan Mission-Based Performance Indicator (MMBPI) System. This oversight involves the use of standardized performance indicators, which are derived from a systematic approach to the ongoing collection and rigorous analysis of data that is deemed both valid and reliable. The performance measures employed were established by the Michigan Department of Health and Human Services (MDHHS) and encompass key areas such as access to services, operational efficiency, and overall outcomes for clients. In accordance with regulatory requirements, this critical data is submitted to MDHHS at designated intervals, adhering to strict timelines and prescribed formats to ensure compliance and transparency. Furthermore, the Quality Improvement Unit compiles and shares this data on a quarterly basis with various stakeholders involved in the QI infrastructure. These stakeholders include committees such as the Program Compliance Committee, the Quality Improvement Steering Committee, and the Quality Operations Technical Assistance Workgroup, among others. This collaborative approach helps to foster an environment of continuous improvement and accountability, ensuring that the data drives meaningful enhancements to the quality of care provided.

Behavioral Treatment Review

DWIHN has assigned the responsibility for the Behavioral Treatment (BT) review process to all contracted Mental Health (MH) Clinically Responsible Service Providers (CRSP). This delegation ensures that these providers adhere to the requirements established for the Behavior Treatment Plan Review Committee (BTPRC), which are clearly outlined in their written contracts. As of now, DWIHN manages a total of twenty (20) BTPRCs, which are held at the various MH CRSPs to oversee the implementation and review of behavioral treatment strategies. The QAPIP program conducts comprehensive quarterly reviews that analyze extensive data gathered from the BTPRCs. This analysis focuses on key aspects such as the approval and actual use of intrusive or restrictive behavioral techniques with members. It also examines situations in which physical management interventions have been employed or when emergency services, such as law enforcement, have been contacted during behavioral crises. Furthermore, the analysis includes a detailed breakdown of the duration for which these physical management interventions are applied for each individual, allowing for a nuanced understanding of their use. The techniques permitted for use are governed by the Technical Requirements for Behavior Treatment Plans and must receive prior approval through person-centered planning conducted with the member or their legal guardian. Data collection encompasses not only the number of interventions performed but also the specific length of time each intervention is applied to individuals. This meticulous data tracking enables a thorough evaluation of intervention efficacy and adherence to established protocols. In addition to reviewing data, the BTPRC also assesses the implementation of established procedures. It evaluates the overall effectiveness of each committee in the context of its specified responsibilities, identifying areas where corrective action may be necessary.

The Committee plays a critical role in comparing system-wide key indicators, which may include rates of psychiatric hospitalization, progress related to behavior stabilization, and fluctuations in the application of behavior treatment plans. By systematically analyzing these indicators, the Committee can make informed decisions aimed at enhancing the quality and effectiveness of care provided to members.

Committee Structure

To enhance the overall quality within the DWIHN organization, a series of dedicated committees have been established with the primary responsibility of overseeing and implementing various quality improvement initiatives. These committees play a critical role in ensuring that best practices are followed, and that continuous improvement is a core focus across all levels of the organization. Supporting these committees is a comprehensive infrastructure designed to facilitate collaboration among key stakeholders, including department heads, process owners, and cross-functional teams. This collaborative approach ensures that diverse perspectives and expertise are incorporated into the decision-making process, allowing for more effective quality enhancement strategies. Considering the challenges posed by the COVID-19 global pandemic, these committees have adapted by utilizing virtual meeting platforms. This shift has enabled them to maintain communication, share insights, and coordinate their efforts despite physical distancing requirements. By leveraging technology, the committees continue to engage with one another and remain committed to advancing quality improvement initiatives within the organization.

Program Compliance Committee (PCC)

The Program Compliance Committee (PCC) functions as a vital component of the Board of Directors, providing strategic leadership for the Quality Improvement process at DWIHN. The committee plays a crucial role in supporting and guiding the implementation of various quality improvement activities aimed at enhancing the organization's overall performance and service delivery. In its capacity, the PCC is responsible for regularly reviewing proposed changes to quality improvement protocols and assessing the necessity for any actions that require Board approval. This ensures that the initiatives are aligned with the organization's goals and comply with established standards. Furthermore, the committee is tasked with the biennial approval of the Quality Assessment and Performance Improvement Plan (QAPIP) Description, ensuring that it accurately reflects the organization's quality objectives and strategies. Additionally, the PCC evaluates the QAPIP annually and provides oversight for the associated Work Plan, ensuring that the activities outlined effectively address areas of improvement and achieve the desired outcomes for the organization and its stakeholders.

Membership:

DWIHN's PCC Committee consists of members of the Board of Directors. The Vice President of Clinical Operations is the liaison to the committee. Meeting notices are posted in public places and on DWIHN's website. Meetings are open to the public.

Function of the Committee:

The committee monitors the effectiveness of the QAPIP and make recommendations on the following:

- Annual evaluation of the effectiveness of the QAPIP and recommends approval of reports to the Board.
- System-wide trends and patterns of key indicators.
- Opportunities for improvement.
- Studies in areas identified from data review as having the potential for affecting the outcomes of care and related quality concerns.
- Policies and Procedures.
- System-wide attainment of goal(s) and objective(s).
- Developing and approving the QAPIP description and evaluation.
- Establishing measurable objectives based upon priorities identified using established criteria for improving the quality and safety of clinic services.
- Developing indicators of quality on a priority basis.

- Periodically assessing information based on the indicators, acting as evidenced through quality improvement initiatives to solve problems and pursue opportunities to improve quality.
- Establishing and supporting specific quality improvement initiatives.
- Reporting to the Full Board of Directors on quality improvement activities on a regular basis.
- Review of program operations.
- Recommend Board Actions to the Full Board of Directors.

Quality Improvement Steering Committee (QISC)

The Quality Improvement Steering Committee (QISC) at DWIHN serves as a vital advisory group dedicated to fostering system-wide representation in various aspects of DWIHN's continuous quality improvement program. This committee is tasked with ensuring that all stakeholders are involved in the planning, implementation, support, and evaluation processes, facilitating a collaborative approach to quality enhancement. The QISC is responsible for providing ongoing operational leadership for the continuous quality improvement initiatives across DWIHN. To maintain effective oversight and to promote ongoing dialogue, the committee meets at least once a month, ensuring a minimum of nine (9) meetings each year. These gatherings allow committee members to assess current quality improvement efforts, share insights, and strategize on practice improvement projects. Additionally, the QISC plays a critical role in leading various practice improvement initiatives aimed at enhancing service delivery and operational efficiency. It acts as a communication hub, effectively coordinating quality improvement activities and ensuring that information flows seamlessly throughout the entire quality improvement program structure. Through these efforts, the QISC strives to uphold high standards of quality and improve outcomes for the individuals and communities served by DWIHN.

Membership:

Membership includes the Chief Medical Officer, directors of DWIHN's units or designee, chairperson of the committees within the Quality Improvement structure or designee, members, advocates, and Contracted Providers of services to members with Serious Mental Illness, Severe Emotional Disturbance, Substance Use Disorders, Intellectual Developmental Disabilities, and Co-Occurring Disorders.

Function of the Committee:

- Establish and annually review committee operational guidelines, such as confidentiality, meeting frequency, management of information requests, number of members required for a quorum, membership, etc.
- Establish committee goals and timelines for progress and achievement.
- Participate in the development and review of quarterly/annual reports to the Program Compliance Committee and the Full Board of Directors regarding the Quality Improvement System.
- Annually review and evaluate the effectiveness of the Quality Assessment Performance Improvement Program. Oversee a circular communication process to ensure that all involved constituencies, including the Board of Directors, DWIHN staff, and members, providers and other stakeholders are a part of the Quality Improvement Process.
- Provide recommendations and feedback on process improvement, program implementation, program results and program continuation or termination.
- Examine quantitative and qualitative aggregate data at predetermined and critical decision-making points and recommend courses of action.
- Review reports from regulatory DWIHN reviews.
- Review of DWIHN improvement plans and make recommendations based on these reviews.
- Monitor progress and completion of plans of correction in response to recommended remedial actions identified for the DWIHN or by regulatory organizations.

- Review quality Improvement operating procedures and propose changes in procedures as needed.
- Oversee a process for establishing, continuing, or terminating subcommittees, standing committees, improvement teams, task groups and work groups.
- Identify training needs and opportunities for staff development in the quality Improvement process.
- Identify future trends and make recommendations for next steps.
- Develop standardized forms required for the work of the Steering Committee.
- Initiate and participate in recognition and acknowledgement of successes in quality Improvement for the DWIHN and the community mental health system.
- Leadership in practice improvement projects.

Improving Practices Leadership Team (IPLT)

DWIHN's initiatives are dedicated to the implementation and support of Best Practices and Evidence-Based Practices (EBP) within the organization and its affiliated programs. To effectively oversee and ensure the success of these initiatives, the Improving Practices Leadership Team (IPLT) has been established. The IPLT is responsible for a range of critical functions, including the development of comprehensive work plans that outline specific goals and actions. They coordinate the regional training and technical assistance strategy, which involves assessing the training needs of staff and ensuring that they receive the necessary support to improve their practices. In addition, the IPLT integrates data collection efforts to track the effectiveness of the implemented practices and inform decision-making. They also formulate financial strategies and mechanisms to ensure sustainable funding for these initiatives, allowing for long-term success. To maintain program fidelity, the team closely monitors adherence to established practices and guidelines, ensuring that interventions are delivered consistently and effectively. Regular evaluations are conducted to assess the impact of these practices on service delivery, and the team closely monitors clinical outcomes to ensure that the initiatives lead to positive results for the individuals served. By maintaining a focus on these areas, the IPLT plays a crucial role in enhancing the quality and effectiveness of services within the organization.

Membership:

The IPLT committee is chaired by the Clinical Officer and Chief Medical Officer that includes Improving Practice Leadership Specialists in the following areas:

- Individuals with Serious Mental Illness (SMI)
- Children with Serious Emotional Disturbance (SED)
- Individuals with Intellectual and/or Developmental Disabilities (I/DD)
- Individuals with Substance Use Disorders (SUD)
- Quality Improvement
- Finance
- Data Evaluation
- Member employed by the system.
- Family Member of a child receiving PIHP services Peer support specialist.
- An identified program leader for each practice being implemented.
- Identified program leader for peer-directed or peer-operated services.

Function of the Committee:

Develop and communicate a strategy that is tailored to the context and the roles, capabilities, and interests of the stakeholder groups involved in the public mental health system:

- Identify and mobilize program leaders or change agents within the organization to implement the activities required to achieve the desired outcomes.
- Develop an on-going process to maximize opportunities and overcome obstacles.

- Monitor outcomes and adjust processes based on learning from experience.
- Align relevant persons, organizations, and systems to participate in the transformation process.
- Support Membership of a Member/Certified Peer Support to represent the PIHP/CMHSP on the Recovery Council of Michigan.
- Assess parties' experience with change.
- Establish effective communication systems.
- Ensure effective leadership capabilities.
- Enable structures and process capabilities.
- Improve cultural capacity.
- Demonstrate their progress in system transformation by implementing evidence based, promising and new and emerging practices.

Standing Committee

DWIHN's Quality Improvement System is designed to systematically oversee and enhance the quality of care and services provided to members through a structured framework of standing committees. These committees play a critical role in the continuous monitoring, peer evaluation, and improvement of various functions within the organization. Each standing committee is tasked with receiving, reviewing, and analyzing data that pertains to their designated areas of responsibility, such as specific care outcomes, service delivery metrics, and operational efficiency measures. The overarching aim of this structured approach is to significantly improve the quality of care for DWIHN members, streamline provider operations, and enhance overall internal processes to ensure efficiency and effectiveness. Committees may either be given specific quality indicators by DWIHN leadership to track various aspects of care and service delivery or may have the autonomy to establish their own indicators based on identified needs. These indicators are crucial in assessing performance and identifying areas for improvement. Each committee includes qualified representatives from various DWIHN units, provider organizations, and, when appropriate, stakeholders—including members—who contribute valuable insights and perspectives to the quality improvement process. A key responsibility of the committees is to determine which aspects of services and support warrant monitoring for continuous improvement.

This determination is guided by priorities outlined in the MDHHS contract, along with an emphasis on addressing the needs of high-risk members and programs that either have high service volumes or exhibit a tendency for operational challenges. The insights drawn from DWIHN's Performance Indicators System—an extension of the MDHHS data collection program—serve as a vital resource in pinpointing specific areas that require ongoing monitoring and evaluation. With this data in hand, committees develop comprehensive plans to review relevant information within their scope of responsibility, enabling them to identify both strengths and opportunities for improvement. The Quality Improvement (QI) staff work closely with these committees to ensure adherence to data-driven continuous quality improvement principles, thereby fostering an environment of ongoing evaluation and enhancement.

Each standing committee is also responsible for monitoring the effectiveness of any improvements that have been implemented, carefully assessing their impact on organizational outcomes and member experiences. This feedback loop is essential in determining whether the changes made are yielding the desired results or if further adjustments are necessary. Moreover, standing committees play a crucial role in identifying and recommending the establishment of quality improvement teams when specific issues arise that require focused attention and collaborative problem-solving. They may also seek external resources and expertise as needed to support team initiatives and encourage active participation from a diverse array of stakeholders, which includes internal staff, providers, members, and various external groups with an interest in quality improvements. In summary, the structure and function of DWIHN's standing committees form the backbone of their Quality Improvement System, fostering a culture of accountability, collaboration, and continuous enhancement aimed at delivering the highest standard of care and services to all members.

Sentinel Events Committee/Peer Review Committee (SEC/PRC)

The Critical/Sentinel Event process is a comprehensive framework designed to ensure the reporting and analysis of all actual or alleged incidents that may pose a significant risk or result in substantial harm to the physical or mental health, safety, or overall wellbeing of individuals receiving services within the DWIHN's service delivery area. These incidents encompass a wide range of occurrences, which, at a minimum, include member deaths, arrests, hospitalizations resulting from injuries, and medication errors. Each of these events is critical for understanding and improving the quality of care and safety within the system. The SEC/PRC (Safety Event Committee/Peer Review Committee) holds the authority to make the final determination on whether an incident is classified as a Critical or Sentinel Event. This means that their judgment is vital in identifying the severity of an incident and determining the necessary steps for response and prevention. In certain situations, especially when there are specific questions or concerns regarding an incident, the SEC/PRC may request the attendance of additional stakeholders or experts. This collaborative approach is aimed at fostering a comprehensive understanding of the incident and ensuring the development of effective strategies for improvement. It is important to note that all peer review clinical activities facilitated within this process are both privileged and confidential. These activities adhere strictly to applicable state and federal laws and regulations that govern peer review processes, ensuring that discussions remain protected and focus on enhancing the quality of care provided to members.

All unexpected* deaths of Member who at the time of their deaths were receiving specialty supports and services must be reviewed and must include:

- Screens of individual deaths with standard information (e.g., coroner's report, death certificate).
- Involvement of medical personnel in mortality reviews.
- Documentation of the mortality review process, findings, and recommendations.
- Use of mortality information to address quality of care.
- Aggregation of mortality data over time to identify possible trends.

* Unexpected deaths include those that resulted from suicide, homicide, an undiagnosed condition, accidental, or suspicious for possible abuse or neglect. As applicable, when necessary to respond to questions/concerns of the DRC other persons will be requested to attend.

SEC/PRC Membership includes but is not limited to:

- Chief Medical Officer/Designee
- Quality Performance Improvement Team/Manager/Director
- Utilization Management
- Managed Care Operations
- Substance Use Disorders Initiatives
- Office of Recipient Rights
- Children's Initiatives
- Clinical Performance Improvement

Function of the Committee:

The mission and goal of the SEC/PRC is to ensure the Contracted Providers and/or Clinically Responsible Service Providers (CRSP) conduct a thorough review of incidents with an action plan to remediate or reduce the risk of the incident reoccurring.

SEC/PRC also ensures that a thorough review of the Member's death has been conducted by the Member's respective Service Provider, CRSP, Recipient Rights and Clinical Practice Improvement Units. All reviews are conducted in accordance with DWIHN's Death Reporting Policy and procedures, state and federal laws and regulations that govern death review activities.

The SEC/PRC uses a three-tiered system of peer review activity. In the first tier, the Critical and Sentinel Events are reviewed by Quality Performance Improvement Team (QPIT) for standard-of-care and scope of service issues. Requests for additional documents, completeness of the information are forwarded to the CRSP with notification to DWIHN Department leaders as appropriate.

In the second tier, the Critical/Sentinel Events are reviewed by DWIHN's SEC/PRC Committee. Findings from the SEC/PRC can include requests for additional information, corrective action plans, or Recipient Rights, Compliance or Contract action referrals. Repeated deficits or failures to correct identified deficits may result in recommendations for performance sanctions as defined by DWIHN policy, procedures, and contracts.

In the third tier, the data collection is reviewed by the QPIT for policy updates and implementation, patterns, trends, compliance, education and improvement and presentation to DWIHN Program Compliance Committee of the Board of Directors.

Behavioral Treatment Advisory Committee (BTAC)

The Behavioral Treatment Advisory Committee (BTAC) of the Detroit Wayne Integrated Health Network (DWIHN) plays a crucial role in overseeing the activities and effectiveness of nineteen Behavioral Treatment Plan Review Committees (BTPRCs) within the network. This oversight is not just a routine function; it is a contractual obligation that DWIHN has toward the Michigan Department of Health and Human Services (MDHHS), ensuring compliance with state regulations and standards. The primary objective of the BTAC is to implement a systematic approach to monitoring service providers, thereby guaranteeing that they adhere to the standards set forth by MDHHS for BTPRCs. This oversight involves a thorough analysis of system-wide trends and patterns within the BTPRCs. The committee examines various key performance indicators, including the rates of psychiatric hospitalizations, measures of behavioral stabilization, and shifts in the application of interventions, crisis intervention plans, and individualized behavior treatment plans. Members of the BTAC are appointed for a two-year term, with a total of sixteen members serving during the fiscal years 2023-2025. The composition of the committee includes a diverse range of professionals with expertise in behavioral health care, which enhances the quality of their oversight. Additionally, representatives from network providers are invited to take part in the case validation review process during BTAC meetings.

This collaborative effort is a vital component of the continuous quality improvement initiatives at the Prepaid Inpatient Health Plan (PIHP) level, fostering partnership and open communication among stakeholders. To ensure transparency and accountability, the BTAC submits detailed quarterly data analysis reports on the activities and outcomes of the BTPRCs to MDHHS. These reports not only provide insights into the functioning of the committees but also serve as a mechanism for assessing the overall effectiveness of behavioral treatment strategies and interventions being implemented within the network. This structured approach ultimately aims to enhance the quality of care for individuals receiving behavioral health services.

Membership:

- The committee consists of DWIHN's Chief Medical Officer, DWIHN Consultant Physician, licensed psychologist, Members,
  DWIHN staff, provider representatives and Office of Recipient Rights (ORR).
- The representative of DWIHN's ORR is required to attend BTPRC meetings.
- Each of the providers' BTPRC consists of a licensed psychologist, a physician/psychiatrist and DWIHN's ORR.

Function of the Committee:

DWIHN's BTAC provides oversight and monitoring of Behavior Treatment Plan Review Committees (BTPRC) to ensure compliance with MDHHS Technical requirements and collects data and information on implementation issues including:

- Types of challenging behaviors resulting in use of law enforcement
- Types of interventions used.
- Revising and Updating DWIHN Policy on Behavior Treatment Plans
- Frequency and duration of interventions used (Restrictive and Intrusive)
- Frequency of review of behavior treatment plans.
- Number of Critical/Sentinel Events involving challenging behaviors.
- Root Cause Analysis Reviews along with Sentinel Events Committee
- Percent of care staff at all levels trained in behavior management (i.e., positive behavior management, the culture of gentle teaching, management of challenging behaviors, etc.).
- Number of behavior management related ORR complaints.

Credentialing Committee

The primary objective of the committee is to establish a comprehensive and clear framework for the functions and responsibilities of DWIHN's Credentialing Verification Organization (CVO) and the various Service Providers involved in delivering care. This includes detailing the specific roles that each entity plays in the credentialing process, which is vital for ensuring quality and compliance with regulatory standards. The committee has the important responsibility of implementing robust credentialing and re-credentialing processes that adhere to best practices and applicable regulations. These processes are designed to verify the qualifications, experience, and competence of healthcare providers, ensuring that only those who meet the required standards can participate in the delivery of services. Operating under the guidelines set forth by the PIHP agreement with MDHHS, the Credentialing Committee plays a critical role in maintaining a skilled and capable workforce within DWIHN. This workforce is essential for effectively delivering services that are funded by Medicaid and Medicare, ensuring that clients receive high-quality care. Furthermore, the guidelines established by the committee align with the federal regulations outlined in 45 CFR 438.214, which pertains to Provider Selection. By adhering to these regulations, the committee ensures that the selection and ongoing evaluation of providers meet the necessary criteria for quality and performance. Through these efforts, the committee aims to foster a healthcare environment that is both safe and effective for all individuals served by DWIHN.

Function of the Committee:

The Committee thoroughly reviews completed files that have undergone a comprehensive process known as primary source verification. This rigorous verification includes the examination of several key components: Education Credentials. Confirming the educational background of practitioners to ensure they have the necessary qualifications. Licensure. Verifying that all practitioners hold valid and current licenses to practice in their respective fields and locations. Certifications. Checking for any additional certifications that affirm a practitioner's expertise in specialized areas of their profession. Work History. Evaluating the professional work history to assess experience and reliability in their practice. Malpractice History. Investigating any past malpractice claims to gauge the practitioner's professional conduct and risk factors. Current Malpractice Insurance. Ensuring that practitioners carry appropriate malpractice insurance to protect themselves and their patients. Exclusions from Medicare and Medicaid. Checking against federal databases to confirm that practitioners are not excluded from participating in these critical healthcare programs.

This entire verification process is conducted by a Credentialing Verification Organization (CVO) that is accredited by the National Committee for Quality Assurance (NCQA). The Committee plays a vital role in approving files that meet all specified requirements and denying those that fail to do so, thereby maintaining high standards for the provider network. Additionally, the Committee provides ongoing oversight for the CVO, monitoring exclusion and preclusion databases monthly to ensure up-to-date compliance with regulatory requirements. Each Committee member is required to sign an attestation, affirming their commitment to confidentiality and adherence to procedures that prevent discrimination against practitioners and providers of varied backgrounds. In accordance with the Credentialing and Re-credentialing processes outlined by MDHHS, DWIHN has developed structured written policies and procedures. These are designed to guarantee that the credentialing and re-credentialing of its provider network is conducted appropriately and transparently. Furthermore, the Quality Improvement department continually evaluates the qualifications of the provider network staff to ensure conformity with all relevant federal, state, and local regulations. To uphold the highest standards of care, performance monitoring is conducted at least once a year through a well-established process. This process verifies that care and support providers possess the necessary qualifications and are adequately equipped to perform their duties effectively and safely, ultimately contributing to the overall quality of care provided to clients.

The Committee provides oversight for the CVO and monitors exclusion and preclusion databases monthly. All Committee members sign an attestation to maintain confidentiality and to ensure that decisions are made without discrimination against practitioners and providers. In compliance with the Michigan Department of Health and Human Services (MDHHS) Credentialing and Re-credentialing processes, the Detroit Wayne Integrated Health Network (DWIHN) has established written policies and procedures to ensure appropriate credentialing and re-credentialing of its provider network. Quality Improvement continually monitors the qualifications of the provider network staff, ensuring compliance with federal, state, and local regulations. Performance monitoring is conducted at least annually through an established process to confirm that care or support providers are qualified to perform their duties.

Membership:

- Chief Medical Officer
- Behavioral Health and Substance Use Disorder Providers
- DWIHN Staff

Risk Management

The purpose of the committee is to thoroughly review incidents involving Members and the provider system, ensuring that all discussions and findings are conducted with strict confidentiality to safeguard sensitive information. This committee is designated as the Risk Management Committee and operates on an ad hoc basis, convening as necessary to address specific incidents and assess risks that may arise within the provider system. The committee's reviews aim to identify patterns, recommend improvements, and enhance overall safety and quality of care for all Members involved.

Membership:

- Vice President of Finance
- Chief Medical Officer
- Executive Vice President of Operations
- Vice President of Compliance
- Others as needed.

Function of the Committee:

- Continuously improve member safety and minimize and/or prevent the occurrence of errors, events, and system breakdowns leading to harm to patients, staff, volunteers, visitors, and others through proactive risk management and patient safety activities.
- Minimize adverse effects of errors, events, and system breakdowns when they do occur.
- Minimize losses to the organization overall by proactively identifying, analyzing, preventing, and controlling potential clinical, business, and operational risks.

Cost Utilization Steering Committee

The analysis of clinical services encompasses several key elements, including utilization rates, established standards, and accessibility for patients. Specifically, Cost Utilization focuses on evaluating our spending patterns across various clinical services. This involves a thorough examination of where our resources are allocated, identifying trends over time, and assessing their impact on overall service delivery. By leveraging Strategic Initiatives and Market Forecasts, we can make informed recommendations aimed at optimizing our operations and improving patient outcomes. Additionally, our approach incorporates an analysis of historical data to better understand past performance and to inform future strategic decisions. This comprehensive evaluation is essential for ensuring that our clinical services are both efficient and effective in meeting the needs of the population we serve.

Membership:

- Vice President of Finance
- Chief Medical Officer
- Executive Vice President of Operations
- Vice President of Compliance
- Vice President of IT Services

Function of the committee:

- To receive data from the Cost Integrity Group (CIG), Procedure Code Work Group, along with the contractual expectations.
- Review the needs for improved clinical outcomes (UM/QM/CPI data or input), state mandates (such as EBPs).
- Finds ways to fund necessary functions or services. It contemplates state funding (revenue) and network funding (costs), and fund source management along with cost and utilization data integrity and even system processes.
- As a steering committee it would set the priorities for managing our funding to achieve our operating expectations.

Compliance Committee

The Compliance Committee serves as an organization-wide body dedicated to overseeing and ensuring adherence to operational compliance standards. To fulfill its responsibilities effectively, the committee shall convene at a minimum of once per quarter throughout the fiscal year. These meetings will provide an opportunity for committee members to discuss compliance issues, review operational processes, and assess adherence to relevant regulations and policies. In addition to the scheduled quarterly meetings, the Vice President of Compliance has the authority to call for additional meetings as needed. This flexibility allows the committee to respond promptly to urgent compliance matters or emerging issues that may require immediate attention. All committee members are encouraged to actively participate in discussions and contribute to the ongoing improvement of compliance practices within the organization.

Membership:

- Vice President of Compliance
- Executive Vice President of Operations
- Vice President of Legal Affairs
- Vice President of Finance
- Chief Medical Officer

Function of the Committee:

- Assist the Vice President of Compliance with risk assessment and the need for and design of compliance reviews within the organization.
- Advise the Vice President of Compliance on training needs within the organization and assist. in arranging for and conducting such compliance training.
- Assist the Vice President of Compliance with developing organizational policies. supporting the Compliance Plan.
- Assist the Vice President of Compliance with implementation of the Compliance Plan.
- Assist the Vice President of Compliance with evaluation of the effectiveness of the Compliance Plan.
- Refer all matters to the Program Compliance Committee (PCC) and the Board for review that relate to the following:
  - Violations that require notification to federal, state, and/or local agencies.
  - Violations that have an economic impact (i.e., budgetary) on the Network and/or require funds to be returned to federal or state agencies.
  - Any other information that the Compliance Committee deems appropriate for Board notification.

Customer Service Committee

The primary objective of this committee is to deliver comprehensive procedural and operational guidance on the mandated standards and functions related to Customer Service. This guidance is intended for several key stakeholders, including DWIHN (Detroit Wayne Integrated Health Network), various service providers, the Access Center, crisis services vendors, and other organizations contracted to provide Customer Service on behalf of DWIHN. By clarifying the expectations and requirements of Customer Service, this committee aims to enhance the quality and consistency of services offered to individuals in need. The committee convenes on a quarterly basis to review current practices, address challenges, share best practices, and ensure that all parties are aligned with DWIHN's goals and objectives in delivering effective and compassionate customer service.

Membership:

DWIHN Staff:

- Customer Service Director
- Customer Service Administrator
- Customer Service Due Process Manager and Grievance and Appeals staff.
- Member Engagement Manager
- Access Center Director

Service Provider Staff:

- Customer Services Management
- Grievance, and Appeal staff
- Quality Department staff
- Others as needed.

Function of the Committee:

The quarterly meetings, facilitated by DWIHN's Customer Service Department, serve a crucial role in promoting collaboration and communication among service providers. These gatherings are designed to coordinate efforts between the Customer Service, Grievance, and Appeals management teams at the service provider level. During the meetings, participants discuss a wide range of topics related to DWIHN's Customer Service operations, including the latest updates, challenges, and solutions in the Grievance and Appeals processes. This setting not only helps in addressing current issues but also fosters an environment for continuous improvement in service delivery. Moreover, the meetings create valuable opportunities for networking among service providers, enabling them to share best practices, innovative programs, and effective processes. Participants can also announce upcoming events and initiatives in their networks, fostering collaboration and ensuring that all providers stay informed and engaged. Overall, these quarterly meetings are essential for enhancing the quality of service provided to clients and improving overall customer satisfaction.

Recipient Rights Advisory Council (RRAC)

The RRAC is established in accordance with the Michigan Mental Health Code (MCL 330.1757). This committee is dedicated to enhancing mental health services and promoting resilience within the community. The RRAC convenes every other month, specifically on the first Monday of each odd-numbered month, from 1:00 PM to 3:00 PM. During these meetings, members discuss various topics related to mental health policies, programs, and initiatives aimed at supporting individuals and families. The meetings are held in compliance with the Open Meetings Act, ensuring transparency and accountability. As a result, the public is not only welcome but also encouraged to attend, participate, and share their insights. By engaging the community, the RRAC aims to foster a collaborative environment that promotes mental health awareness and advocacy.

Membership:

Is broadly based to best represent the varied perspectives of the CMHSP's geographical area. At least 1/3 of the Membership shall be primary Member or family Member, and of that 1/3, at least ½ shall be primary Member.

Function of the committee:

- Protect the Office of Recipient Rights (ORR) from pressures that could interfere with the impartial, even-handed, and thorough performance of its functions.
- Serve in an advisory capacity to the executive director and the director of ORR Other specific functions.
- Review the process for funding ORR.
- Recommend candidates for the position of Director of ORR to the Executive Director.
- Consult with the Executive Director regarding any proposed dismissal of the Director of ORR.
- Receive education and training in ORR policies and procedures.
- Review the Semi-Annual report submitted to the MDHHS.
- Review the Annual report submitted to MDHHS.
- Provide "Goals for ORR" and "Recommendations for ORR" for the Annual Report.
- The RRAC also serves as the Recipient Rights Appeals Committee.

Access Committee (AC)

The Access Committee plays a critical role in ensuring that the Detroit Wayne Integrated Health Network (DWIHN) provides a comprehensive array of behavioral health services tailored to meet the diverse needs of its various populations. These populations include adults, children, individuals with developmental disabilities (I/DD), those who suffer from serious mental illnesses and serious emotional disturbances (SMI/SEI), individuals facing substance use disorders (SUD), and those diagnosed with autism spectrum disorder. One of the primary responsibilities of the Access Committee is to conduct thorough reviews of existing providers and service delivery locations. This involves assessing the efficacy of current services and identifying gaps that may necessitate the addition of new providers or locations to enhance service availability. By facilitating the progression of these providers into the credentialing process, the Committee ensures that all services offered meet the required standards of care. In addition to provider oversight, the Access Committee is tasked with ensuring that DWIHN adheres to appointment availability and timeliness standards established by regulatory bodies.

These standards are outlined in various governing documents, including the Michigan Department of Health and Human Services (MDHHS) Access Standards policy, the External Quality Review (EQR) Checklist and Standards, as well as specific contractual provisions, such as 42 CFR §438.206(c)(1) (i-vi) Contract Schedule A–1(E)(7)(a). The Committee must develop and implement strategies to continuously monitor compliance with these standards, which are essential for ensuring timely access to care for individuals in need. To carry out its mission effectively, the Access Committee will engage in detailed discussions that focus on data analysis, operational challenges, and potential solutions. This collaborative process will involve reviewing quantitative data on service usage, appointment wait times, and other relevant metrics to identify trends and areas for improvement. Based on this analysis, the Committee will establish actionable steps aimed at enhancing availability and facilitating access to care for all individuals served by DWIHN.

The recommendations generated by the Access Committee will be comprehensive and targeted. They will include the documentation and implementation of clear expectations for providers regarding access standards, as well as outlining specific consequences for instances where these standards are not met. To ensure that quality care is consistently delivered, the Committee will promote the establishment of robust quality-of-care monitoring systems. Additionally, the Committee will implement mechanisms to systematically track access-related complaints and measure the percentage of available appointments relative to the established access standards. By monitoring these metrics, the Committee aims to create an environment where individuals receive timely and appropriate behavioral health services, ultimately enhancing the overall quality of care within the DWIHN network.

Membership includes but not limited to:

- Chief Medical Officer
- Clinical Officer
- Clinical Practice Improvement
- Managed Care Operations
- Quality Improvement
- Utilization Management
- Integrated Health Care
- Substance Use Disorders
- Customer Services
- Director of Crisis Services

Function of the committee:

- Improved and increased member access.
- Improved operational workflows.
- Enhanced data monitoring and compliance with all Regulatory agencies.
- Improved organizational strategic initiatives and organizational operational alignment.
- Review data reporting on appointment type slots availability per provider.
- Review quality access reports on how provider organizations are meeting the access standards and measuring initiatives and implemented strategies to address challenges will be discussed and action steps will be developed to ensure availability.

Research Advisory Committee (RAC)

The committee's primary objective is to function as a collaborative group dedicated to fostering the development of research and evaluation proposals that align with the strategic priorities of the Detroit Wayne Integrated Health Network (DWIHN). This group aims to enhance the quality and impact of research initiatives by ensuring they are closely tied to the organization's mission and goals. The Research Advisory Committee (RAC) is committed to convening a minimum of four times a year, with the option to hold additional meetings as necessary. These gatherings will serve as important opportunities for members to discuss ongoing projects, address emerging challenges, and share insights that will aid in fulfilling the committee's responsibilities. The RAC's work will not only support the development of relevant research but also promote a culture of collaboration and innovation within the organization.

Function of the committee:

- Provide recommendations regarding research and evaluation projects presented to the RAC.
- Encourage and promote the utilization of research-based practice.
- Ensure that evaluation proposals follows the process of obtaining informed consent by complying with the requirements of 45 CFR 46.116 and the documentation of informed consent comply with 45 CFR 46.117.

Membership:

- The DWIHN Chief Clinical Officer will appoint members to the RAC at the recommendation of the Committee Co-Chairs and/or other Committee members. One Co-Chair shall be the DWIHN Chief Medical Officer.
- The RAC will be comprised of members with a variety of skills, expertise, and experiences, representing DWIHN, its Direct Contractors, service recipients, and other stakeholders, including research and funding communities.

Constituent's Voice

The Constituents' Voice (commonly referred to as "CV") is an advisory group comprised of members from the DWIHN community. This group plays a crucial role in providing guidance and recommendations to the Network. Specifically, the CV is responsible for driving policies and initiatives that promote the inclusion of community members. By representing diverse perspectives and experiences, the CV works to ensure that the voices of constituents are heard and considered in decision-making processes, ultimately fostering a more inclusive and supportive environment within the community.

Membership:

A diverse group of member advocates, along with secondary members, convenes monthly to discuss relevant topics and share insights. These meetings are generally held on the third Friday of each month, running from 10:00 AM to 12:00 PM. In the current format, the meetings are hybrid, allowing for both in-person and virtual participation. For those attending in person, the specific location will be communicated well in advance to ensure everyone can join. Additionally, all meetings are accessible online through the Zoom platform, accommodating those who prefer to attend remotely. This setup fosters an inclusive environment where all members can engage, contribute, and collaborate regardless of their location.

Function of the Constituent's Voice:

The Community Voice (CV) serves as an advisory committee to the CEO of DWIHN, focusing on enhancing the experiences of community members. Its primary mission is to offer thoughtful recommendations concerning community and member issues, while fostering open dialogue with other DWIHN staff members. This collaboration is essential for integrating member feedback into the development and refinement of policies, programs, and other operational functions within the system. To fulfill its mission, the CV hosts a diverse range of events that educate the community about the services offered by DWIHN, as well as a variety of other important topics. These events are designed to promote a stigma-busting agenda and foster a sense of community inclusion. One of the hallmark initiatives of the CV is the Annual Dreams Come True Mini-Grant Project. This program gives member applicants the opportunity to apply for a grant of $500, which can be used to support their pursuit of personal goals that contribute positively to their recovery journey. This initiative not only empowers individuals but also helps to reinforce the values of autonomy and self-direction in their personal development.

In addition to the Mini-Grant Project, the CV is actively involved in various advocacy and civic initiatives that aim to further community engagement and support. Among these efforts is the annual Walk-A-Mile in My Shoes Rally, hosted by the Michigan Association of Community Mental Health Boards (MACMHB) in Lansing, Michigan. This event gathers individuals from across the state to raise awareness about mental health issues and promote empathy and understanding. Another significant component of the CV's work is its Voter Education Registration and Participation (VERP) program. This initiative is dedicated to informing and empowering community members regarding their voting rights, with a particular focus on advocating for the rights of individuals with disabilities. Through this program, the CV not only promotes voter registration but also provides essential education on the voting process to ensure that all members feel informed and empowered to participate in democratic processes. Overall, the CV's comprehensive approach seeks to engage, support, and elevate the voices of community members within the DWIHN system.

Quality Improvement Teams, Ad Hoc Committees and Workgroup

DWIHN may identify various areas where improvements can be made that do not conform to the current structure of standing committees. To effectively address these identified opportunities, temporary teams will be established. These teams may take the form of ad hoc teams, workgroups, or quality circles, each designed to concentrate on specific tasks or objectives as needed. The formation of these temporary teams will be guided by the requirements of the organization and may be initiated by several entities, including the Quality Improvement Steering Committee, the Quality Improvement Department, or a Standing Committee. The choice of who appoints these teams will be based on the specific organizational needs and the nature of the improvement required. Furthermore, all activities and findings from the different committees, ad hoc teams, DWIHN units, and workgroups will be documented in reports. These reports will contain critical outcome measures that assess the effectiveness of the initiatives undertaken. Once compiled, these reports will be submitted to the Quality Improvement Steering Committee (QISC) for evaluation, discussion, and guidance in the ongoing pursuit of quality enhancements within DWIHN.

Utilization Management (UM)

The Utilization Management (UM) program plays a vital role in DWIHN's Quality Assessment and Performance Improvement Plan (QAPIP). As part of regulatory requirements, DWIHN must maintain a comprehensive written description of its Utilization Management Program. This document details the procedures for evaluating the medical necessity of services, including the specific criteria that inform these evaluations, the various sources of information utilized, and the systematic process for reviewing and ultimately approving medical services. Within the UM program, there are established mechanisms designed to identify and rectify instances of both under-utilization and over-utilization of healthcare services. This proactive approach ensures that patients receive appropriate levels of care while optimizing resource allocation. The procedures encompass key areas of review:

- Reviewing, denying, or reducing service decisions.
- Efforts to gather all necessary information, including relevant clinical data and consultations with the treating physician when appropriate.
- Clear documentation of the reasons for decisions, which are made available to the member.
- Well-publicized and easily accessible appeal mechanisms for both providers and service recipients, as well as notifications regarding any denials.
- Timely decisions and appeals in accordance with the urgency of the situation.
- Mechanisms for evaluating the program's effects using data on member and provider satisfaction, or other relevant measures.

To successfully achieve our objectives, the DWIHN Utilization Management (UM) department has meticulously crafted a comprehensive Utilization Management Program Description Plan targeting our provider network. This plan is designed to ensure that we meet all relevant compliance standards in the healthcare industry. Our approach includes several key activities aimed at identifying instances of underutilization in service delivery. These activities encompass the generation of various service utilization reports, which provide insights into how effectively services are being utilized by our members. We monitor performance measures that gauge the quality of care provided, and we require adherence to established clinical practice guidelines to ensure that care is both appropriate and effective. In addition to these measures, we conduct detailed profiling of both providers and members. This profiling helps us understand patterns of utilization and identify potential areas for improvement in care delivery. We also analyze appeals and grievances to gain insights into patient experiences and concerns.

The analysis of data related to both overutilization and underutilization is conducted on a regular schedule, as well as on an ad-hoc basis when necessary. We compile the findings from these analyses and present them annually to the UM Committee, which reviews the results comprehensively and decides on actionable steps to enhance service delivery. For more specific information about the processes and procedures that have been put into place as part of our UM efforts, we encourage you to consult the UM Program Description Plan, which provides in-depth details about our strategies and methodologies.

Clinical Practice Guidelines

DWIHN has developed its Clinical Practice Guidelines, basing them on a solid foundation of scientific evidence, established professional standards, and a consensus among board-certified healthcare professionals actively working in the field. These guidelines are crafted with particular care, ensuring they are evidence-based and, whenever possible, aligned with nationally recognized sources, such as leading medical organizations and professional associations. In the process of creating these clinical guidelines, DWIHN conducts comprehensive literature searches that systematically review existing practice guidelines from reputable national organizations and associations. This thorough approach ensures that the guidelines are not only grounded in the latest research but also reflect best practices identified by leaders in the field. After the initial draft of the Clinical Practice Guidelines is completed, DWIHN engages contracted providers—healthcare professionals who treat the relevant conditions—by sending them the drafts for review. This collaboration allows providers to contribute their insights and expertise, ensuring that the guidelines are practical and applicable in real-world clinical settings. These providers are given a period of 21 days to thoroughly review the draft and submit their feedback via the PolicyStat system. To maintain transparency and accountability, DWIHN keeps a detailed written record of all comments and feedback received during this peer review process. For any significant comments that require further discussion or consideration, the facilitator and co-facilitator will address these points during the Improving Practices Leadership Team (IPLT) meetings.

In cases where comments cannot be integrated, a thorough rationale will be provided to explain why those suggestions were not implemented. The IPLT plays a crucial role in this process, holding the ultimate responsibility for ensuring the effectiveness and reliability of evidence-based practices through the careful development or adoption of comprehensive clinical guidelines. This team is composed of subject matter experts drawn from both DWIHN's internal departments and external subspecialty populations, alongside individuals who have experienced relevant health conditions firsthand. By including diverse perspectives, the IPLT enriches the guidelines, making them more inclusive and practical for different patient populations. Members of the IPLT are actively invited to take part in the adoption of the Clinical Practice Guidelines, collaborating on their development and engaging in a constructive review process. Each clinical practice guideline undergoes a thorough presentation process before the IPLT for official approval. These guidelines are not static; they are reviewed and updated at least annually, or more frequently if there are significant changes in national guidelines that necessitate a prompt response. To communicate these vital Clinical Practice Guidelines to practitioners and stakeholders, DWIHN ensures that they are readily accessible by posting them on the DWIHN website as part of the comprehensive policy manual. This public access is further complemented by DWIHN's commitment to supporting its members in effectively managing their health conditions through various initiatives. The organization aims to make these practice guidelines not only accessible online but also integrated into specific quality improvement initiatives and activities, reinforcing their importance in promoting high-quality healthcare delivery.

Adequacy of Quality Improvement Resources

The Quality Improvement (QI) Unit is headed by a highly experienced Director of Quality Improvement, who plays a pivotal role in guiding the unit's initiatives and strategies. The Director is supported by a dedicated team that includes two full-time Quality Administrators, each responsible for various aspects of quality management and improvement processes. The QI Director collaborates extensively with the DWIHN Senior Leadership Team to ensure that quality improvement is aligned with organizational goals and priorities. This collaboration also extends to the Quality Improvement Steering Committee (QISC), which is responsible for steering quality-related initiatives and monitoring progress toward the establishment and achievement of specific quality improvement goals and objectives. In addition to the internal collaboration with leadership, the QI Unit works closely with DWIHN's Information Technology (IT) Unit, acknowledging the critical role that technology and data play in quality assurance and performance improvement. The IT Unit is instrumental in the Quality Assurance and Performance Improvement Program (QAPIP), as it undertakes a variety of essential functions, including the provision of both internal and external data analysis.

This analysis is crucial in assessing organizational performance and identifying areas for improvement. Moreover, the IT Unit supports business modeling and strategic planning by facilitating quality initiatives and optimizing general business operations. Their responsibilities include developing and maintaining robust databases that securely store vital information, offering expert consultations to various departments, and providing technical assistance to enhance the overall efficiency of QI activities. When guiding QAPIP projects, the IT Unit engages in complex data analyses. This includes performing statistical evaluations of outcomes data to determine the significance of changes over time, mining large and comprehensive data sets to extract valuable insights, and analyzing factors that contribute to performance outliers—instances where outcomes significantly deviate from expected performance benchmarks. Additionally, the IT Unit conducts correlation analyses to explore and understand the relationships between different variables that may impact quality. Based on the results generated through these analyses, the IT Unit produces detailed reports, summaries, and tailored recommendations. They also create visual representations of data that facilitate understanding and communication of key findings, all aimed at bolstering Quality Improvement activities. Finally, the following chart provides an overview of the internal staff members involved in the Quality Improvement Steering Committee (QISC), detailing their respective titles and the percentage of time they commit to quality improvement activities. This information highlights the structure and dedication of the team to the ongoing efforts in quality enhancement within the organization.

Title	Department	Percent of time per week devoted to QI
Chief Medical Officer	Administration	100%
Director of Quality Improvement	Quality Improvement	100%
Quality Improvement Administrator	Quality Improvement	100%
Director of Utilization Management	Utilization Management	50%
Clinical Officer	Clinical Practice Improvement	55%
Director of Customer Service	Customer Service	50%
Director of Integrated Health Care	Integrated Health Care	50%
Director of Managed Care Operations	Managed Care Operations	10%
Strategic Planning Manager	Compliance	10%
Information Technology	Information Technology	65%
Practitioner Participation	Provider Network	100%

Quality Improvement Evaluation

The Quality Improvement evaluation is a comprehensive assessment conducted annually at the conclusion of each fiscal year. This evaluation process is undertaken by the Detroit Wayne Integrated Health Network (DWIHN) and subsequently submitted to the Michigan Department of Health and Human Services (MDHHS). Once submitted, the evaluation is maintained on file along with the Quality Assurance and Performance Improvement Plan (QAPIP) description. These crucial documents are examined by both the Health Services Advisory Group (HSAG) and MDHHS as part of the broader certification process to ensure compliance with established health service standards. The evaluation provides a detailed summary of the goals and objectives outlined in DWIHN's Quality Improvement Work Plan. This Work Plan is a strategic document that delineates the specific quality improvement activities that DWIHN plans to implement in the upcoming year.

The formulation of the Work Plan is based on a thorough analysis of the strengths and weaknesses identified from the previous year's evaluation, as well as key issues that have been highlighted through the analysis of quality metrics. Furthermore, the Work Plan serves a dual purpose: it not only outlines quality improvement initiatives but also acts as a mechanism for monitoring and tracking these activities over time. The Work Plan is regularly updated to reflect changes and to assess the ongoing progress of the quality improvement initiatives in place. At its core, the foundation of the Work Plan addresses several critical focus areas established by the National Committee for Quality Assurance (NCQA), ensuring that DWIHN's efforts align with national standards for quality improvement in health services. This alignment underscores DWIHN's commitment to enhancing service delivery and outcomes for the populations it serves. The foundation of the Work Plan addresses the following NCQA focus areas:

- Quality and safety of clinical care
- Quality of service
- Member experience
- Yearly goals and objectives
- Planned activities
- Monitoring of previously identified issues
- Evaluation/outcomes
- Time frame for completing each activity
- Staff member responsible for each activity
- Evaluation of the Quality Improvement (QI) program

Each year, the Quality Improvement Work Plan undergoes a thorough review and approval process. This process is conducted by two key bodies: the Program Compliance Committee (PCC) and the Full Board of Directors. The PCC meticulously evaluates the plan to ensure it aligns with established standards and organizational goals, while the Full Board of Directors provides final approval, ensuring that all necessary resources and support are allocated for effective implementation. This annual review ensures that the Quality Improvement Work Plan remains relevant and effective in enhancing our programs and services.

Goals for Fiscal Year 2025

- Maintain the National Committee for Quality Assurance (NCQA) Re-accreditation. Ensure that all standards set by NCQA are met consistently to retain accreditation status, demonstrating commitment to high-quality care.
- Pursue Certified Community Behavioral Health Clinic (CCBHC) Certification. Actively work towards achieving certification as a CCBHC, enhancing service capacity and access to comprehensive mental health and substance use services.
- Enhance Children's Services. Focus on expanding and improving specialized services for children, especially through programs like the Mobile Crisis Response for Children and Intensive Crisis Stabilization, ensuring timely and effective interventions.
- Improve Healthcare Services. Continuously strive to elevate the quality, appropriateness, availability, accessibility, coordination, and continuity of healthcare services for all members across the entire care spectrum, tailoring services to meet individual needs.
- Implement Home and Community-Based Services. Progress with the implementation and transition of Home and Community-Based Services (HCBS), ensuring that these services are fully integrated within the community healthcare network for better support of members.
- Maintain Enrollment Standards. Consistently achieve and uphold an enrollment rate of 95% or higher for Health and Behavioral (HAB) waiver slots, as mandated by MDHHS, ensuring that more individuals receive necessary services.
- Timely Access to Services. Guarantee that all members receive prompt access to a comprehensive range of behavioral health services, reducing wait times and barriers to care.
- Enhance Member and Provider Satisfaction. Actively work on initiatives that improve satisfaction levels for both members and healthcare providers, addressing feedback and making necessary adjustments to services and policies.
- Build a High-Quality Network. Ensure the network is comprised of high-quality, well-trained professionals by implementing rigorous credentialing, peer review, and contracting processes that uphold best practices in care delivery.
- Collaborative Care Coordination. Foster collaboration with healthcare providers to share insights, best practices, and jointly develop strategies that enhance care coordination, and the overall quality of services provided to members.
- Cultural Change to Reduce Suicide Rates. Lead and implement a comprehensive cultural change initiative across the organization aimed at significantly reducing suicide rates, prioritizing mental health awareness and prevention strategies.
- Enhance Member Outcomes. Continuously monitor and improve member outcomes, targeting satisfaction and safety as key metrics, and utilizing data to inform decisions and strategies.
- Compliance with Regulatory Standards. Maintain outstanding compliance with all state and federal regulatory requirements, as well as adhere to accreditation standards to uphold integrity and trustworthiness within the organization.
- Promote Cultural Competency and Diversity. Ensure that DWIHN’s initiatives around cultural competency and diversity are effectively designed and executed to meet the diverse needs of its member population.
- Provider Performance Training and Monitoring. Continue to fulfill the regional role in statewide training and the ongoing monitoring of provider performance in reciprocity activities to ensure consistency and quality across services.
- Community Outreach for Families. Engage in dedicated outreach activities focused on children and families, such as attending community events, school visits, and partnerships with child service providers to raise mental health awareness, share information, and improve access to needed services.

- Improved Performance Metrics Development. Collaborate with DWIHN to develop and implement enhanced performance metrics for services and supports related to MDHHS incentive payments, focusing on areas such as post-hospitalization follow-up for mental health, follow-up care for substance use disorders after emergency room visits, and initiatives addressing health disparities among various populations, including veterans.
- Commitment to Clinical Safety. Actively demonstrate and communicate DWIHN's commitment to enhancing safe clinical practices across the network, ensuring that all members receive care in a secure and supportive environment.
- Naloxone Training Expansion. Continue to boost training efforts among healthcare providers, jail staff, drug court staff, community organizations, and regional members on the effective use of Naloxone for reversing opioid overdoses, aiming to equip community members with the necessary skills to respond to overdose situations.

Appendix 1

SENTINEL EVENT COMMITTEE/ PEER REVIEW COMMITTEE PROCESS

The Quality Performance Improvement Team is comprised of licensed a social worker, counselor, registered nurses, and a psychologist. Daily this time is reviewing all events entered into MH-WIN by ALL contracted providers in the DWIHN network. These reviews look at all documents for the member including but not limited to: IPOS, Crisis Plans, Behavior Tx Plans, Progress Notes, Urgent Care Documents, Recipient Rights Reports, Police/Fire/EMS Reports (as available) and CPS/APS reports.

PROCESS – PAGE 2

The review process: QPIT Review → Missing Information notification to CRSP Provider to upload within deadline → Final review of QPIT (possible closure at this point for health-related events) → SEC/PRC Review (Sentinel/Risk Events) recommendations for remediation by case and within system, systemic impact identified, trends, recommended training topics, etc.

QAPIP Work Plan
FY 2024- 2025 (October 1, 2024 through September 30, 2025)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
Customer Pillar							
Goal I (Members Experience and Quality of Service)	**Improve Members Experience with Services**						
I.1	ECHO Annual Satisfaction Surveys (Adult and Children)	Director of Customer Service	The results of the 2023 ECHO® Survey (Children and Adult) will be collected, reviewed, analyzed and reported by April of 2024.	The goal is to enhance various aspects of health care, including the treatment of care issues, access to care, timeliness and appropriateness of care, members perceptions. We aim to improve health outcomes, cultural competency in care, and address the nuances of the relationship between the members and practitioners for both children and adults.	Previously identified issues; Data was unavailable for review and analysis during FY2024. This goal will be continue in FY2025.		Submit quarterly reports to the PCC regarding reporting measures. The Annual Evaluation Report for FY-2024 will be presented to the QISC and PCC in the third quarter of FY-2024.

QAPIP Work Plan
FY 2024- 2025 (October 1, 2024 through September 30, 2025)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
I.2	Provider and Practitioner Satisfaction Survey	Director of Strategic Operations, Director of Managed Care Operations (MCO)	In the fourth quarter FY 2024, we will collect, review and analyzed the results to compare FY2023 and FY2024. Additionally, the results of the 2024 Practitioner Satisfaction Survey will be compiled, reviewed, analyzed, and reported by November 2024. Our goal is to increase the response rates for both Provider and Practitioner surveys by 5% or more.	The goal is to increase survey Reponses from Providers and Practitioners by 5% or more.	Issues previously identified include modifications to Provider Satisfaction survey questions in FY2022. Baseline data was collected during FY2023, the provider response rate (38.8%) and practitioner (21.8%). In FY2024, provider rate (26.1%) and the practitioner rate (26.5%). Provider response decreased in FY2024 and Practitioner response rate increased in FY2024. This goal will be continue in FY2025.		Submit quarterly reports to the PCC regarding reporting measures. The Annual Evaluation Report for FY-2024 will be presented to the QISC and PCC in the first quarter of FY-2025.

QAPIP Work Plan
FY 2024- 2025 (October 1, 2024 through September 30, 2025)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
I.3	Grievance/Appeals	Director of Customer Service	Results for FY 2023-2024 (October 1, 2023 through September 30, 2024) will be collected, reviewed, analyzed and reported by Q2 of January 2025.	The objective is to enhance outcomes by addressing grievances and appeals promptly.	There were no previously identified issues during FY2023. This goal will be continue in FY2025.		Submit quarterly reports to the PCC regarding reporting measures. The Annual Evaluation Report for FY-2024 will be presented to the QISC and PCC in the first quarter of FY-2025.

QAPIP Work Plan
FY 2024- 2025 (October 1, 2024 through September 30, 2025)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
I.4	Timeliness of Utilization Management Decisions	Director of Utilization Management	Data reporting for FY 2023-2024 will take place quarterly from October 1, 2023 through September 30, 2024. The collected data will be reviewed and analyzed.	The goal is to meet or exceed performance standards for non-urgent request decisions within seven (7) calendar days.	There were no previously identified issues during FY2023. The new goal is to meet or exceed performance standards for non-urgent request decisions within seven (7) calendar days for FY2025.This goal will be continue in FY2025.		Submit quarterly reports to the PCC regarding reporting measures. The Annual Evaluation Report for FY-2024 will be presented to the QISC and PCC in the first quarter of FY-2025.
I.5	Practice Guidelines	Chief Medical Officer	FY 2023-2024 (October 1, 2023 through September 30, 2024). Guidelines are reviewed and distributed throughout the provider network at least once every two years.	The goal is to ensure guidelines are reviewed every two years and shared with the provider network for feedback through reports, clinical record reviews, and/or process indicators.	There were no previously identified issues during FY2023. This goal will be continue in FY2025.		Submit quarterly reports to the PCC regarding reporting measures. The Annual Evaluation Report for FY2024 will be presented to the QISC and PCC in the first quarter of FY-2025.

QAPIP Work Plan
FY 2024- 2025 (October 1, 2024 through September 30, 2025)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
I.6	Cultural and Linguistic Needs	Director of Customer Service, Director of Managed Care Operations, Director of Quality Improvement Diversity, Equity & Inclusion Administrator	FY 2023-2024 (October 1, 2023 through September 30, 2024). Data will be collected and reviewed on a quarterly basis.	The goal is to improve outcomes through cultural competency, language, and physical accessibility by identifying existing racial and ethnic disparities within our provider network across all populations.	There were no previously identified issues during FY2023. This goal will be continue in FY2025.		Submit quarterly reports to the PCC regarding reporting measures. The Annual Evaluation Report for FY-2024 will be presented to the QISC and PCC in the first quarter of FY-2025.
Access Pillar							
Goal II (Quality of Service and Quality of Clinical Care)	**Improve members Access to Services, Quality of Clinical Care, and Health and Safety**						
	Michigan Mission Based Performance Indicators (MMBPI)						
II.1	Indicator 1(a) and 1(b) - Percentage of pre-admission screenings for psychiatric inpatient care (Children and Adults) for whom disposition was completed within three hours.	Director of Quality Improvement	FY 2023-2024 (October 1, 2023 through September 30, 2024). Data reporting is collected, reviewed and analyzed quarterly.	The goal is to meet or exceed performance standard of 95% or higher.	There were no previously identified issues during FY2024. This goal will be continue in FY2025.		Submit quarterly reports to the PCC regarding reporting measures. The Annual Evaluation Report for FY2024 will be presented to the QISC and PCC in the first quarter of FY-2025.

QAPIP Work Plan

FY 2024- 2025 (October 1, 2024 through September 30, 2025)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
II.2	Indicator 2(a) and 2(b) - Percentage of persons (Children and Adults) receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.	Director of Quality Improvement	FY 2023-2024 (October 1, 2023 through September 30, 2024). Data reporting is collected, reviewed and analyzed quarterly.	The goal is to meet or exceed performance standard of 57% or higher.	There were no previously identified issues during FY2024. This goal will be continue in FY2025.		Submit quarterly reports to the PCC regarding reporting measures. The Annual Evaluation Report for FY2024 will be presented to the QISC and PCC in the first quarter of FY-2025.
II.3	Indicator 3(a) and 3(b) - Percentage of persons (Children and Adults) needed on-going service within 14 days of a non-emergent assessment with a professional.	Director of Quality Improvement	FY 2023-2024 (October 1, 2023 through September 30, 2024). Data reporting is collected, reviewed and analyzed quarterly.	The goal is to meet or exceed performance standard of 83% or higher.	There were no previously identified issues during FY2024. This goal will be continue in FY2025.		Submit quarterly reports to the PCC regarding reporting measures. The Annual Evaluation Report for FY-2024 will be presented to the QISC and PCC in the first quarter of FY-2025.
II.4	Indicator 4a(1) and 4a(2) - Percentage of discharges from a psychiatric inpatient unit (Children and Adults) who are seen for follow up care within 7 days.	Director of Quality Improvement	FY 2023-2024 (October 1, 2023 through September 30, 2024). Data reporting is collected, reviewed and analyzed quarterly.	The goal is to meet or exceed performance standard of 95% or higher.	There were no previously identified issues during FY2024. This goal will be continue in FY2025.		Submit quarterly reports to the PCC regarding reporting measures. The Annual Evaluation Report for FY-2024 will be presented to the QISC and PCC in the first quarter of FY-2025.

QAPIP Work Plan
FY 2024- 2025 (October 1, 2024 through September 30, 2025)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
II.5	Indicator 4b - Percentage of discharges from a Substance Abuse Detox Unit who are seen for follow-up care within 7 days.	Director of Quality Improvement	FY 2023-2024 (October 1, 2023 through September 30, 2024). Data reporting is collected, reviewed and analyzed quarterly.	The goal is to meet or exceed performance standard of 95% or higher.	There were no previously identified issues during FY2024. This goal will be continue in FY2025.		Submit quarterly reports to the PCC regarding reporting measures. The Annual Evaluation Report for FY-2024 will be presented to the QISC and PCC in the first quarter of FY-2025.
II.6	Indicator 10 (a) and 10 (b) - Percentage of readmissions (Children and Adults) to inpatient psychiatric unit within 30 days of discharge.	Director of Quality Improvement	FY 2023-2024 (October 1, 2023 through September 30, 2024). Data reporting is collected, reviewed and analyzed quarterly.	The goal is to meet performance standard of 15% or less.	Previously identified issues resulted in failure to meet the goal. This goal will be continue in FY2025.		Submit quarterly reports to the PCC regarding reporting measures. The Annual Evaluation Report for FY-2024 will be presented to the QISC and PCC in the first quarter of FY-2025.
II.7	Complex Case Management	Director of Integrated Health Care	Results for FY 2023-2024 (October 1, 2023 through September 30, 2024) will be collected, reviewed, analyzed and reported by first quarter of FY2024.	The goal is to improve medical and behavioral health concerns and increase overall functional status by 20% as measured by PHQ and WHO-DAS scores.	There were no previously identified issues during FY2023. This goal will be continue in FY2025.		Submit quarterly reports to the PCC regarding reporting measures. The Annual Evaluation Report for FY-2024 will be presented to the QISC and PCC in the first quarter of FY-2025.

QAPIP Work Plan
FY 2024- 2025 (October 1, 2024 through September 30, 2025)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
II.8	Crisis Intervention Services	Director of Utilization Management, Director of Crisis Services	FY 2022-2023 (October 1, 2022 through September 30, 2023). Data reporting is collected, reviewed and analyzed quarterly.	The goal is to reduce the rates of re-hospitalization within 30 days of discharge to 15% or less for adults.	Previously identified issues. Targeted goal for in the Recidivism in the adult population were not met for three out of four quarters. This goal will be continue in FY2025.		Submit quarterly reports to the PCC regarding reporting measures. The Annual Evaluation Report for FY-2024 will be presented to the QISC and PCC in the first quarter of FY-2025.
Workforce Pillar							
Goal III. (Quality of Service)	**Develop and maintain a Competent Workforce through the Credentialing and Re-Credentialing Process**						

QAPIP Work Plan
FY 2024- 2025 (October 1, 2024 through September 30, 2025)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
III.1	Maintain Competent Workforce	Director of Innovation and Community Engagement, Provider Network Administrator Credentialing, Director of Quality Improvement, Director of Clinical Practices Improvement, Director of Managed Care Operations	FY 2023-2024 (October 1, 2023 through September 30, 2024). Data reporting is collected, reviewed and analyzed quarterly.	The goal is to establish a skilled workforce by conducting performance reviews that assess the job performance and competencies.	There were no previously identified issues during FY2023. This goal will be continue in FY2025.		Submit quarterly reports to the PCC regarding reporting measures. The Annual Evaluation Report for FY-2023 will be presented to the QISC and PCC in the first quarter of FY-2025.
Finance Pillar							
Goal IV (Quality of Service)	**Maximize Efficiencies and Control Costs**						
IV.1	Verification of Services	Director of Quality Improvement, Corporate Compliance Officer	FY 2023-2024 (October 1, 2023 through September 30, 2024). Data reporting will be collected, reviewed and analyzed bi-quarterly; the first and second quarters (October 1, 2023 - March 31, 2024) and the third and fourth quarters (April 1, 2024 - September 30, 2024).	The objective is to review all randomly selected Paid Encounters/Claims to eliminate fraud, waste and abuse within the provider network.	There were no previously identified issues during FY2023. This goal will be continue in FY2025.		Submit quarterly reports to the PCC regarding reporting measures. The Annual Evaluation Report for FY-2024 will be presented to the QISC and PCC in the first quarter of FY-2025.
Quality Pillar							
Goal V (Safety of Clinical Care)	**Improve Quality Performance, Member Safety and Member Rights system-wide**						

QAPIP Work Plan
FY 2024- 2025 (October 1, 2024 through September 30, 2025)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V.1	Provider Network Performance Monitoring - Clinically Responsible Service Provider (CRSP)	Director of Quality Improvement	FY 2023-2024 (October 1, 2023 through September 30, 2024). Data reporting will be collected, reviewed and analyzed quarterly.	The goal is to increase provider reviews from FY2023 by at least 15% to ensure Continuous Quality Improvement.	There were no previously identified issues during FY2023. This goal will be continue in FY2025.		Submit quarterly reports to the PCC regarding reporting measures. The Annual Evaluation Report for FY-2024 will be presented to the QISC and PCC in the first quarter of FY-2025.
V.2	Residential Treatment Providers	Director of Quality Improvement	FY 2023-2024 (October 1, 2023 through September 30, 2024). Data reporting will be collected, reviewed and analyzed quarterly.	The goal is to increase Residential provider reviews from FY2023 by 5% to ensure Continuous Quality Improvement.	There were no previously identified issues during FY2023. This goal will be continue in FY2025.		Submit quarterly reports to the PCC regarding reporting measures. The Annual Evaluation Report for FY-2024 will be presented to the QISC and PCC in the first quarter of FY-2025.
V.4	Provider Network Self Monitoring (Inter-Rater Reliability)	Director of Quality Improvement	FY 2023-2024(October 1, 2023 through September 30, 2024). Data reporting will be collected, reviewed and analyzed quarterly.	The goal is to increase provider's participation in self monitoring reviews from the pervious year by 15% or more to ensure inter rater reliability.	There were no previously identified issues during FY2023. This goal will be continue in FY2025.		Submit quarterly reports to the PCC regarding reporting measures. The Annual Evaluation Report for FY-2024 will be presented to the QISC and PCC in the first quarter of FY-2025.
V.5	Autism Services	Director of Quality Improvement, Director of Children's Initiatives	FY 2023-2024 (October 1, 2023 through September 30, 2024). Data reporting will be collected, reviewed and analyzed quarterly.	The goal is to complete 100% of the reviews for the autism providers.	There were no previously identified issues during FY2023. This goal will be continue in FY2025.		Submit quarterly reports to the PCC regarding reporting measures. The Annual Evaluation Report for FY-2024 will be presented to the QISC and PCC in the first quarter of FY-2025.

QAPIP Work Plan
FY 2024- 2025 (October 1, 2024 through September 30, 2025)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V.6	Critical/Sentinel/Unexpected Death and Risk Reporting	Director of Quality Improvement	FY 2023-2024 (October 1, 2023 through September 30, 2024). Data reporting will be collected, reviewed and analyzed quarterly.	The goal is comply with MDHHS reporting requirements and ensure the safety of clinical care for members.	There were no previously identified issues during FY2023. This goal will be continue in FY2025.		Submit quarterly reports to the PCC regarding reporting measures. The Annual Evaluation Report for FY-2024 will be presented to the QISC and PCC in the first quarter of FY-2025.
V.7	Behavior Treatment Review	Director of Quality Improvement, Chief Medical Officer	FY 2023-2024 (October 1, 2023 through September 30, 2024). Data reporting will be collected, reviewed and analyzed quarterly.	The goal is to meet the BTPRCs technical requirements established by MDHHS through reviews of randomly selected cases., maintaining a threshold 95% or above.	There were no previously identified issues during FY2023. This goal will be continue in FY2025.		Submit quarterly reports to PCC on reporting measures. The Annual Evaluation Report for FY-2024 will be presented to QISC and PCC in Quarter 1 of FY-2025.
(Quality of Clinical Care)	**Quality Improvement Projects (QIP's)**						
V.8a	Improving the availability of a follow up appointment with a Mental Health Professional with-in 7 days after Hospitalization for Mental Illness.	Director of Integrated Health Care Director of Quality Improvement	Annual 2024(January 1, 2024 through December 31, 2024). Data reporting will be collected, reviewed and analyzed quarterly. Annual 2024 data will not be available until April 2025.	The goal is to meet the MDHHS comparison benchmark for children (79%); Adults (58%) by 2024.	Previously identified issues resulted in unmet targeted goals for Adults (18-64) 31.55%; Adults (65 older) 20.91% and Children (6-17) 43.17% . This goal will continue to be addressed in FY2025.		Continue to collect and analyze data, and provide report to QISC and PCC at least once a quarter in 2024 regarding the reporting measure. The Annual Evaluation Report for 2024 will be presented to QISC and PCC in the first quarter of 2025.

QAPIP Work Plan
FY 2024- 2025 (October 1, 2024 through September 30, 2025)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V.8b	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Director of Integrated Health Care Director of Quality Improvement	Annual 2024 (January 1-December 31, 2024) Data reporting will be collected, reviewed and analyzed quarterly. Annual 2024 data will not be available until April 2025.	The goal is to meet the comparison benchmark of Quality Compass 66.28%	Previously identified issues resulted in unmet targeted goal for FY2024 (47.99%). This goal will continue to be addressed in FY2025.		Continue to collect and analyze data, and provide report to QISC and PCC at least once a quarter in 2024 regarding the reporting measure. The Annual Evaluation Report for 2024 will be presented to QISC and PCC in the first quarter of 2025.
V.8c	Antidepressant Medication Management for People with a New Episode of Major Depression 2 measurements, chronic and acute	Director of Integrated Health Care, Director of Quality Improvement	Annual 2024 (January 1, 2024 through December 31, 2024). Data reporting will be collected, reviewed and analyzed quarterly. FY2024 data will not be available until April 2025.	The goal is to meet the comparison benchmark to Quality Compass Chronic (50.71%); Acute (66.93%)	Previously identified issues resulted in unmet targeted goal for year 2024 Acute (39.89%); Chronic (16.76%) This goal will continue to be addressed in FY2025.		Continue to collect and analyze data, and provide report to QISC and PCC at least once a quarter in 2024 regarding reporting measure. The Annual Evaluation Report for 2024 will be presented to QISC and PCC in the first quarter of 2025.

QAPIP Work Plan
FY 2024- 2025 (October 1, 2024 through September 30, 2025)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V.8d	Improving Diabetes Monitoring for People with Schizophrenia and Bipolar Disorder	Director of Integrated Health Care, Director of Quality Improvement	Annual 2024 (January 1, 2024 through December 31, 2024). Data reporting will be collected, reviewed and analyzed quarterly. Year 2024 data will not be available until April 2025.	The goal is to meet the comparison benchmark to Quality Compass 80.99%	Previously identified issues resulted in unmet targeted goal for year 2024 (68.47%). This goal will continue to be addressed in FY2025.		Continue to collect and analyze data, and provide report to QISC and PCC at least once a quarter in 2024 regarding the reporting measure. The Annual Evaluation Report for 2024 will be presented to QISC and PCC in the first quarter of year 2025.
V.8e	Reducing Risk of Hepatitis, C in SUD Members	Director of Integrated Health Care, Director of Quality Improvement	FY 2023-2024 (October 1, 2023 through September 30, 2024). Data reporting will be collected, reviewed and analyzed quarterly.	The goal is to meet the comparison benchmark to MDHHS of 5%.	The previous issue identified and assessed. We will established a new goal for FY2024 to ensure better performance. This goal will continue to be addressed in FY2025.		Continue to collect and analyze data, and provide report to QISC and PCC at least once a quarter in 2023 regarding the reporting measure. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in the second quarter of FY-2024.

QAPIP Work Plan
FY 2024- 2025 (October 1, 2024 through September 30, 2025)

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V.8f	Wellness/My Strength	Director of Adult Initiatives	FY 2024-2025 (October 1, 2024 through September 30, 2025). Data reporting will be collected, reviewed and analyzed quarterly.	The goal is to meet the comparison benchmark of 75.0% or higher.	Previously identified issues; Data was unavailable for review and analysis during FY2024. This goal will continue to be addressed in FY2025.		Continue to collect and analyze data, and provide report to QISC and PCC at least once a quarter in 2023 regarding the reporting measure. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in the second quarter of FY-2024.
V. 8g	Reducing the Call Abandonment Rate	Director of Call Center	FY 2023-2024 (October 1, 2023 through September 30, 2024). Data reporting will be collected, reviewed and analyzed quarterly.	The goal is to meet the comparison benchmark of 5% or less.	No previous identified issue. This goal will continue to be addressed in FY2025.		Continue to collect and analyze data, and provide report to QISC and PCC at least once a quarter in 2023 regarding the reporting measure. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in the second quarter of FY-2024.

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V. 8h	Children's Metabolic Screening for Children on Antipsychotics. (APM)	Director of Children's Initiative	FY 2023-2024 (October 1, 2023 through September 30, 2024). Data reporting will be collected, reviewed and analyzed quarterly.	The goal is to meet the comparison benchmark of 38.0% or higher.	No previous identified issue. During rating period 1/1/2023 - 12/31/2023 Measurement 1 goal was 23.36% that was not met and Measurement 2 goal was 32.7% that was not met. During rating period 1/1/2024 - 1/31/2024 the goal for Measurement 1 remained as 23.36% in which goal was not met and Measurement 2 goal also remained at 32.7% as well that was not met. This goal will continue to be addressed in FY2025.		Continue to collect and analyze data, and provide report to QISC and PCC at least once a quarter in 2023 regarding the reporting measure. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in the second quarter of FY-2024.

QAPIP Work Plan
FY 2024- 2025 (October 1, 2024 through September 30, 2025)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V. 8i	Follow up for Children on ADHD medication.	Director of Children's Initiative	FY 2023-2024 (October 1, 2023 through September 30, 2024). Data reporting will be collected, reviewed and analyzed quarterly.	The goal is to meet the comparison benchmark of 50% or higher.	No previous identified issue. New goal for FY2024. During rating period 3/1/23 - 2/28/24: Measurement 1 new goal was 58.95% that was met and Measurement 2 new goal was 70.25% which was not met. During rating period of 3/1/24 - 2/28/25 Measurement 1 new goal is 64% that was not met and Measurement 2 new goal is 76% that was not met. This goal will continue to be addressed in FY2025.		Continue to collect and analyze data, and provide report to QISC and PCC at least once a quarter in 2023 regarding the reporting measure. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in the second quarter of FY-2024.

QAPIP Work Plan
FY 2024- 2025 (October 1, 2024 through September 30, 2025)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V. 8j	Reducing racial and ethnic disparity with African Americans for the percentage of discharges from a psychiatric inpatient unit that were seen for follow-up care within 7 days.	Director Of Quality Improvement	FY 2023-2024 (October 1, 2023 through September 30, 2024). Data reporting will be collected, reviewed and analyzed quarterly.	The goal is to meet the comparison benchmark of 40% or higher.	No previous identified issue. This goal will continue to be addressed in FY2025.		Continue to collect and analyze data, and provide report to QISC and PCC at least once a quarter in 2023 regarding the reporting measure. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in the second of FY-2024.
V.8l	PHQ-9 Implementation	Director of Clinical Practice Improvement	FY 2023-2024 (October 1, 2022 through September 30, 2023). Data reporting will be collected, reviewed and analyzed quarterly.	The goal is 95% or higher.	No previously identified issue. Targeted goal met FY22 (99.1%). This goal will continue to be addressed in FY2025.		Continue to collect and analyze data, and provide report to QISC and PCC at least once a quarter in 2023 regarding the reporting measure. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in the second quarter of FY-2024.

QAPIP Work Plan
FY 2024- 2025 (October 1, 2024 through September 30, 2025)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V.8m	PHQ-A Implementation	Director of Children's Initiative	FY 2023-2024 (October 1, 2022 through September 30, 2023). Data reporting will be collected, reviewed and analyzed quarterly.	The goal is 100%	No previously identified issue. Targeted goal not met FY23 (99.2%). This goal will be continued. During rating period 10/1/2023 - 9/30/2024 Measurement 1 goal remained at 100% (Not met) and Measurement 2 goal was 95% (Not met).This goal will continue to be addressed in FY2025.		Continue to collect and analyze data, and provide report to QISC and PCC at least once a quarter in 2024 regarding the reporting measure. The Annual Evaluation Report for FY-2024 will be presented to QISC and PCC in the second quarter of FY-2024.

QAPIP Work Plan
FY 2024- 2025 (October 1, 2024 through September 30, 2025)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V.8n	Decreasing Wait for Autism Services	Director of Children's initiative	FY 2023-2024 (October 1, 2023 through September 30, 2024). Data reporting will be collected, reviewed and analyzed quarterly.	The goal is 100%	Previously identified issue. Targeted goal not met (67.5%). This goal will be continued. During December 2023 the goal changed to 70%; in which goal was met for 10/1/23 - 12/31/24 rating period. This goal will continue to be addressed in FY2025.		Continue to collect and analyze data, and provide report to QISC and PCC at least once a quarter in 2023 regarding the reporting measure. The Annual Evaluation Report for FY-2023 will be presented to QISC and PCC in the second quarter of FY-2024.
	Advocacy Pillar						
Goal VI.	**Increase Community Inclusion and Integration**						
VI.1	Home and Community Based Services (HCBS)	Director of Quality Improvement	FY 2023-2024 (October 1, 2023 through September 30, 2024). Data reporting will be collated, reviewed and analyzed quarterly.	The goal is to have a provider network that is fully compliant with Home and Community Based Services (HCBS).	Previously identified issue. Targeted goal not met for FY23. This goal will be continue in FY2025.		Submit quarterly reports to PCC regarding reporting measures. The Annual Evaluation Report for FY-2024 will be presented to the QISC and PCC in the second quarter of FY-2024.
Goal VII (Quality of Service)	**External Quality Reviews**						

QAPIP Work Plan

FY 2024- 2025 (October 1, 2024 through September 30, 2025)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
VII.1	MDHHS Annual 1915 © Waiver Review	Director of Quality Improvement, Director of Managed Care Operations, Director of Customer Service, Director of Recipient Rights , Deputy Chief Financial Officer, Director of Workforce, Provider Network Administrator Credentialing, Director of Integrated Health Care, Director of Human Resources	FY 2023-2024 (October 1, 2023 through September 30, 2024). Data reporting will be collected, reviewed and analyzed quarterly.	The objective is to achieve a compliance review score of 95% or higher for the waiver.	There were no previously identified issues during FY2023. DWIHN was not reviewed by MDHHS in FY2023.This goal will be continue in FY2025.		Submit quarterly reports to the PCC regarding the reporting measures. The Annual Evaluation Report for FY-2024 will be presented to the QISC and PCC in the third quarter of FY-2024.

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FY 2024- 2025 (October 1, 2024 through September 30, 2025)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
VII.2	NCQA Accreditation	Director of Quality Improvement, Director of Managed Care Operations, Director of Customer Service, Director of Recipient Rights , Deputy Chief Financial Officer, Director of Workforce, Provider Network Administrator Credentialing, Director of Integrated Health Care, Director of Human Resources	January 1, 2022-January 1, 2024. Data reporting will be collected, reviewed and analyzed during the required look back period.	The goal is to maintain recertification status in FY2024.	There were no previously identified issues during FY2024. This goal will be continue in FY2025.		Submit quarterly reports to the PCC regarding the recertification process. DWIHN will be revaluated for re-certification in January 2027.

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QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
VII.3	Health Services Advisory Group (HSAG)-Validation of Performance Projects (PIP)	Director of Quality Improvement	FY 2023-2024 (October 1, 2023 through September 30, 2024). Data reporting will be collected, reviewed and analyzed during the required look back period.	The goal is to evaluate whether DWIHN's new Performance Improvement Plan (PIP) effectively reduces racial and ethnic disparities among African Americans in the percentage of discharges from a psychiatric inpatient unit who receive follow-up care within seven days. This evaluation will focus on the soundness of the methodology used in its design, implementation sed a sound methodology in the design, implementation, analysis, and reporting.	There were no previously identified issues, Targeted goal met during FY23. DWIHN received 100% compliance for barriers, interventions and for the data analysis for submission requirements. This goal will be continue in FY2025.		Submit quarterly reports to the PCC regarding performance outcomes. The Annual Evaluation Report for FY-2024 will be presented to the QISC and PCC in the third quarter of FY-2025.

QAPIP Work Plan

FY 2024- 2025 (October 1, 2024 through September 30, 2025)

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
VII.3a	Health Services Advisory Group (HSAG)- Compliance Review	Director of Quality Improvement, Director of Managed Care Operations, Director of Customer Service, Director of Recipient Rights , Deputy Chief Financial Officer, Director of Workforce, Provider Network Administrator Credentialing, Director of Integrated Health Care, Director of Human Resources	FY 2023-2024 (October 1, 2023 through September 30, 2025). Data reporting will be collected, reviewed and analyzed during the required look back period.	The goal is to complete action plans of action from (Year 1) and (Year 2) to address each deficiency noted during the Compliance Review in (Year 3) of August 2024.	There were no previously identified issues. Targeted goal met during FY2024. This goal will be continue into FY2025.		Submit quarterly reports to the PCC regarding performance outcomes. The Annual Evaluation Report for FY-2024 will be presented to the QISC and PCC in the fourth quarter of FY-2025.

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FY 2024- 2025 (October 1, 2024 through September 30, 2025)

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	Health Services Advisory Group (HSAG)-Validation of Performance Projects (PIP)	Director of Quality Improvement, IT Administrator, Claims Administrator	FY 2023-2024 (October 1, 2022 through September 30, 2023). Data reporting will be collected, reviewed and analyzed during the required look back period.	The goal is to achieve 95% or higher.	There were no previously identified issues during FY2024. This goal will be continue in FY2025.		Submit quarterly reports to the PCC regarding the performance outcomes. The Annual Evaluation Report for FY-2024 will be presented to the QISC and PCC in the second quarter of FY-2025.

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QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
VII.4	Annual Needs Assessment	Director of Quality Improvement, Director of Managed Care Operations, Director of Customer Service, Director of Recipient Rights , Deputy Chief Financial Officer, Director of Workforce, Provider Network Administrator Credentialing, Director of Integrated Health Care, Director of Human Resources	FY 2023-2024 (October 1, 2023 through September 30, 2024). Data reporting will be collected, reviewed and analyzed during the required look back period.	The goal is to prioritize and implement planned actions as identified by our stakeholders, members and the provider network.	There were no previously identified issues, Targeted goal met during FY2023.This goal will be continue in FY2025.		Submit quarterly reports to the PCC regarding performance outcomes. The Annual Evaluation Report for FY-2024 will be presented to the QISC and PCC in second of FY-2025.
QAPIP Goals/Pillars	**Yearly Planned QI Activities/Objectives Measure of Service**	**Staff Members Responsible for each Activity**	**Time frame for Each Activity's Completion**	**Monitoring of Previously Identified Issues**	**Previously Identified Issues Requiring Follow-up**	**Evaluation of QI Program**	**Oversight of QI Activities by Committee**

QAPIP Work Plan

FY 2024- 2025 (October 1, 2024 through September 30, 2025)

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VII. 5	The QAPIP Plan Description is a comprehensive two-year strategy that outlines DWIHN objectives and initiatives from FY2023 to 2025. This written plan aligns with MDHHS contract requirements, NCQA standards, and complies with 42 CFR federal regulations.	Director of Quality Improvement	QAPIP Plan Description for FY2023-2025;To maintain regulatory compliance and ensure the plan remains relevant, DWIHN bylaws require a thorough annual review of the plan.	No previous issues were identified in FY2023, and during the review in 2024, no issues were found.	There have been no previous issues requiring follow-up in 2023 and 2024.		Present the QAPIP description to the QISC, PCC, and Full Board in the first quarter of FY2025.
VII. 6	The QAPIP Evaluation is a comprehensive annual report that is prepared and finalized at the conclusion of each fiscal year. This evaluation assesses the effectiveness of the Quality Assurance Performance Improvement Plan (QAPIP) and provides insights into the progress made over the year. It includes detailed analyses of performance metrics, outcomes, and areas for improvement, helping to inform future strategies and ensure continuous quality enhancement within the organization.	Director of Quality Improvement	Annual (FY2023). This will continue in FY2024.	The goal is to comprehensively assess the performance metrics and outcomes of the preceding year.	Previous issues identified during FY2022: Not all QI goals were achieved during FY2023 and FY2024.		Present the QAPIP description to the QISC, PCC, and Full Board in the first quarter of FY2025.

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VII. 7	QAPIP Work Plan; The QI workplan is created after reviewing the previous year's work plan. It is continuously evaluated and updated to reflect the status of the QI goals.	Director of Quality Improvement	The QAPIP Work Plan will be created annually to outline specific goals and objectives for the upcoming year. This work plan will detail strategies that ensure the organization consistently improves its quality of care and operational efficiency.	The objective is to ensure the work plan includes all MDHHS and NCQA requirements. Annual results will be shared with stakeholders and members.	Previous issues identified during FY2023. Goal completion rate for FY2024 was ??% Threshold is 95% or higher.		Present the QAPIP description to the QISC, PCC, and Full Board in the first quarter of FY2025.
END							