# Detroit Wayne Integrated Health Network (DWIHN)
# Quality Assurance Performance Improvement Plan (QAPIP)
## Evaluation of Fiscal Year 2024 and Work Plan

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**Approved:**

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| **Approved by Quality Improvement Steering Committee (QISC)** | **1/28/2025** |
| **Approved by Program Compliance Committee (PCC)** | **2/12/2025** |
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**Executive Summary**

The Detroit Wayne Integrated Health Network (DWIHN) plays a crucial role in providing mental health services as both the Pre-Paid Inpatient Health Plan (PIHP) and the Community Mental Health Service Provider (CMHSP) for the Detroit metropolitan area and Wayne County. As the largest community mental health service provider in Michigan, DWIHN is committed to delivering a wide range of behavioral health care and support services to individuals and families in need. An important component of DWIHN's operations is the Quality Assurance Performance Improvement Plan (QAPIP) Evaluation. This comprehensive annual document is designed to evaluate the effectiveness of DWIHN's services, measure the improvements made over the year, and assess the overall outcomes in relation to the goals outlined in the Annual Work Plan for FY2024. The QAPIP Evaluation not only highlights successes but also identifies areas for growth, ensuring that DWIHN continues to enhance the quality of care it provides to the community. Through systematic assessment and ongoing improvement efforts, DWIHN strives to meet the evolving mental health needs of its population while adhering to best practices in service delivery.

**Description of Service Area**

Wayne County, the most populous county in Michigan, serves as a vital region that includes a diverse array of 34 cities and 9 townships. It spans an area of approximately 673 square miles, making it a significant geographic and cultural hub in the state. As of 2024, the estimated population of Detroit, Wayne County's largest city, stands at 633,218 residents. This figure represents an increase of 12,842 individuals from the 2023 fiscal year, when the population was recorded at 620,376. This growth highlights ongoing trends in urban demographics and can impact various services and resources. Throughout this evaluation, populations of members who receive services through DWIHN will be denoted by a specific abbreviation, ensuring clarity in our discussions.

- MI Adults—Adults diagnosed with mental illness.
- SMI Adults—Adults diagnosed with serious mental illness. IDD Adults—
- Adults with intellectual developmental disability
- IDD Children—Children with intellectual developmental disability SUD –
- Adults diagnosed with substance use disorder.
- SED Children—Children diagnosed with serious emotional disturbance. ASD-
- autism spectrum disorders

**Demographics**

During the reporting period of FY2024, DWIHN provided essential services to a total of 76,535 unique members, reflecting the organization's commitment to addressing the diverse needs of the community. A significant portion of those served, specifically 47,640 individuals, accounting for 62.25% of the total, received their support through Medicaid funding. Additionally, 19,459 members, or 25.42%, accessed services funded by the Healthy Michigan Plan, showcasing the importance of these funding sources in promoting health and wellness among vulnerable populations. In terms of further assistance, 1,330 members (approximately 17.38%) were supported by the General Fund, while 6,438 individuals (8.42%) benefited from the substance use disorder (SUD) Block Grant. Another 6,438 (8.41%) received care through MI Health Link, and 5,534 individuals (7.23%) were assisted via State Disability Assistance (SDA). Furthermore, 1,313 members (1.72%) utilized the Habilitation Supports Waiver, and 1,102 individuals (1.44%) were funded through other various sources. Assessing mental health needs, it was reported that 44,336 adults (57.93%) indicated they were living with a Serious Mental Illness (SMI) in FY24. Notably, this figure reflects a decrease of 1.65% compared to the previous year.

In addition, 10,217 individuals (13.35%) reported experiencing Serious Emotional Disturbance (SED), while 14,816 individuals (19.36%) identified as having Intellectual and Developmental Disabilities (IDD). An estimated 1,399 members (4.81%) dealt with substance use disorder (SUD), and 1,166 (1.52%) reported mental health issues without further specification. Of note was the category of individuals with co-occurring disorders, totaling 3,662, and there were 210 (0.27%) cases that were classified as unreported, which illustrates a slight rise of 0.11% in unreported disability designations from the prior year. Demographically, among those served, 43,500 individuals (56.84%) identified as African American, indicating a substantial representation of this community within the services provided. The Caucasian population comprised 22,362 individuals (29.22%). The remaining 13.94% included individuals of various racial and ethnic backgrounds, including those identified as having two or more races, unreported, Asian, American Indian, Native Hawaiian, and Alaskan. When analyzing age demographics, the most significant group served consisted of individuals aged 22 to 50 years, totaling 34,050 individuals (44.49%). Following this group, 17,683 individuals (23.10%) were in the 0-17 age bracket, highlighting the need for services aimed at younger populations. Additionally, there were 14,532 individuals (18.99%) in the 51-64 age range. It is also worth noting that the population aged 65 and over experienced a slight decrease, with a total of 6,611 individuals (8.64%) served in FY2024, underscoring ongoing shifts in demographics and the importance of targeted support for older adults.

Overall, these statistics not only reflect the breadth of services provided by DWIHN but also highlight the ongoing need for tailored interventions that can effectively address the complex and varied challenges faced by these underserved populations. ***Data was extracted for this report on January 13, 2025*.**

## Customer Pillar

**Member Experience with Services**

DWIHN conducts an annual Member Experience Survey to assess and improve the quality of care provided to our members. For this purpose, we use the ECHO® tool, which has been developed by the Consumer Assessment of Healthcare Providers and Systems (CAHPS), a well-respected organization known for its focus on patient-centered care. To ensure maximum confidentiality and encourage honest responses, the surveys are administered by the Wayne State University School of Urban Planning, which serves as a neutral third party. This arrangement enhances the anonymity of participants and fosters an environment where individuals feel comfortable providing sincere feedback about their experiences. Wayne State University is classified as an R1 Research institution, which signifies its commitment to high-level research and academic excellence. This affiliation allows DWIHN to access critical scientific data derived from the survey responses, enabling us to make data-informed decisions that enhance member experiences. Since implementing the ECHO® Adult and Children's Versions in 2020, DWIHN has been able to systematically review and compare survey data year-over-year, which has allowed us to measure our progress and identify areas for improvement over the last four fiscal years. Specifically, we successfully completed these surveys during Fiscal Years 2022 and 2023. In addition to the ECHO® surveys, DWIHN also analyzes other sources of member feedback to gain a comprehensive understanding of member experiences. This includes tracking trends in grievances, recipient rights violations, appeals, and other feedback gathered from various stakeholders. By examining these different dimensions of member experience, DWIHN is committed to continually refining and enhancing the quality of care we provide to our members.

**Quantitative Analysis and Trending of Measures**

In a comprehensive review of the annual ECHO® results, the DWIHN multi-disciplinary team engages in detailed discussions and thorough analyses of the outcomes. This collaborative process aims to identify areas for improvement and to formulate strategic recommendations for intervention planning. The team focuses on optimizing five major categories that are critical to enhancing overall care quality:

- Treatment of Care Issues. Assessing the effectiveness of current treatment protocols and identifying areas where patient care may be lacking.
- Access to Care. Evaluating how easily members can obtain the services they need, including barriers that may impede access, such as transportation, availability of providers, or service coverage.
- Timeliness and Appropriateness of Care. Analyzing the speed at which care is delivered and whether it is suitable for the members' specific health needs, ensuring that individuals receive care when they need it most.
- Members' Perception of Increased Improvement of Health. Gathering feedback from members regarding their personal health journeys, specifically focusing on how they perceive changes in their health status over time and the role that DWIHN services play in that improvement.
- Cultural Competency of Care. Reviewing how well the care provided meets the cultural and individual needs of members, ensuring that practitioners are sensitive to diverse backgrounds and can provide inclusive care.

The team examines various nuances associated with the relationship between members and their practitioners, which is vital for fostering trust and effective communication in the therapeutic process. In their analysis, DWIHN has documented slight improvements across both adult and children's populations by reviewing combined trends. However, it is important to note that there are minor variations in outcomes observed between the two groups. The team continues to monitor these developments closely and adjust strategies as needed to ensure the most effective care for all members.

**Evaluation of Effectiveness**

The tables below provide a comprehensive overview of global measures related to the ECHO® categories for both adults and children over several years. This analysis includes various data trends, evaluations, and outcomes that have been systematically collected, offering valuable insights into the effectiveness and impact of these categories across different populations.

| CATEGORY | FY 2022 | FY 2021 | FY 2020 | FY 2017 | STATUS |
|---|---|---|---|---|---|
| Overall Treatment | 52% | 51% | 51% | 46% | **UP + 6% Improved** |
| Seen Within 15 Minutes | 49% | 44% | 36% | 33% | **UP + 16% Improved** |
| Told About Meds and Side Effects | 76% | 79% | 74% | 75% | **UP + 1% Improved** |
| Engages Family in Treatment | 55% | 60% | 60% | 59% | Down -4% |
| Provides Information on Managing Condition | 80% | 75% | 81% | 78% | **UP + 2% Improved** |
| Information on Rights | 88% | 88% | 88% | 91% | **ABOVE 85%** |
| Member feels able to refuse treatment | 78% | 84% | 81% | 78% | NO GAIN |
| Confidence in Privacy | 91% | 93% | 91% | 91% | **ABOVE 90%** |
| Cultural Needs Met | 76% | 69% | 69% | 76% | NO GAIN |
| Perceived Improvement from Treatment | 59% | 57% | 58% | 52% | **UP + 7 % Improved** |
| Options on Treatment after benefits deplete | 56% | 56% | 55% | 48% | **UP + 8% Improved** |
| **ECHO ADULT** | | | | | **UP 40%** |

| CATEGORY | FY 2022 | FY 2021 | FY 2020 | FY 2017 | STATUS |
|---|---|---|---|---|---|
| Overall Treatment | 49% | 51% | 51% | 46% | **UP + 3% Improved** |
| Seen Within 15 Minutes | 54% | 44% | 36% | 33% | **UP + 21% Improved** |
| Told About Meds and Side Effects | 75% | 79% | 74% | 75% | NO GAIN |
| Engages Family in Treatment | 82% | 60% | 60% | 59% | **UP + 23% Improved** |
| Provides Information on Managing Condition | 78% | 75% | 81% | 78% | NO GAIN |
| Information on Rights | 92% | 88% | 88% | 91% | **ABOVE 90%** |
| Member feels able to refuse treatment | 89% | 84% | 81% | 78% | **UP + 9% Improved** |
| Confidence in Privacy | 95% | 93% | 91% | 91% | **AT 95%** |
| Cultural Needs Met | 74% | 69% | 69% | 76% | Down -2% |
| Perceived Improvement from Treatment | 66 % | 57% | 58% | 52% | **UP + 14 % Improved** |

| | | | | | |
|---|---|---|---|---|---|
| Options on Treatment after benefits deplete | 56% | 56% | 55% | 48% | **UP + 8% Improved** |
| **ECHO Children's** | | | | | **UP 78% total** |

**Opportunities for Improvement**

DWIHN is committed to conducting an in-depth review and discussion within the Quality Improvement Steering Committee (QISC). This committee will analyze and evaluate the changes resulting from various interventions and process improvement planning activities. Additionally, the implementation of the QAPIP will be a central focus of these discussions. The objective of these efforts is to facilitate systemic change within our organization and to enhance health outcomes for the members we serve. By carefully examining the effectiveness of our interventions and making informed adjustments, we aim to create a more responsive and effective health service environment for all participants.

**Member Grievance and Appeals**

DWIHN's Due Process unit plays a crucial role in analyzing member experience trends and occurrences by undertaking a thorough review of Grievance and Appeals data. This review is not conducted in isolation; rather, it is integrated with other agency-wide data to form a comprehensive understanding of member interactions and experiences. By examining this information, DWIHN can pinpoint essential process improvements aimed at enhancing engagement with members, providers, and stakeholders alike. The analysis of this data serves several key functions that are vital for the development and future trajectory of DWIHN's public behavioral health system. It informs policy enhancements, initiates well-planned process improvement strategies, secures funding for new programs and services, and reinforces our workforce capabilities to optimize our system of care. Furthermore, these insights create valuable opportunities for growth and refinement regarding the quality of care administered and the efficacy of services delivered within the DWIHN system. Central to DWIHN's mission is the objective of empowering members and educating providers about the importance of promoting expressions of dissatisfaction and feedback. This emphasis on open communication is vital for recognizing areas that require continuous quality improvements in our delivery of integrated health services. DWIHN is committed to facilitating access for members to receive medically necessary, high-quality, and member-centered integrated health services. This commitment is realized by addressing member concerns—whether these arise from interruptions in services or other service-related challenges—in a thoughtful, sensitive, and timely manner. Such responsive actions not only support the recovery process but also ensure that individuals receiving services feel valued and acknowledged within the system. Moreover, by empowering individuals to advocate for themselves, DWIHN fosters an environment where their voices contribute constructively to enhancing the system for everyone involved. This collaborative approach not only leads to improved outcomes but also cultivates a sense of community and shared responsibility among members, providers, and stakeholders in the ongoing quest for service excellence.

**Quantitative Analysis and Trending of Measures**

The following analysis presents results based on feedback from members who received services during fiscal year 2024. Over the past two fiscal years, there have been a total of 228 grievances reported. These grievances stemmed from two primary sources: either the Service Provider level or directly from the DWIHN (Detroit Wayne Integrated Health Network). As illustrated in the graph below, most grievances occurred in fiscal year 2023, highlighting a peak in reported issues during that time. In contrast, fiscal year 2024 saw a decrease in the overall number of grievances, dropping by approximately 14% compared to the previous year. Despite this reduction, the total number of reported issues in FY 2024 rose to 204. It is important to note that this total includes cases that were categorized as out of jurisdiction, which indicates that members are increasingly aware of the avenues available for addressing their concerns. Our continuous commitment to educating both members and service providers has played a crucial role in increasing the number of issues reported to the Due Process team. This education initiative aims to empower members to voice their concerns and understand their rights within the system. It also involves ongoing communication and collaboration with DWIHN's Member Engagement department, which focuses on enhancing customer service and demonstrating the functions of the Customer Service Due Process team. Overall, these efforts are essential in fostering a better understanding of grievance processes and ensuring that member feedback is effectively addressed, ultimately leading to improved service delivery and member satisfaction.

Grievances Received Fiscal Year ’23 and ‘24


DWIHN has a diverse range of service providers, each offering distinct support and services. Despite this variety, not all providers received grievances from members. However, several providers did attract complaints, and this report highlights those with the most significant grievance activity, as depicted in the accompanying graph. Over the last two fiscal years, Hegira Health emerged as the provider with the highest number of grievances. It is important to note that there was a remarkable downturn in grievances received by Hegira Health from fiscal year 2023 (FY 2023) to fiscal year 2024 (FY 2024), indicating an improvement in service or member satisfaction. In contrast to Hegira Health, The Children’s Center saw a staggering increase in grievance reports during the same period. Specifically, grievances rose from a mere 1 complaint in FY 2023 to 5 in FY 2024, representing a dramatic 400% increase. This sharp rise may warrant further investigation into the underlying causes of dissatisfaction among members. Additionally, many other providers experienced a reduction in grievance activity in FY 2024, suggesting that overall, some improvements were made in member relations and service quality across the DWIHN network. This trend indicates a movement towards better addressing member concerns and enhancing the overall experience with these providers.

**Evaluation of Effectiveness**

The number of grievance categories identified can greatly exceed the total number of grievances submitted. This indicates that a single grievance may encompass multiple issues that fall under different categories. A grievance is not deemed resolved until each category associated with it has been thoroughly investigated, and the findings are evaluated to determine if closure is appropriate. In accordance with requirements set by the Michigan Department of Health and Human Services (MDHHS), the Detroit Wayne Integrated Health Network (DWIHN) categorizes grievances in a structured manner. As depicted in the accompanying graph, during Fiscal Year 2024, a total of 107 grievances were recorded, which is notable for the unprecedented 204 individual issues identified within those grievances. The analysis of grievance data reveals that the most frequently reported categories for FY 2024 were as follows: Interpersonal issues, which accounted for 62 of the grievances, Delivery of Service concerns, representing 50 issues, Access to Service challenges, which comprised 27 issues. These categories highlight significant areas of concern among individuals served. Additionally, Access to Staff and Customer Service were also among the top five categories, reflecting ongoing challenges in these areas. It is noteworthy that the trends in grievance categories have remained consistent across both fiscal years, with the same five categories emerging as the most prevalent. In an interesting development, there have been no transportation-related grievances reported in the past three years. Conversely, grievances regarding wait times have seen a dramatic increase, rising by 100% in Fiscal Year 2024, indicating a growing concern that may require further investigation and attention.

Over the last two fiscal years, specifically Fiscal Year 2023 (FY ’23) and Fiscal Year 2024 (FY ’24), a total of 228 grievances were reported. Analysis of these grievances reveals a notable satisfaction rate among grievant, which exceeds 71%. In FY ’23, an impressive 74% of grievant reported being satisfied with the resolution of their cases. However, this satisfaction rate experienced a slight decline in FY ’24, where 69% found the outcomes to be satisfactory. Breaking down the dissatisfaction, on average, 19.5% of grievant expressed dissatisfaction with the outcomes of their complaints across both fiscal years. This indicates a significant portion of the grievant felt that their concerns were not adequately addressed. Furthermore, it is worth noting that approximately 9% of the grievances from FY ’23 and FY ’24 had an unknown satisfaction status. Specifically, 8% in FY ’23 and 10% in FY ’24 fell into this category. The unknown status primarily resulted from loss of contact with the grievant. Factors contributing to this loss of contact included the grievant not responding to repeated outreach attempts made by staff or other unforeseen circumstances. Additionally, it is important to highlight that the complexity of the grievance cases has notably increased over these fiscal years. This rise in complexity necessitated greater involvement and interaction with the Michigan Department of Health and Human Services (MDHHS), indicating that many of the cases may require more extensive resources and coordination to ensure satisfactory resolutions.

**Identified Barriers**

Overall, member ratings regarding quality, satisfaction, appropriateness, and outcomes continue to show a positive trend, with more than 65% of members expressing satisfaction with the services provided. However, several factors may contribute to the dissatisfaction observed among a portion of the membership. One significant issue is the nature of the outcomes some members seek. For instance, requests for actions such as the termination of staff or monetary compensation are not within the capacity of this department to fulfill. This limitation can lead to frustration among members who feel that their concerns are not adequately addressed. Furthermore, there have been instances where members did not provide feedback on their satisfaction after their issues were resolved, which can hinder our understanding of their experiences and needs. Recently, we have observed a slight but notable trend though it has not yet reached statistical significance where grievant express dissatisfaction with the resolution of their cases. As a result, some members are pursuing avenues to appeal these decisions to higher authorities, specifically MDHHS. This appeal process can indicate a deeper disconnect between member expectations and the resolutions provided by our department. To address these issues and improve overall member satisfaction, we regularly hold interdepartmental meetings with DWIHN staff to discuss member feedback, share insights, and strategize on how to enhance our services. Our goal is to create a more responsive and effective support system that better meets the needs of our members.

**Opportunities for Improvement**

DWIHN is dedicated to significantly expanding our collaborations with community partners to enhance support for our most vulnerable populations. Our goal is to improve both the health and safety of our members through innovative services and strategic partnerships that address their unique needs. To ensure that both our members and providers are well-informed about the grievance process, we will implement a robust training program that emphasizes the importance of effective communication and customer service within our provider network. This training will be designed to systematically address interpersonal issues and provide resources to help mitigate these challenges. In addition, we will evaluate the need for specialized training programs that focus on the specific interpersonal and customer service difficulties experienced by the populations we serve. In partnership with the Member Engagement division, we will roll out a series of initiatives aimed at increasing outreach and education efforts. This will include advocacy programs, the development of peer support networks, and surveys to gather and analyze member experiences.

One of the key events we are planning is the Due Process Summit, set to take place in October 2023. Our objective is to make this summit an annual event that fosters dialogue and collaboration among stakeholders. We also plan to continue the work of the Constituents' Voice Advisory Committee, which plays a critical role in addressing consumer legislative issues. This committee focuses not only on the delivery of services but also on enhancing interpersonal relations and improving overall customer service within the organization. To identify areas that require improvement, we will produce and share data on a quarterly basis with the Managed Care Operations and Quality departments. This data will highlight specific weaknesses within our network and provide insights that will guide our improvement strategies. As part of our commitment to quality enhancement, we will consistently evaluate patterns and trends in the grievances reported by our members. By identifying recurring issues, we can develop targeted strategies to promote quality improvements across our services. Our commitment to our members extends to actively listening to their concerns and effectively resolving any issues of dissatisfaction related to DWIHN. We will be proactive in addressing these concerns to ensure a positive experience for every member. Finally, we recognize that there may be gaps in service provision as the needs of our communities evolve. We will work closely with our leadership team to discuss these gaps and collaboratively develop solutions to address these emerging needs, ensuring that we remain responsive and attentive to our members' requirements.

**Member Appeals**

In the realm of appeals, the unit observed a significant increase in the volume of correspondence processed during Fiscal Year 2024, handling a total of 1,938 pieces of appeal-related communication. This figure represents a notable rise from the 1,359 pieces recorded in Fiscal Year 2023. The correspondence encompasses a range of formats, including both emails and phone calls, reflecting the increasing complexity of member inquiries. This uptick in communication can largely be attributed to a surge in inquiries that, while not formally classified as appeals, necessitated extensive research and follow-up by the Appeal Specialists. These specialists worked diligently to ensure that members were effectively connected to the appropriate services or resources to meet their needs. As a result, the increased correspondence underscores the unit's commitment to providing comprehensive support and fostering better communication with its members.

**Quantitative Analysis and Trending of Measures**

In fiscal year 2024, there was a slight decline in the number of actual appeal cases, with a total of 47 appeals filed. This represents a decrease from the 51 appeals recorded in fiscal year 2023. The data indicates a continuing trend in which administrative appeals remain the most frequently filed category. These administrative appeals predominantly involve cases that result in terminations due to clients' inadequate engagement with their Clinically Responsible Service Providers (CRSP). This highlights ongoing challenges in ensuring consistent participation in mental health services. In terms of monitoring Mental Health Adequate and Advance Adverse Benefit Determination Notices, there was a noted decline in distribution. A total of 20,005 such notices were sent out in fiscal year 2024, compared to 21,607 in fiscal year 2023. This represents a reduction in communication regarding adverse decisions that could affect clients' access to mental health resources. Looking specifically at the Applied Behavioral Analysis (ABA) benefit, there was a very slight change in the number of notices sent. In fiscal year 2023, 1,354 notices were issued, while the following year saw a marginal decline to 1,351 notices. This stability suggests that the ABA benefit is being utilized consistently despite other fluctuations in appeal trends. Conversely, the area concerning substance use disorder (SUD) notices experienced noteworthy growth for the second consecutive year, with an increase of 9.5%. In fiscal year 2023, 1,239 notices were issued, which is a rise from 1,131 notices in the prior year, indicating an increased awareness and response to substance use treatment needs. Moreover, there was a significant decrease of approximately 20% in the number of Adequate and Advance notices distributed for intellectual and developmental disabilities (IDD). There were 4,013 notices sent in fiscal year 2023, which fell to 3,347 in the following year. This decline may point to evolving practices in how notices are communicated to families and individuals affected by IDD services and potentially suggests a shift in the management of those services.

**Identified Barriers**

Most members report satisfaction with the recent appeal determinations, a positive outcome that can largely be attributed to their connections or reconnections with necessary services. This success stems from the dedicated efforts of the Appeals Specialists, who play a crucial role in ensuring that members receive the appropriate support tailored to their individual needs. It is noteworthy that, in some instances, members encounter difficulties returning to the original facility where they previously accessed services. These challenges often arise due to staffing shortages or interpersonal issues that may have developed during their prior interactions. Nevertheless, it is important to highlight that services can still be effectively delivered in alternative settings, thereby fulfilling the members' requests and ensuring continuity of care. Despite these successes, some persistent barriers continue to hinder access to services for certain members. Key obstacles include insufficient staffing levels and difficulties in establishing communication with members after they have requested an appeal, which limits the ability to present viable care options. In response to these challenges, the Detroit Wayne Integrated Health Network (DWIHN) is proactively engaged in evaluating its provider network. This ongoing assessment aims to identify strategies to strengthen and expand service offerings to accommodate the increasing number of members seeking support. Moreover, DWIHN has recently expanded its role as an outpatient provider through the establishment of our Community Care Clinic (CCC). In addition, we are working towards becoming a Certified Community Behavioral Health Clinic (CCBHC) provider. This strategic move is designed to enhance our capacity to deliver critical services to our community, thereby addressing the diverse needs of our members and improving overall health outcomes.

**Opportunities for Improvement**

DWIHN is dedicated to strengthening our collaboration with community partners, aiming to provide enhanced support for our most vulnerable populations. Our goal is to improve the health and safety of our members through innovative services and strategic partnerships that address their unique needs.

To ensure effective service delivery, we will offer ongoing, comprehensive training focused on the appeals process. This training will be designed for both members and service providers, equipping them with the knowledge and skills necessary to navigate the appeals process and resolve service-related issues effectively. In addition, we plan to actively engage multiple departments within DWIHN to facilitate outreach, education, and advocacy initiatives. This engagement will also include conducting thorough surveys and collecting feedback on member experiences to better understand their needs and challenges. We will conduct a thorough review and discussion of appeals data with relevant divisions within DWIHN. This collaborative analysis will serve as an additional tool for evaluating member experiences and identifying trends that require attention.

Moreover, we will prioritize support for our members by addressing and resolving issues related to adverse actions taken by DWIHN. We will work diligently to identify gaps in our service provision and bring these concerns to the attention of our leadership team, ensuring that we proactively address needs as they arise. By enhancing our training, outreach efforts, data analysis, and problem resolution strategies, we are committed to providing our members with high-quality services and a supportive environment.

**Provider and Practitioner Satisfaction Survey**

In October 2024, we initiated a comprehensive feedback collection process by distributing Qualtrics surveys through email to a diverse range of provider organizations. The effort focused on gathering valuable insights from these organizations, which play a crucial role in delivering services, especially in the realm of outpatient care and specifically within the SUD sector. To facilitate meaningful participation, DWIHN established a two-week period during which these organizations could provide their responses, ensuring that they had sufficient time to thoughtfully consider and articulate their feedback.

A total of 283 surveys were disseminated to outpatient provider organizations. To maximize participation rates, we implemented a structured reminder system, sending out follow-up emails every other day. Providers received at least three reminder emails, emphasizing the importance of their input and the value it holds for enhancing services. Despite our efforts, we faced some challenges in this process. Notably, 46 provider emails bounced back to DWIHN, indicating that the addresses were incorrect. This situation has underscored the pressing need for more rigorous management of our contact information to ensure that all stakeholders can be engaged effectively in future surveys. The survey itself consisted of 34 carefully crafted questions aimed at capturing a detailed and comprehensive view of the providers' experiences and perspectives. We designed the survey with usability in mind, estimating that it would take participants approximately 10 minutes to complete. This time frame was chosen to accommodate the busy schedules of providers while still promoting thoughtful responses.

Consistent with DWIHN's policy, each department is required to conduct a thorough review of the survey results. This step is vital for identifying targeted action plans aimed at addressing any scores that fall below an acceptable threshold of 80% or average ratings below 2.75. Understanding this feedback loop is essential for the continuous improvement of our services. I will be reaching out within the next week to discuss in detail the specific areas of improvement you have identified from the survey results. This dialogue is crucial as we work towards effectively tracking our progress and implementing the necessary changes to enhance service delivery.

**Evaluation of Effectiveness**

In Fiscal Year 2024, a total of 283 surveys were distributed to gather comprehensive feedback and insights from stakeholders, which represents a notable decrease from the previous year, FY 2023, when we successfully collected 578 responses. This decline raises important questions about participation and engagement levels. In FY 2024, the DWIHN received 74 completed responses, yielding a response rate of 26%. This lower response rate is a significant consideration, as it can inform our understanding of stakeholder engagement and highlight specific areas where our services may require enhancement. The feedback obtained from these responses is vital for assessing how our initiatives are perceived and identifying opportunities for improvement.

The substantial reduction in both the number of surveys distributed and the completed responses calls for the development of targeted strategies aimed at improving participation in future survey cycles. For comparison, the processing year of FY 2023 yielded 578 responses, whereas FY 2024 saw a drastic drop to just 74 completed surveys. These figures not only reflect the level of engagement from the organizations we reached out to but also establish a benchmark against which we can measure the effectiveness of future survey initiatives. Additionally, it is important to recognize that not all respondents engaged with every question, which resulted in variations in the number of responses per question. This variation offers valuable insights into areas where respondents may have felt less inclined or able to provide input. Understanding these patterns will help us evaluate the feedback more effectively and support the formulation of targeted follow-up action plans to address any identified gaps. Overall, this data will be instrumental in guiding our future engagement strategies and improving the overall stakeholder experience.

**Identified Barriers**

The noticeable decline in both the number of surveys distributed and the number of completed responses underscores the urgent need for the development of specific strategies aimed at enhancing participation in upcoming survey cycles. This downturn not only serves as an indicator of the engagement levels from the organizations we attempted to reach out to, but it also provides us with a crucial benchmark. This benchmark will enable us to assess the effectiveness of future survey initiatives and make necessary adjustments to our approach. In alignment with the policy established by DWIHN, it is a requirement that each department undertakes a comprehensive review of the survey results we have gathered. This review process is of paramount importance, as it enables us to pinpoint areas that require focused attention and improvement. The emphasis will be on creating detailed action plans to address any scores that fall below an acceptable performance threshold of 80%.

Additionally, we will scrutinize average ratings that are below 2.75, as these indicate areas needing significant enhancement. Addressing these issues is more than just a procedural obligation; it is essential to our commitment to fostering continuous improvement in our service delivery. By actively engaging with the feedback provided through the surveys, we can implement targeted interventions that lead to meaningful changes and improvements in our practices. This proactive approach is intended to improve overall satisfaction and effectiveness, ensuring that we meet the evolving needs of our stakeholders and participants.

**Practice Guidelines**

DWIHN adopts clinical practice guidelines that are based on extensive evidence and adhere to nationally recognized standards of care, ensuring they are specifically designed to address the diverse needs of the individuals and communities we serve. Our guidelines undergo a comprehensive review process each year, during which they are meticulously evaluated and ultimately approved by the Chief Medical Officer and the Clinical Officer, ensuring they remain current and effective. To facilitate this ongoing improvement process, the Improving Practices Leadership Team (IPLT) convenes regular meetings where members discuss potential updates, approve revisions, and strategize on how to effectively disseminate these important guidelines across the organization. This collaborative approach fosters an environment of shared knowledge and continuous enhancement of our clinical practices. For easy access, our practice guidelines are made available to both members and providers on DWIHN's official website, ensuring that all stakeholders can utilize these resources to deliver the highest quality of care.

**Evaluation of Effectiveness**

Clinical Practice Guidelines are designed to provide comprehensive guidance to healthcare practitioners regarding the management of common behavioral health disorders. The primary objective is to present promising practices alongside evidence-based recommendations that support clinicians in delivering high-quality care. This encompasses a range of services, including accurate screening and assessment processes, tailored treatment options, and ongoing care that cater to the unique needs of everyone facing psychiatric and behavioral health challenges. The guidelines emphasize the importance of correct diagnosis and the integration of treatment recommendations that are aligned with the specific requirements of the patient. While these guidelines offer a valuable framework, they are intended to complement, not replace, the clinical judgment of healthcare providers.

To ensure that these guidelines are effectively implemented, DWIHN will monitor its provider network with a robust oversight approach. This entails thorough clinical evaluations, quality assurance measures, compliance audits, and utilization management to confirm that the guidelines are being followed appropriately. The primary goal of this oversight is to guarantee the safety and well-being of individuals receiving care, ensuring that no harm results from the application of these clinical practice guidelines. Furthermore, DWIHN is committed to ensuring that the application of these guidelines is based on the principles of medical necessity and clinical appropriateness. Providers will be encouraged to utilize these guidelines flexibly while maintaining the least restrictive treatment setting possible,

aligning care practices with the best interests of the individuals served. This holistic approach aims to foster an environment of effective treatment that respects individual rights and promotes optimal health outcomes.

During Fiscal Year 24, DWIHN collaborated with Vital Data to enhance the HEDIS Scorecard, a vital tool designed to provide comprehensive performance metrics for all Clinically Responsible Service Providers (CRSP), Medicaid Health Plans, and Integrated Care Organizations within the network. This Scorecard allows stakeholders to evaluate their performance both as a collective network and as individual entities, using a framework based on established alignment measures. In this latest update, DWIHN incorporated new performance measures specifically for Certified Community Behavioral Health Clinics (CCBHC), Opioid Health Homes (OHH), and Behavioral Health Homes (BHH). These additions not only broaden the scope of the Scorecard but also allow for a more targeted approach in assessing how well these specialized services are delivering care. The Scorecard features an extensive dataset that dates to 2019, enabling stakeholders to identify long-term trends and areas in need of improvement.

This historical perspective is essential for informing strategic planning and resource allocation. The database underlies the Scorecard, containing detailed information that supports the claims data displayed in the Scorecard. This database includes critical elements such as patient diagnoses, prescribed medications (Rx), physician details related to each claim and identified care gaps that need to be addressed. Importantly, access to this database is strictly controlled; individuals can only view data pertaining to the members they serve, ensuring confidentiality and compliance with privacy regulations. DWIHN and Vital Data are committed to ongoing improvements and exploring opportunities to expand the capabilities of the platform.

The goal is to provide information that enhances the integration of care processes across the network. The rollout of the Scorecard to all CRSP providers and four Medicaid Health Plans took place in November 2022, marking a significant step in increasing transparency and accountability in service delivery. To support continuous improvement, the Integrated Health Care (IHC) team meets with representatives from the CRSP every 45 days. During these meetings, they review key performance measures to assess progress and strategize on necessary actions. Additionally, the IHC's Registered Nurse (RN) plays a pivotal role in monitoring HEDIS measures. This RN sends out quarterly correspondence to CRSP CEOs, summarizing current scores and identifying specific areas requiring attention or enhancement. Furthermore, the Adult Initiatives team has recently welcomed new staff members who are dedicated to directly collaborating with CRSP providers to drive improvements in their HEDIS scores. The IHC also organizes quarterly "lunch and learn" sessions focused on educating providers about HEDIS measures and best practices for achieving higher scores.

These multifaceted efforts are designed to increase HEDIS scores, which ultimately means that more individuals are receiving integrated care that supports improved outcomes for both their behavioral and physical health needs. It is important to note that the measure goals are informed by Quality Compass, a benchmark that Medicaid Health Plans utilize to set performance targets. Recent improvements in HEDIS scores include significant gains in the following areas: follow-up Care for Children, prescribed ADHD Medications, enhancing ongoing maintenance follow-up, follow-up After Hospitalization, improving post-discharge care for both adults and children, adherence to Antipsychotic Medications and promoting consistent medication management for patients. Through these initiatives, DWIHN and its partners aim to foster a higher standard of care and better health outcomes for the communities they serve.

**Identified Barriers**

The implementation of clinical practice guidelines is significantly hindered by the considerable time investment required to thoroughly review the guidelines' content. Many practitioners face challenges in finding adequate time for this critical review, primarily due to staffing shortages, extensive documentation requirements, and various training obligations imposed at the organizational level. To address these challenges and improve the implementation process, organizations could benefit from adopting one or two select guidelines that align closely with their specific service delivery goals. By narrowing the focus, practitioners can allocate time and resources more effectively. Additionally, conducting research on the latest publications from credible sources, such as peer-reviewed journals or recognized health organizations, will allow practitioners to stay informed about the most recent evidence-based practices. This strategy not only helps fulfill the requirement for the PIHP to demonstrate that clinical guidelines were developed with valuable feedback from providers but also empowers practitioners to engage in continuous learning. Ultimately, by prioritizing evidence-based practices, organizations can enhance the quality of care they provide, leading to better outcomes for their clients.

## Access Pillar

**Mission Michigan Based Performance Indictors (MMBPI)**

The Michigan Mission Based Performance Indicators (MMBPI) serve as a critical tool in assessing how effectively DWIHN facilitates access to care for individuals in need. These indicators provide valuable data concerning two key areas: the timeliness of care and the frequency of inpatient psychiatric hospitalizations. The Michigan Department of Health and Human Services (MDHHS) has defined five specific performance indicators that are mandatory for Pre-Paid Inpatient Health Plans (PIHP) to collect and report on a quarterly basis. Among these indicators, #1 and #4 set a high benchmark, requiring a minimum performance level of 95% or greater to ensure that individuals receive timely and efficient care. In contrast, indicator #10 establishes a more lenient benchmark with a maximum allowable rate of 15% or less for specific performance aspects. In June 2023, MDHHS introduced benchmarks for two additional indicators, namely #2a and #3, aimed at improving service delivery. Indicator #2a tracks the percentage of new individuals who complete a biopsychosocial assessment within 14 calendar days following a non-emergency service request. The benchmark for this indicator is set at 57% or higher, reflecting the department's commitment to timely assessments. Indicator #3 evaluates the percentage of new individuals who commence any medically necessary ongoing service within 14 days after completing a non-emergent biopsychosocial assessment, with a benchmark of 83.8% or greater. This ensures that once individuals have been assessed, they can quickly access necessary services, minimizing gaps in care. These newly established benchmarks are designed to apply to all services related to Intellectual and Developmental Disabilities (IDD) as well as Mental Illness (MI). It is important to note that these benchmarks will take effect in the first quarter of 2024, beginning on October 1, 2023. By adhering to these performance indicators and benchmarks, DWIHN aims to enhance the quality of care delivered to vulnerable populations, ultimately improving health outcomes and access to essential services.

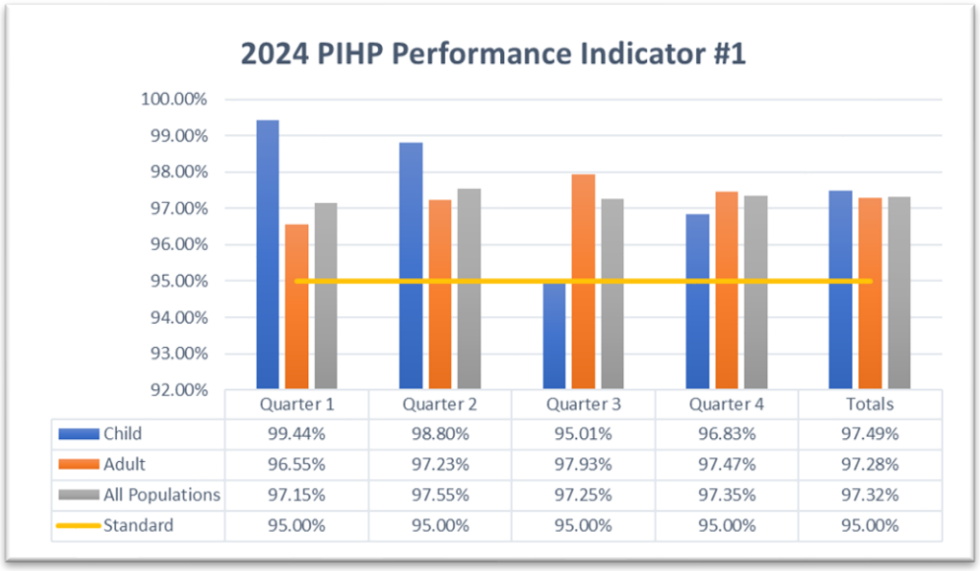
**Qualitative Analysis and Trending of Measures Indicator**

**#1- Pre-Admission Screening within 3 hours**

The percentage of persons during FY2024 receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.

**Goal**: The goal is to attain and maintain performance standards as set by the MDHHS contract. Standard 95% or above.

**Results:** FY2024 standard met for all populations. Total population rate (97.32%).

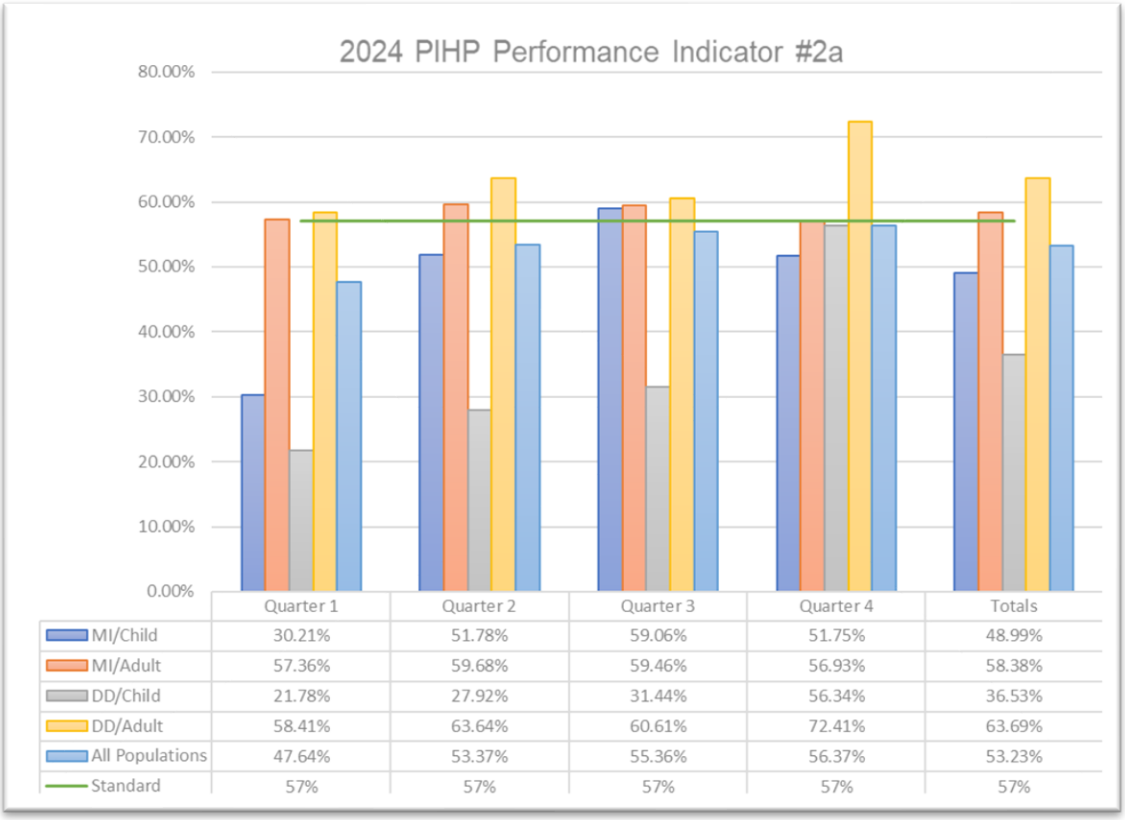



| | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 | Totals |
|---|---|---|---|---|---|
| Child | 99.44% | 98.80% | 95.01% | 96.83% | 97.49% |
| Adult | 96.55% | 97.23% | 97.93% | 97.47% | 97.28% |
| All Populations | 97.15% | 97.55% | 97.25% | 97.35% | 97.32% |
| Standard | 95.00% | 95.00% | 95.00% | 95.00% | 95.00% |

**Indicator #2- Access/1st Request Timeliness**

The percentage of persons during FY2024 receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.

**Goal**: The goal is to attain and maintain performance standards as set by the MDHHS contract. The goal for FY2024 is 57.0%. **Results**: Q1 (47.64%), Q2 (53.37%), Q3 (55.36%) and Q4 (56.37%). Total population rate for FY2024 was 53.23%.

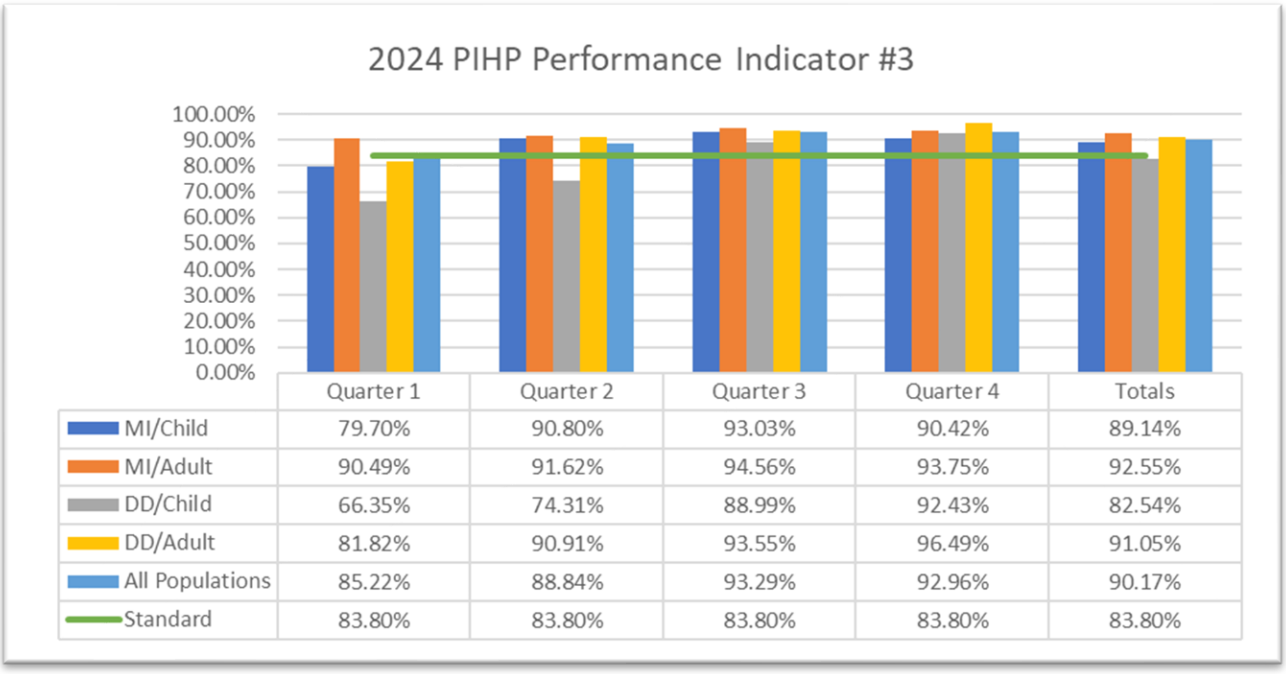



| | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 | Totals |
|---|---|---|---|---|---|
| MI/Child | 30.21% | 51.78% | 59.06% | 51.75% | 48.99% |
| MI/Adult | 57.36% | 59.68% | 59.46% | 56.93% | 58.38% |
| DD/Child | 21.78% | 27.92% | 31.44% | 56.34% | 36.53% |
| DD/Adult | 58.41% | 63.64% | 60.61% | 72.41% | 63.69% |
| All Populations | 47.64% | 53.37% | 55.36% | 56.37% | 53.23% |
| Standard | 57% | 57% | 57% | 57% | 57% |

**Indicator #3- Access/1st Service Timeliness**

The percentage of persons during FY2024 needed on-going service within 14 days of a completed non- emergent biopsychosocial assessment.

**Goal**: The goal is to attain and maintain performance standards as set by the MDHHS contract. FY2024 standard is 83.8%. **Results:** Q1 (85.22%), Q2 (88.84%), Q3 (93.29%) and Q4 (92.96%). Total population rate (90.17%). The FY2024 goal was met for MI children, MI adults, IDD adults and the total population. The IDD children population did not meet 83.8%. Total population rate (89.46%).

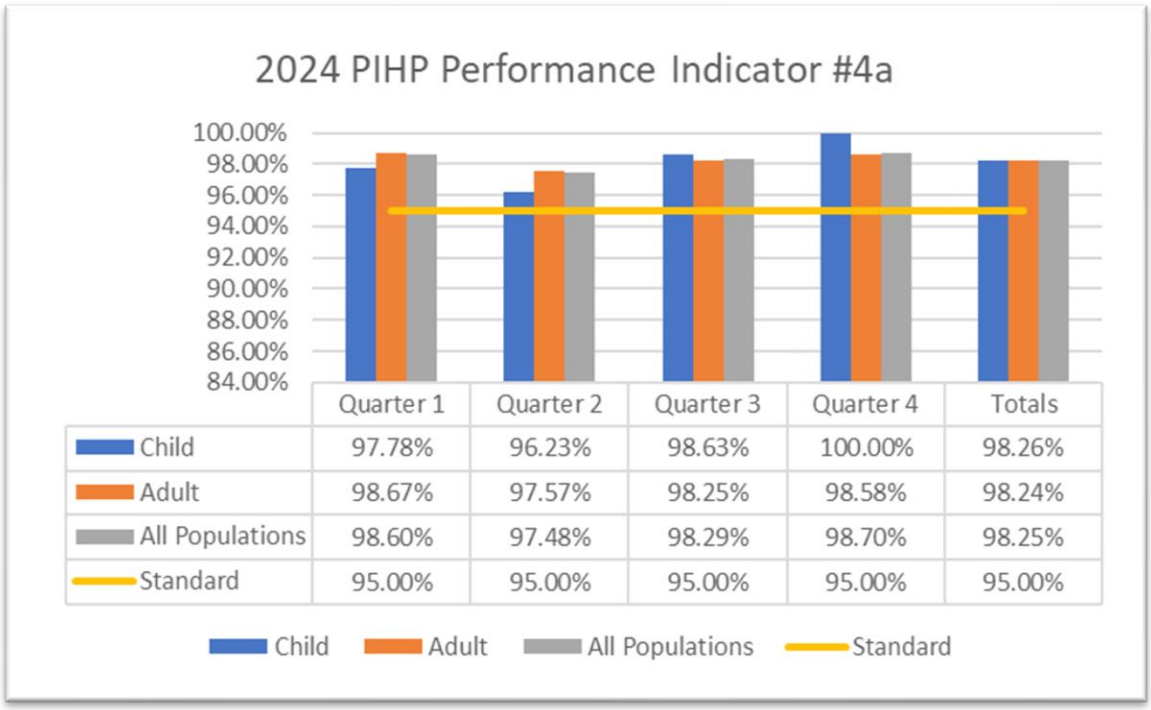



| | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 | Totals |
|---|---|---|---|---|---|
| MI/Child | 79.70% | 90.80% | 93.03% | 90.42% | 89.14% |
| MI/Adult | 90.49% | 91.62% | 94.56% | 93.75% | 92.55% |
| DD/Child | 66.35% | 74.31% | 88.99% | 92.43% | 82.54% |
| DD/Adult | 81.82% | 90.91% | 93.55% | 96.49% | 91.05% |
| All Populations | 85.22% | 88.84% | 93.29% | 92.96% | 90.17% |
| Standard | 83.80% | 83.80% | 83.80% | 83.80% | 83.80% |

**Indicator #4a- Hospital Discharge Follow-Up**

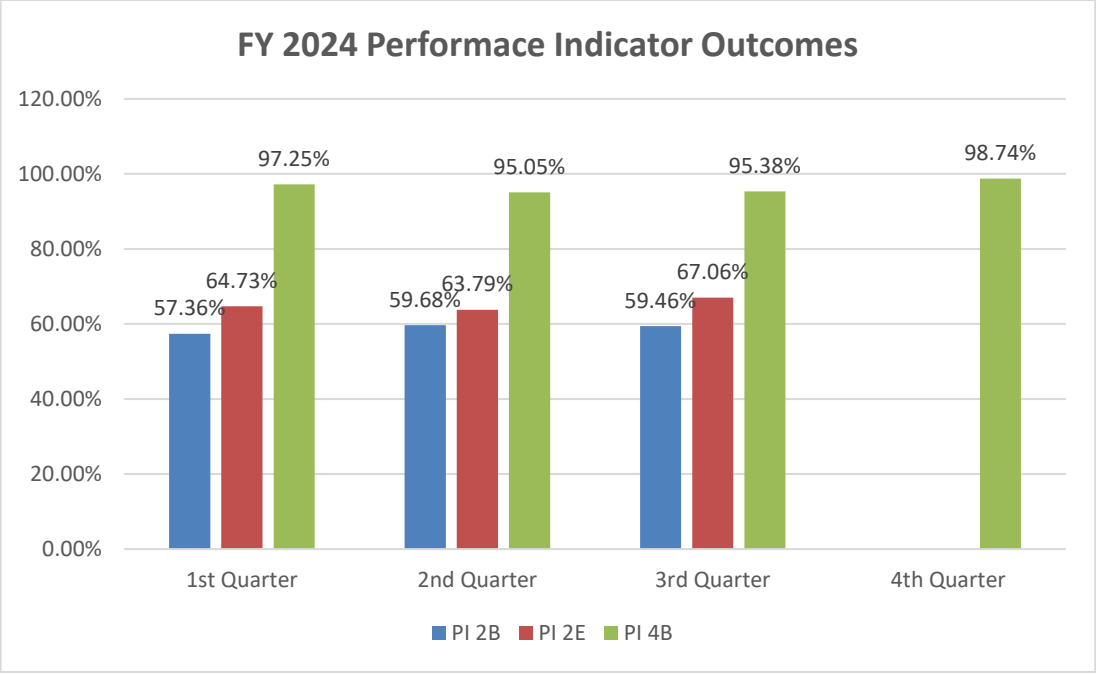
The percentage of discharges from a psychiatric inpatient unit during FY2024 who are seen for follow-up care within seven days.

**Goal**: The goal is to attain and maintain performance standards as set by the MDHHS contract. Standard 95% or above. **Results**: All populations met the standard for all FY2024. Total population rate for FY2024 was 98.25%.




| | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 | Totals |
|---|---|---|---|---|---|
| Child | 97.78% | 96.23% | 98.63% | 100.00% | 98.26% |
| Adult | 98.67% | 97.57% | 98.25% | 98.58% | 98.24% |
| All Populations | 98.60% | 97.48% | 98.29% | 98.70% | 98.25% |
| Standard | 95.00% | 95.00% | 95.00% | 95.00% | 95.00% |

**Indicator #4b- SUD Detox Discharge Follow-up**
The percentage of discharges from a psychiatric inpatient unit during FY2024 who are seen for follow-up care within seven days.
**Goal**: The goal is to attain and maintain performance standards as set by the MDHHS contract. Standard 95% or above. **Results**: All populations met the standard for all FY2024. Total population rate for FY2024 was 98.25%.




**Identified Barriers to achieving performance indicator goals:** SUD: % of Persons Requesting a Service who Received Treatment or Support within 14 Days. To address the identified barriers to achieving the performance indicator goal related to SUD, specifically the percentage of people requesting a service who received treatment or support within 14 days, it is essential to consider several key factors:

Many individuals may not be aware of the services available to them or how to navigate the system to access support. Improving public awareness through community outreach and educational programs can bridge this gap.

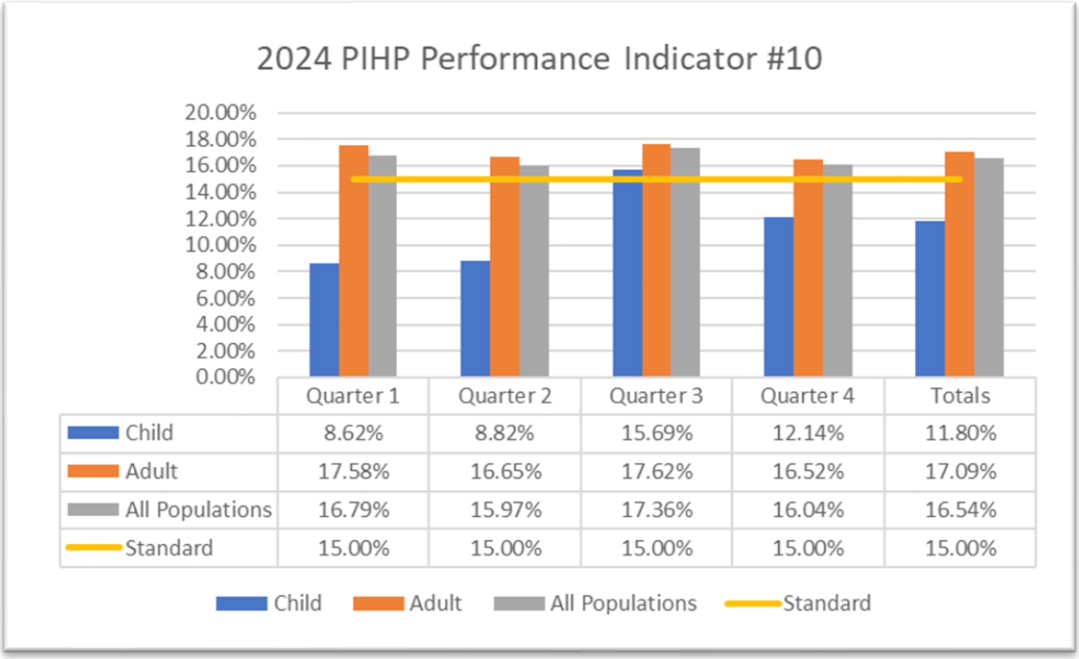
**Interventions to improve rates:** To overcome and improve indicator 2b and use the MHWIN system effectively, SUD has implemented various interventions. Technical assistance sessions and collaboration with DWIHN have been provided to ensure that providers are aware of the Performance indicator goals, know how to achieve them, and have the best practices in place to achieve those goals. Moreover, SUD has been sending weekly reports to remind providers to pay attention to performance indicators and keep them informed and engaged in the process. Regular feedback and coaching are given to help providers understand their performance, identify areas for improvement, and develop action plans to address deficiencies.

**Interventions measured:** To assess the impact of the interventions, SUD has conducted a series of before-and-after comparisons on the reports that were run and sent to providers. To achieve this, SUD compared performance indicators before and after implementing the interventions, using periods such as monthly and quarterly reports. By analyzing the changes in performance indicators over time, we gained insight into the interventions' effectiveness.

**Indicator #10- Inpatient Recidivism**

The percentage of readmissions of children and adults during FY2024 to an inpatient psychiatric unit within 30 calendar days of discharge from a psychiatric inpatient unit.

**Goal**: The goal is to attain and maintain performance standards as set by the MDHHS contract. Standard 15% or below. **Results:** The child population met the 15% and below standard each quarter for FY2024. Total population rate for the year (16.54%).




| | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 | Totals |
|---|---|---|---|---|---|
| Child | 8.62% | 8.82% | 15.69% | 12.14% | 11.80% |
| Adult | 17.58% | 16.65% | 17.62% | 16.52% | 17.09% |
| All Populations | 16.79% | 15.97% | 17.36% | 16.04% | 16.54% |
| Standard | 15.00% | 15.00% | 15.00% | 15.00% | 15.00% |

**Evaluation of Effectiveness**

DWIHN successfully met the performance standards for each quarter for the following performance indicators: PI#1 (Children & Adults), PI#3 (MI/Adults), and PI#4a (Children & Adults) during the period identified as FY2024. Specifically for PI#1, DWIHN achieved an impressive rate of 97.32% in providing pre-admission screenings for psychiatric inpatient care within a three-hour window following a request for service. This efficiency is largely attributed to the dedicated efforts of DWIHN's Crisis and Access team, which collaborates extensively with various crisis providers to facilitate the pre-admission screenings. The Hegira Health COPE unit is responsible for conducting screenings for adults, while child screenings are managed by New Oakland, The Guidance Center, and The Children's Center. This multi-agency approach ensures that both children and adults receive timely access to necessary psychiatric care. To further enhance compliance and address any potential issues, DWIHN has instituted a process in which monthly out-of-compliance reports are requested from all crisis providers. These reports must outline the reasons for any instances where the pre-admission screenings exceeded the established 2- and 3-hour timeframes. This systematic tracking has been crucial for DWIHN and COPE in monitoring their operations, rectifying any technical or procedural obstacles, and continuously improving service delivery. The performance rates for PI#1 during the fourth quarter are as follows:

- The child rate stood at 96.83%, which surpasses the 95% standard; however, this reflects a decline of 2.57 percentage points compared to the first quarter, where the rate was 99.44%.
- The adult rate for the same quarter was 97.47%, also above the 95% standard, and it indicates a positive trend with an increase of 0.92 percentage points from the first quarter, where the rate was 96.55%.
- The overall rate for all populations in Q4 was 97.35%, exceeding the 95% standard, and representing a slight improvement of 0.20 percentage points from Q1, which had a rate of 97.15%. This detailed analysis underscores DWIHN's commitment to providing timely psychiatric care and its proactive approach in addressing challenges encountered in the service delivery process.

DWIHN's overall population rate for PI#2a in 2024 was recorded at 53.23%. While this figure did not meet DWIHN's projected expectations, it is important to note that the overall rates for PI#2 demonstrated consistent improvement throughout each quarter in FY2024. Since MDHHS eliminated exceptions for PI#2a in 2020, this standard has become a critical focus area for DWIHN. The combination of the regulatory change and the ongoing challenges brought on by the COVID-19 pandemic has significantly complicated the ability to meet this standard. To address these challenges, DWIHN organized regular 45-day meetings throughout the year. These meetings included collaboration among several key departments, such as Quality, Managed Care Operations, Integrated Health Care, and the Access Center, as well as representatives from 19 Clinically Responsible Service Providers (CRSPs). The primary purpose of these meetings was to identify and discuss the obstacles encountered with PI#2a and to develop effective interventions. By facilitating this collaboration, DWIHN has been able to work alongside CRSPs to pinpoint barriers and implement strategies that aim to enhance performance. This year marked a significant milestone, as MDHHS introduced specific benchmarks for both PI#2a and PI#3. The establishment of these benchmarks provided DWIHN with clear data points to evaluate its progress and set attainable goals for improvement. Breaking down the rates for specific populations under PI#2:

- The MI/child rate was reported at 51.75% for Q4, reflecting a substantial increase of 21.54 percentage points compared to Q1's rate of 30.21%. This indicates a positive trend in service delivery for children with mental illness.
- The MI/adult rate was at 56.93% for Q4, which represents a slight decrease of 0.43 percentage points from Q1's rate of 57.36%. This slight decline suggests the need for ongoing efforts to maintain or improve service delivery for adults with mental illness.
- The IDD/child rate for Q4 stood at 56.34%, showing a significant increase of 34.56 percentage points from Q1's rate of 21.78%. This improvement highlights progress in the support provided to children with intellectual and developmental disabilities.

- The IDD/adult rate was reported at 72.41% for Q4, demonstrating an increase of 14.00 percentage points from Q1's rate of 58.41%. This indicates strong movement toward enhancing services for adults with intellectual and developmental disabilities.
- Finally, the total population rate for PI#2 reached 56.37% in Q4, marking an increase of 8.73 percentage points from Q1's rate of 47.64%. This overall improvement reflects DWIHN's commitment to monitoring and elevating the quality of services provided to its diverse population.

Overall, the efforts undertaken this year have laid a foundation for continued growth and enhanced service delivery across different populations served by DWIHN.

DWIHN has consistently achieved some of the highest performance rates among all the Pre-Paid Inpatient Health Plans (PIHPs) in the state of Michigan for Performance Indicator #3 (PI#3). This indicator specifically tracks the percentage of individuals who receive follow-up services within 14 days following the completion of an Integrated Biopsychosocial Assessment, which is crucial for ensuring continued care and support for individuals after an assessment. In the latest reporting period, DWIHN's overall rate for PI#3 reached an impressive 90.17%. This statistic underscores the organization's effectiveness in facilitating timely follow-up services and highlights its commitment to improving mental health outcomes for the community. To further enhance performance and accountability, DWIHN conducted 45-day meetings with 19 Clinically Responsible Service Providers (CRSPs). During these sessions, detailed discussions centered on each CRSP's individual quarterly performance rates. This collaborative approach not only allowed for the sharing of best practices but also ensured that all departments and agencies involved were harmonized in their strategies and efforts towards improving service delivery. A breakdown of the Q4 performance rates for PI#3 is as follows:

- MI Children: The rate for Michigan children was 90.42%, which marks a significant increase of 10.72 percentage points from the Q1 rate of 79.70%. This improvement indicates a successful enhancement in engagement and follow-up for younger clients.
- MI Adults: For Michigan adults, the rate climbed to 93.75%, reflecting an increase of 3.26 percentage points compared to Q1's rate of 90.49%. This stable performance showcases DWIHN's ongoing commitment to adult mental health services.
- IDD Children: The rate for children with Intellectual and Developmental Disabilities (IDD) reached 92.43%, a remarkable increase of 18.08 percentage points from the Q1 rate of 66.35%. This improvement is particularly noteworthy and demonstrates significant progress in addressing the needs of this vulnerable population.
- IDD Adults: Among adults with IDD, the rate stood at 96.49%, which is an increase of 14.67 percentage points from the previous Q1 rate of 81.82%. This high percentage illustrates DWIHN's focus on ensuring adequate follow-up for adults with IDD.

Overall, the total population rate for PI#3 was 92.96%, representing an increase of 7.74 percentage points from Q1's 85.22%. This cumulative data reinforces the effectiveness of the services provided. These results highlight DWIHN's dedication to continuous improvement in mental health care and its proactive efforts to engage individuals in services that support their ongoing needs.

For performance indicator PI#4a, which tracks the percentage of individuals discharged from a psychiatric inpatient unit—encompassing both children and adults—who received follow-up care within 7 days of their discharge, DWIHN successfully met the MDHHS standard of 95% or higher for the reporting period associated with FY2024. By adhering to MDHHS's established formula, which permits certain exceptions, DWIHN effectively achieved an impressive follow-up care rate of 98.25%. This means that many members discharged from psychiatric inpatient hospitalization were seen by a healthcare provider within the critical 7-day window, emphasizing DWIHN's commitment to continuity of care. Regarding overall performance for PI#4, the follow-up rate for children in the fourth quarter (Q4) stood at a perfect 100.00%. This figure reflects a notable increase of 2.22 percentage points compared to the first quarter (Q1), where the rate was 97.78%. This upward trend indicates a significant improvement in the accessibility and timeliness of follow-up care for pediatric patients. Conversely, the follow-up rate for adults during Q4 was recorded at 98.58%. This represents a slight decrease of 0.09 percentage points from the Q1 rate of 98.67%. While the adult rate remains high, the small decline suggests the need for ongoing monitoring and potential interventions to maintain and improve follow-up care for this demographic.

In 2024, the performance indicator PI#10 for children successfully met the MDHHS standard of 15% or less for recidivism rates in three out of four quarters. This achievement is notable, especially when comparing it to the adult population, which failed to meet the 15% threshold in any quarter throughout the year. As highlighted in the previous section, these 2024 rates signify a significant improvement over those recorded in 2021. During the 45-day meetings, the PI#10 rates were an important topic for discussion, indicating a proactive approach to addressing recidivism. To facilitate these discussions, detailed recidivism reports from the Children's Residential Services Program (CRSP) are requested at the end of each quarter. These reports ensure that CRSPs conduct comprehensive reviews of each individual who has recidivated, allowing for tailored interventions and support. To encourage high performance among CRSPs, financial incentives were put in place during FY2024. The criteria for qualifying for these incentives were set at a recidivism rate of 10% or less for the Adult Mental Illness (AMI) population and 5% or less for individuals with Serious Emotional Disturbance (SED). This strategy aims to promote higher standards of care and outcomes within the CRSPs. When a CRSP records a rate above 15% for any given quarter, a Performance Improvement Plan (PIP) is required. This plan aims to identify the underlying issues contributing to the elevated recidivism rates and to implement corrective measures to enhance performance moving forward. In terms of specific rates for Q4, the following data was recorded:

- For children, the PI#10 rate was 12.14%, which reflects an increase of 3.52 percentage points compared to Q1, where the rate stood at 8.62%.
- In the adult population, the PI#10 rate was 16.52% for Q4, marking a decrease of 1.06 percentage points from Q1's rate of 17.58%.
- Across the total population, the PI#10 rate for Q4 was 16.04%, showing a decrease of 0.75 percentage points from Q1's rate of 16.79%. These figures underscore the ongoing challenges in managing recidivism, particularly among the adult population, while also highlighting the progress being made in addressing the needs of children.

The results outlined below demonstrate that the various initiatives and interventions implemented have proven to be generally effective in decreasing recidivism rates among the target populations. These programs were initially launched in FY2021 and have been sustained through the year 2024. Notably, several targeted interventions developed by the DWIHN's Crisis and Access team have played a significant role in this reduction. As per the data collected, the adult recidivism rate has seen a decrease from 17.94% in Quarter 1 of FY2021 to 16.52% in Quarter 4 of FY2024. Overall, this has led to a combined population recidivism rate of 16.04%. It is important to note that the established threshold for Performance Indicator #10 (PI#10) is a recidivism rate of 15% or lower, indicating continued efforts are necessary to achieve this target. To ensure ongoing improvement, individual recidivism rates for each Clinically Responsible Service Provider (CRSP) have been consistently shared during the regular 45-Day CRSP meetings, which are convened every 45 days. At the end of each quarter, detailed recidivism reports are distributed to CRSPs. These reports prompt CRSPs to review each member with a history of recidivism and to provide thoughtful responses to the DWIHN regarding their cases. For those CRSPs who did not achieve the goal of a recidivism rate of 15% or lower, Performance Improvement Plans have been mandated. These plans outline specific strategies and actions designed to enhance service delivery and ultimately reduce recidivism rates. Additionally, to encourage and reward high-performing CRSPs, financial incentives were introduced during the reporting period of FY2024. The eligibility criteria for these incentives were set at a recidivism rate of 10% or lower for Adult Mental Illness (AMI) cases, and 5% or lower for Serious Emotional Disturbance (SED) cases.

DWIHN's Recidivism Workgroups, which are spearheaded by the DWIHN Crisis and Access team, comprise a collaboration of our Clinically Responsible Service Providers (CRSPs). These workgroups focus on assessing and improving recidivism reduction strategies, sharing best practices, and enhancing service delivery to vulnerable populations. Through these comprehensive approaches, DWIHN continues to strive for improved outcomes in reducing recidivism rates.

| Indicator 10: Percentage who had a Re-Admission to Psychiatric Unit within 30 Days | Population | 2023 | | | | 2024 | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| | Children | 8.94% | 12.03% | 6.76% | 8.22% | 8.62% | 8.82% | 15.69 | 12.14 |
| | Adults | 17.94% | 17.34% | 17.03% | 15.01% | 17.58% | 16.65% | 17.62% | 16.52% |
| | Total | 17.12% | 16.97% | 16.23% | 14.51% | 16.79% | 15.97% | 17.36% | 16.04% |

Finally, DWIHN's Crisis Services Department plays a crucial role in identifying and assisting members who undergo crisis assessments and exhibit patterns of recidivism. Specifically, individuals are classified as recidivistic if they have a crisis encounter followed by re-admission to an inpatient care facility within 30 days of their previous admission. To address this issue, the team has implemented a systematic process to accurately identify these recidivistic members. This process includes notifying the assigned Clinically Responsible Service Provider (CRSP) responsible for their care, as well as connecting members who do not already have a CRSP to appropriate providers for ongoing treatment services within the community. In July, the department observed a significant reduction in the number of adult and child members who experienced recidivistic admissions. This decrease highlights the success of the team's interventions and indicates potential areas for further improvement. The team has also identified opportunities to divert members to the Care Center, which could effectively reduce unnecessary recidivistic inpatient hospitalizations. This approach aims to provide timely and appropriate care to members before their conditions escalate to a point that requires hospitalization. Furthermore, the team recognizes the critical importance of CRSPs engaging with their members while they are in inpatient units. Such interactions can greatly enhance discharge planning processes, ensuring that members have the necessary support and resources upon leaving the hospital. Reiterating the value of these connections not only aids in a smoother transition but also fosters continuity of care, which is essential for improving overall member outcomes and reducing the likelihood of future hospitalizations.

**Identified Barriers and Interventions**

DWIHN successfully achieved MDHHS goals across several performance indicators. Specifically, for Performance Indicator #1 (PI#1), which measures the timeliness of psychiatric screenings, DWIHN ensured that screenings were completed within 3 hours, with a proper disposition provided. In relation to Performance Indicator #2a (PI#2a), which focuses on the Integrated Biopsychosocial Assessment for adults with mental illness (MI) and developmental disabilities (DD), the assessments were completed within the mandated timeframe of 14 days following a request. Performance Indicator #3 (PI#3), which tracks the timely follow-up services provided to all populations except individuals with intellectual and developmental disabilities (IDD) children, was also met, confirming that follow-up services were rendered within 14 days of completing the Integrated Biopsychosocial Assessment. Additionally, DWIHN met the criteria for PI#4a and PI#10, which addresses recidivism rates among children. At this time, DWIHN reported no significant barriers to meeting these goals, nor were there notable opportunities for improvement identified. The organization is committed to a continuous review of data to proactively identify and address any barriers that may emerge in the future. In 2024, the implementation rates for PI#2a were 48.99% for MI children and 36.53% for IDD children.

Both rates fell significantly below the MDHHS benchmark of 57%. Although this data is concerning, it is important to highlight that the rates for IDD children demonstrated a consistent upward trend each quarter, while MI children showed an impressive recovery from the first quarter of the year. The use of 45-day Continuous Quality Improvement meetings (CRSP) and the establishment of Quarterly Performance Improvement Plans were vital in crafting targeted strategies for enhancement. These CRSP meetings fostered collaboration among various departments, allowing stakeholders to collectively address challenges, propose interventions, and optimize performance outcomes. Moreover, the implementation of Performance Indicator Financial Incentives further supported the CRSPs, providing additional motivation and resources to improve service delivery throughout the year. For PI#3, the rate for IDD children in 2024 was reported at 82.54%, which is slightly below the established goal of 83.80%. This shortfall can be attributed, in part, to an exceptionally low rate of 66.35% during the first quarter of 2024. The entire network faced significant challenges regarding staffing for the IDD child population during this period. Nonetheless, DWIHN's network demonstrated resilience and improved its performance rates in the subsequent quarters. By the latter half of the year, the network achieved a commendable rate exceeding 90%. This positive trend signals the potential for DWIHN to meet or surpass the 83.80% goal in future assessments, ultimately enhancing the quality of care provided to IDD children.

In 2022, DWIHN took significant steps to enhance its service delivery by developing comprehensive dashboards designed to measure and track the efficacy of evidence-based practices. These practices are integral to DWIHN's value-based service models, which aim to improve the overall quality of care while maintaining cost-effectiveness. The dashboards are specifically crafted to monitor the financial incentives tied to a variety of standards linked to service outcomes. For the project at hand, the module focused on several key performance indicators (KPIs), namely PI#1, PI#2a, PI#3, PI#4a, and PI#10. Clinically Responsible Service Providers (CRSPs) were granted access to their data during FY2024 through DWIHN's electronic health record system, known as MHWIN. This access allowed providers to begin evaluating their compliance rates by the end of 2022, particularly through the visualization tool called the "CRSP Risk Matrix," which is part of the Power BI Module. Furthermore, the Quality Improvement staff have committed to ongoing collaboration with the IT module developer to refine the accuracy and reliability of the data collected. Despite these advancements, DWIHN has faced persistent challenges related to workforce shortages, particularly impacting its child populations. This issue mirrors trends in many other sectors that are currently grappling with staffing deficits. CRSPs have consistently reported that recruiting and retaining qualified staff remains their most critical challenge in meeting established standards of care. Contributing to this dilemma is the competitive landscape created by the Michigan school system, which has recently raised salaries in response to increased state funding. This adjustment, combined with the attractive benefit of summer breaks, has drawn potential employees away from DWIHN.

Additionally, the network has seen a significant loss of staff to private practice therapy companies that offer more lucrative compensation packages, flexible working arrangements, minimal administrative duties, and the convenience of remote work. Notably, these private companies have recently been able to hire individuals with limited licensure, a significant shift from prior regulations that restricted such hiring practices. The consequences of this staffing shortage have been severe, with some CRSPs temporarily suspending the acceptance of new members. Consequently, other agencies have become inundated with requests, resulting in delays of 30 to 60 days for initial intake appointments, which is far above the recommended 14-day timeline. This situation has also influenced the overall number of appointments missed within the 14-day period, revealing a systemic challenge that DWIHN needs to address urgently. In response to this staffing crisis, DWIHN explored the possibility of increasing base salaries for children's service staff to improve workforce retention and child service rates. However, efforts to implement salary increases were complicated by various union-related issues, preventing any changes from being made. Additionally, CRSPs have noted that staff retention suffered after DWIHN instituted a telehealth policy, which suggested that telehealth services be used only when necessary.

This policy led to a greater expectation for in-office presence among staff, which resulted in further departures. Despite these challenges, DWIHN reported robust performance indicator rates for FY2024. Financial incentives were extended to high-performing CRSPs for ongoing adherence to PI#2a, PI#3, PI#4a, and PI#10. This project represents a multi-year initiative, and it appears that FY2024 marked a pivotal year in which the effects of previous interventions began to manifest in measurable outcomes. Notably, a significant adjustment was made in the calculation of rates—excluding cases where delays in providing care within the 14-day window resulted from circumstances outside the CRSPs' control.

This modification was crucial in allowing a greater number of CRSPs to qualify for financial incentives. For the first three quarters of 2024, a series of financial incentives were disbursed to the network, with 4th quarter payments scheduled for distribution in March 2025. These incentives were meticulously designed to incentivize improvements in staff recruitment and retention as well as enhance the overall quality of care provided to members.

- FY2024 1st Quarter- 42 payments for a total of $891,693
    - $502,886 was awarded to the AMI providers
    - $201, 205 was awarded to SED providers
    - $187,602 was awarded to IDD providers
- FY2024 2nd Quarter- 40 payments for a total of $668,369
    - $354,511 was awarded to the AMI providers
    - $189,098 was awarded to SED providers
    - $124,760 was awarded to IDD providers
- FY2024 3rd Quarter- 54 payments for a total of $1,109,417
    - $582,746 was awarded to the AMI providers
    - $246,349 was awarded to SED providers
    - $280,321 was awarded to IDD providers

DWIHN's Children's Initiatives Department has implemented a series of strategic measures aimed at significantly improving coordination of care among DWIHN, local hospitals, and the Clinically Responsible Service Providers (CRSP). In a pivotal development in 2024, the Children's Director reported the addition of two new providers to the CRSP network. This initiative was specifically designed to address persistent staffing challenges that have affected service delivery across the system. Moreover, recognizing the importance of ongoing communication, the Children's Initiative team has incorporated discussions about care coordination in all Children's Provider meetings scheduled for FY2024. This move ensures that providers are aligned on best practices and are continuously informed about developments in care strategies. In response to the growing concerns regarding transportation barriers for members needing services, DWIHN launched a new intervention in 2023. To facilitate better access to care, DWIHN engaged two transportation providers to offer non-emergency transportation services throughout the network. This service allows members to travel to critical appointments, including physician visits, outpatient behavioral health sessions, and follow-up appointments after hospital discharge. To utilize this service, members must submit their transportation requests at least 48 hours in advance. This program was officially rolled out in the fourth quarter of FY2023, with an accompanying memo issued in October 2023 to inform stakeholders of the new initiative. The implementation faced some initial delays; however, the Access Center is actively collaborating with the IT department to establish reliable methods for tracking outcome data to assess the program's effectiveness over time.

DWIHN continues to grapple with the challenge of decreasing hospital admissions and readmissions, particularly in psychiatric care. The organization remains committed to reducing psychiatric inpatient admissions while ensuring that members have access to safe, timely, and high-quality treatment alternatives. A holistic approach is taken to guarantee members receive the necessary care without resorting to hospitalization unless absolutely required. To monitor progress, CRSP rates are meticulously reviewed at every 45-day CRSP meeting, while quarterly Performance Improvement Plans are disseminated to promote accountability and progress tracking among providers. Furthermore, the Crisis Department plays a crucial role by producing quarterly reports that offer a detailed review of each hospitalized member, thereby enabling CRSPs to analyze and address specific cases. To further improve care delivery, DWIHN is dedicated to expanding the comprehensive continuum of crisis services and support available to members. Initial data shows a slight reduction in hospitalization rates quarter over quarter, reflecting the effectiveness of these interventions. A significant milestone was reached in 2024 with the opening of DWIHN's Crisis Care Center, which aims to provide immediate and effective support for individuals in crisis. DWIHN is optimistic that this facility will enhance the overall coordination of care and help alleviate some of the historical challenges that have impacted the network's ability to serve its members effectively.

**Opportunities for Improvement**

DWIHN will continue to monitor and focus its efforts on some of the following identified interventions:

- Address staff shortages throughout its network to ensure members can receive services within the appropriate timeframes.
- Continue to work with DWIHN's Crisis Team to identify potential delays in care for PI#1, PI#4a, and PI#10. The Crisis Care Center could improve this indicator as well as the coordination of care throughout the network.
- Work on expansion of "Med Drop" Program to improve outpatient compliance with goals to decrease need for higher level of care inpatient hospitalizations.
- Continue engagement and collaboration with members' outpatient (CRSP) providers to ensure continuity of care and when members present to the ED in crisis but may not require hospitalization.
- Properly navigate and divert members to the appropriate type of service and level of care.
- Provide referrals to Complex Case Management (CCM) for members with high behavioral needs.
- Continue coordination and collaboration with crisis screeners on measures to decrease inpatient admission.
- Improve CRSP involvement with member prior to discharge from a hospital.
- Improve education and coordination with hospitals regarding DWIHN's initiatives and goals.
- Hospital, DWIHN and CRSP improve accuracy of member's contact information. Incorrect or outdated contact information continued to be a frequent topic throughout FY2024.
- Continue to educate network on new transportation companies and increase usage of program.
- Continue the Performance Indicator financial incentives program.
- Review CRSPs and continue to increase the number of children's CRSPs/network capacity.

**Timeliness of Utilization Management**

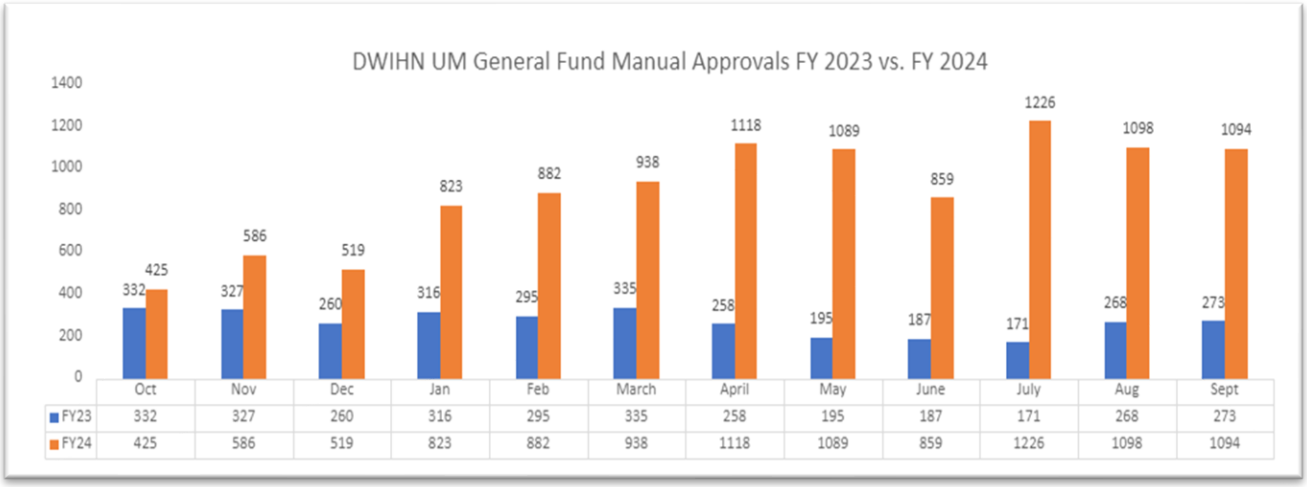
The Utilization Management (UM) Department plays a crucial role in DWIHN by overseeing and monitoring the utilization of health services by its members. This department is dedicated to ensuring that all service requests are thoroughly assessed for medical necessity, thereby confirming that the services provided are appropriate and suitable for the individual's specific level of care. The UM Department's primary responsibilities involve a careful review process for authorization requests across a wide array of services. These services include outpatient care, acute inpatient psychiatric hospitalization, partial hospitalization programs, crisis residential units, substance use disorder (SUD) services, autism services, Habilitation Supports Waiver (HSW), Children with Serious Emotional Disturbances Waiver (SEDW), Children's Waiver Program (CWP), Self-Determination/Self-Directed (SD) Services, as well as General Fund Exception and County of Financial Responsibility (COFR) services.

**Quantitative Analysis and Trending of Measures**

The chart below provides a comprehensive overview of the monthly trends in unique members served in our Habilitation Supports Waiver (HSW) program during the specified period of FY2024. Throughout the fiscal year, we proudly maintained a utilization rate that consistently exceeded the state program's requirement of 95% each month. This high level of service utilization underscores our commitment to ensuring that members enrolled in the HSW program not only have access to traditional State Plan services but also receive crucial additional support tailored to help them develop the skills necessary for independent living in community settings. This approach allows our members to thrive within their communities. The positive impact of our dedicated services is further reflected in the recent decision by MDHHS to allocate an additional forty-one (41) slots to DWIHN, effective October 1, 2024. This allocation will increase our total number of available slots from 1,084 to 1,125, significantly enhancing our capacity to serve a greater number of members and providing them with the support they need to live independently and achieve their personal goals.

| HSW Utilization Fiscal Year 2023-24 | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** | **April** | **May** | **June** | **July** | **Aug** | **Sept** |
| **Total Slots Owned** | 1084 | 1084 | 1084 | 1084 | 1084 | 1084 | 1084 | 1084 | 1084 | 1084 | 1084 | 1084 |
| **Used** | 1062 | 1080 | 1084 | 1084 | 1083 | 1083 | 1083 | 1084 | 1078 | 1082 | 1082 | 1082 |
| **Available** | 22 | 4 | 0 | 0 | 1 | 1 | 1 | 0 | 0 | 2 | 2 | 2 |
| **New Enrollments** | 12 | 27 | 10 | 4 | 6 | 8 | 4 | 4 | 8 | 3 | 13 | 22 |
| **Disenrollments** | 2 | 4 | 2 | 2 | 5 | 3 | 1 | 9 | 2 | 8 | 2 | 2 |
| **Utilization** (%) | 98 | 99.6 | 100 | 100 | 99.9 | 99.9 | 99.9 | 100 | 100 | 99.8 | 99.8 | 99.8 |

The General Fund Exception is a vital process implemented to guarantee the continuous provision of essential services, even as efforts are made to obtain or reinstate insurance coverage for beneficiaries. Recently, DWIHN has observed a notable rise in the number of manual approvals for the General Fund Exception during the transition from fiscal year 2023 (FY-23) to fiscal year 2024 (FY-24). This increase follows the termination of the Pandemic Emergency Order, which had enacted several temporary modifications to Medicaid program eligibility requirements, administrative procedures, and policies. These adjustments were crucial in ensuring that beneficiaries did not lose their health insurance coverage during the pandemic. As a result of these changes and the subsequent shift in policy, many individuals have found themselves in need of manual approvals to access necessary services under the General Fund Exception. The accompanying chart provides a detailed comparison of the number of manual approvals granted in FY-23 versus FY-24, highlighting the significant impact of the policy changes on service delivery and the reliance on the General Fund Exception during this period.




| | Oct | Nov | Dec | Jan | Feb | March | April | May | June | July | Aug | Sept |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY23 | 332 | 327 | 260 | 316 | 295 | 335 | 258 | 195 | 187 | 171 | 268 | 273 |
| FY24 | 425 | 586 | 519 | 823 | 882 | 938 | 1118 | 1089 | 859 | 1226 | 1098 | 1094 |

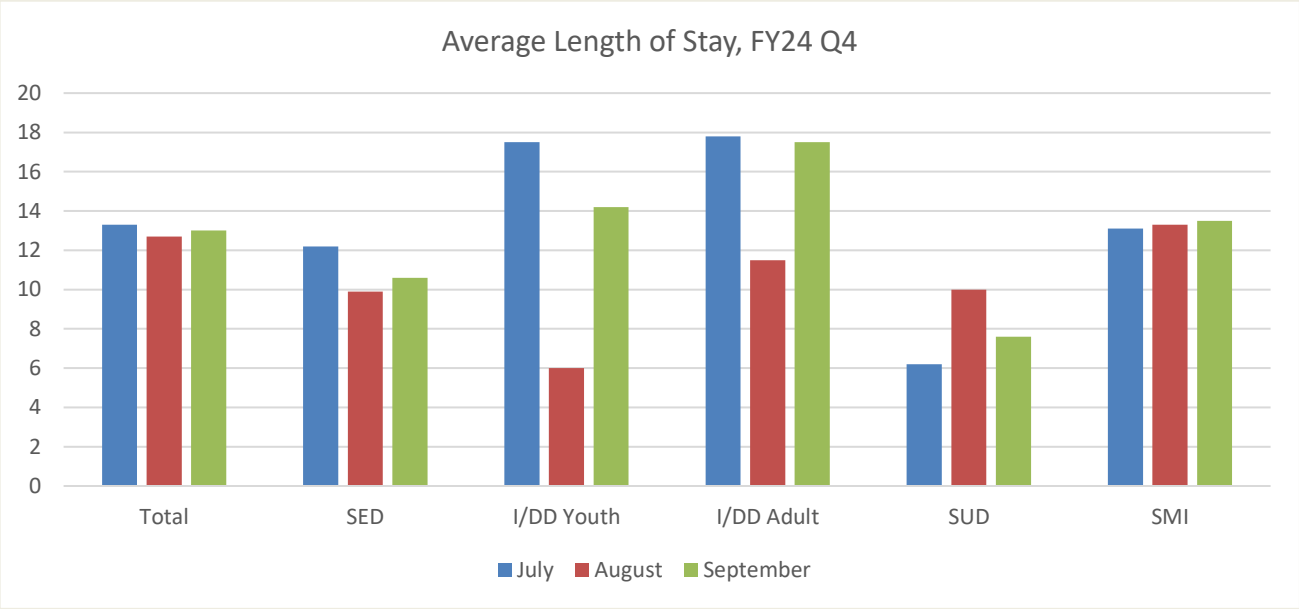
In response to the increasing number of General Fund Exception requests, the Utilization Management (UM) team has undertaken a significant revision of the General Fund Benefit Grid. This revision was carried out in collaboration with clinical teams and various subject matter experts to ensure that it meets the needs of our members effectively. The newly updated Benefit Grid now provides clear and comprehensive information regarding essential services that are accessible to members without Medicaid coverage. This clarity is intended to facilitate better understanding and utilization of the available resources.

**Evaluation of Effectiveness**

The UM team collaborated closely with the PIHP Crisis Services to develop and provide specialized training focused on utilization management principles for the newly formed Pre-Admission Review (PAR) Dispatch team, as well as for existing screening entities. This training is critical for enhancing the team's ability to handle referrals and assessment efficiently. The implementation of an electronic notification system designed for healthcare providers. This system will proactively inform them about any returned authorizations, ensuring that they are kept in the loop regarding the status of their requests. The primary goal of this system is to enhance the timeliness of communication and to expedite the processing of authorization requests, ultimately leading to quicker access to necessary services for our members. The UM team has been active in participating in interdepartmental clinical consultations. These discussions are aimed at addressing the complex needs of members who are considered "high priority" due to their complexity and/or high rates of recidivism. By working collaboratively across departments, we strive to create holistic and effective support strategies for these individuals, ensuring that they receive the comprehensive care they require.

**Hospitalization**

Inpatient psychiatric services play a vital role in providing immediate support to members experiencing a crisis. However, we also emphasize the significance of offering ongoing assistance within the community, ensuring that individuals receive care in the least restrictive environment possible. To effectively reduce the length of hospital stays and minimize the number of admissions, as well as to strengthen community support, the UM department actively organizes regular case conferences. During these conferences, we conduct thorough reviews of complex cases, focus on recidivism among members who have frequently required hospitalization, and analyze cases where the length of stay has exceeded 14 days. This comprehensive approach allows us to identify patterns, address underlying issues, and develop targeted strategies for improvement. Moreover, the UM department collaborates extensively with various stakeholders, including the PIHP Crisis Services, Residential Services, and both Adult and Children's Initiatives, along with Integrated Care teams. This multidisciplinary collaboration enables us to formulate holistic, individualized plans that are tailored to the specific needs of each member. By doing so, we aim to equip our members with the necessary tools and resources to successfully reintegrate into their communities and achieve their personal goals following discharge from the hospital. Our commitment to ongoing support and collaboration is essential in promoting recovery and enhancing overall well-being.




**Alternative Levels of Care**

There are various levels of alternative care available to support our members within the community, aiming to prevent the need for inpatient psychiatric hospitalization. One of the key resources is the Crisis Residential Unit (CRU), which serves as a short-term alternative for individuals experiencing an acute psychiatric crisis. These units are specifically designed for individuals who meet the criteria for psychiatric hospitalization or those who are at risk of needing admission. However, they can be effectively supported in less intensive settings. The CRU offers a safe and structured environment, which is essential for our members during such critical times. Another important alternative is Partial Hospitalization, a cost-effective and structured treatment option that is appropriate for individuals when inpatient hospitalization is not necessary. This program provides a comprehensive treatment experience that includes individual therapy sessions, group therapy, psychoeducation, and skills-building activities. Participants also undergo regular evaluations to monitor their progress. A significant advantage of Partial Hospitalization is that individuals can return home at the end of each program day, allowing them to maintain their community ties and support systems while still receiving the necessary care. Additionally, our UM Department plays a crucial role in overseeing the authorization and clinical review of outpatient treatment services. This includes support for individuals with Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI), as well as those with Intellectual and Developmental Disabilities (I/DD).

The department ensures that appropriate services are provided effectively and that members receive the care they need. The UM Department also manages autism services, including Behavioral Health Treatment, such as Applied Behavior Analysis (ABA). Furthermore, it oversees substance use disorder (SUD) services, self-directed services, and various waiver programs, including Serious Emotional Disturbance Waiver (SEDW), Children's Waiver Program (CWP), and Home and Community-Based Services Waiver (HCBS). This comprehensive approach ensures that all members receive the necessary support tailored to their unique needs.

**Opportunities for Improvement**

- Conduct ongoing training on authorization, code usage, and modifiers for the Provider Network.
- Aim to reduce response and disposition times for standard prior authorization requests.
- Continue updating current processes and procedures to comply with 42 CFR requirements. This includes Providing oral notification to members, utilizing extension letters for decision timeframes, and updating language in Adverse/Adequate Benefit Determinations.
- Offering ongoing staff training to support departmental changes.
- Continue cross-training of UM Clinical Specialists.
- Maintain participation in acute psychiatric hospital meetings in collaboration with the PIHP Crisis Services Department. This will help build positive rapport, foster collaborative working relationships, and promote resource sharing with inpatient psychiatric hospital teams.
- Develop and implement a collaborative discharge planning process involving PIHP Crisis Services, Adult and Children's Initiatives, and Access Call Center teams. This process aims to ensure appropriate and supportive discharge plans for members while assisting in reducing recidivism and the over-utilization of higher levels of care.
- Improve the depth of reporting for higher levels of care (inpatient, partial hospitalization, crisis residential), including detailed authorization and provider information, as well as recidivism data.
- Place specific focus on inpatient discharge planning needs for individuals with Intellectual and Developmental Disabilities (I/DD), as they often experience longer lengths of stay due to complex needs or insufficient resources.

**Residential Services Authorization**

The Residential Department is tasked with the important responsibility of thoroughly reviewing requests for residential authorization. These requests specifically highlight the personal care needs and community-living support services required by individuals. The department's oversight includes members who reside in a variety of settings, whether they are in licensed facilities that meet regulatory standards or in unlicensed environments that may offer more informal support options. By carefully assessing each request, the department ensures that all members receive the appropriate level of care and support tailored to their unique needs.

Authorization dispositions must be completed within 14 days of submission to the Detroit Wayne Integrated Health Network (DWIHN). In the months of October and November 2024, a notable 93.3% of these authorization dispositions were successfully provided within this required timeframe, reflecting a commitment to maintaining efficient processing times. To enhance the continuity of care for members, the Residential Department is implementing a tracking system that generates reports at intervals of 30, 60, and 90 days. These reports are sent to Clinically Responsible Service Providers (CRSP) and detail when each member's treatment plans are set to expire. This proactive approach is designed to ensure that members consistently have access to updated treatment plans and necessary authorizations, ultimately preventing any interruptions in their services. In December 2024, the Residential Services Department took significant steps forward by establishing a new process for medical staff to review authorization denials. This process aims to streamline and expedite the decision-making regarding denials, ensuring that determinations are made in a timely manner, which is critical for patient care. Furthermore, DWIHN is dedicated to improving the quality of clinical documentation skills among its staff. To this end, the organization continues to provide bi-monthly training sessions targeted at CRSP case holders and their supervisors. These training sessions focus on enhancing documentation practices to promote consistency and improve the evaluation of medical necessity for services provided to members. Since October 2024, the Residential Services Department has successfully onboarded four new residential providers, which has resulted in the addition of 18 residential placements to the existing network.

This expansion is crucial in meeting the growing needs of the community. Currently, there are 244 licensed settings and 222 unlicensed settings available for adults with mental illness (AMI). Additionally, there are 233 licensed settings, and 240 unlicensed settings designated for adults with intellectual and developmental disabilities (I/DD). Lastly, the Residential Services Department has made significant strides in transitioning individuals from institutional care to community living. Since October 2024, the department has successfully discharged eight individuals from state hospital facilities into community settings, marking an important step towards enhancing individual autonomy and integrating them into supportive environments.

**Complex Case Management (CCM)**

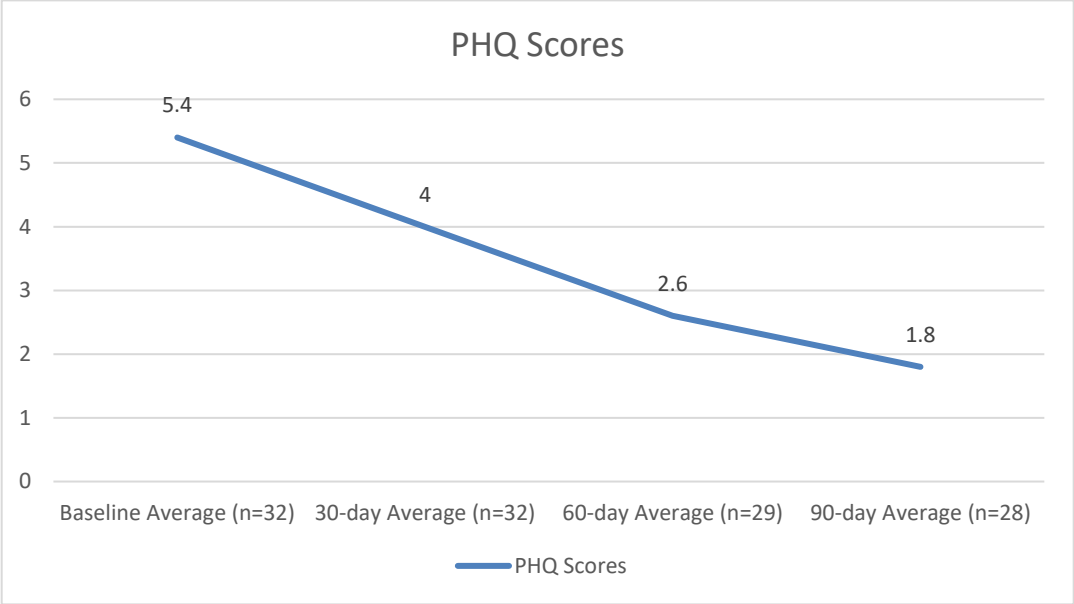
DWIHN implements a comprehensive approach to evaluate the effectiveness of its Care Coordination Management (CCM) program, aiming to enhance outcomes for all members involved. To achieve this, a range of evidence-based assessment tools are utilized, specifically the Patient Health Questionnaire-9 (PHQ-9), the Patient Health Questionnaire for Adolescents (PHQ-A), and the World Health Organization Disability Assessment Schedule (WHO-DAS). These assessments are systematically conducted at the initiation of CCM services and are repeated every 30 days thereafter to closely monitor progress and identify any changes in the member's mental and physical health. This regular evaluation helps ensure that members are receiving the necessary support and interventions tailored to their individual needs. In addition to these assessments, DWIHN conducts a thorough analysis of members' utilization patterns, focusing on Emergency Department visits and hospital admissions prior to and following the initiation of CCM services. This analysis provides valuable insight into how CCM services impact overall healthcare usage and can highlight areas for further improvement. Furthermore, the organization evaluates members' use of outpatient services after beginning CCM, which helps gauge the long-term effectiveness of the program in promoting ongoing care. Lastly, to gather feedback on the quality and impact of the CCM services, DWIHN administers a Satisfaction Survey to all members when they conclude their participation in the program. This survey serves as a crucial tool for understanding members' experiences, addressing their concerns, and refining the program based on their input. By combining quantitative data with personal feedback, DWIHN strives to continuously improve the CCM program and the health outcomes for its members.

**Qualitative Analysis and Trending of Measures**

The fiscal year 2024 spans from October 1, 2023, to September 30, 2024, during which these measures were evaluated. A total of 40 members were enrolled in the Complex Case Management (CCM) services during FY24. Of these, 34 members were enrolled in CCM for at least 60 days, and 30 members were enrolled for at least 90 days. The primary goals of the Detroit Wayne Integrated Health Network's (DWIHN) CCM Program are:

- To improve medical and/or behavioral health concerns and enhance overall functional status, as indicated by a 20% improvement in Patient Health Questionnaire (PHQ) scores and a 20% improvement in World Health Organization Disability Assessment Schedule (WHO-DAS) scores at the time of CCM closure for members enrolled for at least 90 days.
- To provide early intervention for members eligible for Complex Case Management, aiming to prevent recurrent crises or unnecessary hospitalizations. This will be measured by achieving a 10% reduction in Emergency Department (ED) utilization and a 10% reduction in hospital admissions, comparing the 90 days prior to receiving CCM services to the 90 days following CCM services for members who were enrolled for at least 60 days and reached closure.
- To increase participation in outpatient appointments, aiming for a 10% increase in the use of outpatient behavioral health services from 90 days prior to receiving CCM services to 90 days after, for members who were enrolled for at least 60 days and closed as of October 2024.
- To improve the number of members who attended two outpatient behavioral health services within 60 days of starting CCM services, targeting a 10% increase in participation for those who were open for at least 60 days.
- To achieve member satisfaction scores of 85% or higher for members at closure who received CCM services.

During the reporting period of FY2024, information was collected to assess the prevalence of depression symptoms among members. Symptoms of depression were measured using the Patient Health Questionnaire (PHQ-9) for adults (aged 18 and older) and the Patient Health Questionnaire for Adolescents (PHQ-A) for children (under 18). These PHQ assessments are integrated into the Complex Care Management (CCM) evaluations for both adults and children. They are completed at the onset of CCM services and then every 30 days until the CCM services conclude. A higher score on the PHQ-9 or PHQ-A indicates more severe symptoms of depression, while a decrease in score reflects an improvement in symptoms. PHQ scores were collected from the CCM assessments conducted at the start of services and at 30, 60, and 90 days afterward. For members who participated in the CCM program for at least 90 days during fiscal year 2024, the PHQ scores were analyzed at the time of their closure. The baseline PHQ scores for members ranged from 0 to 11, with an average score of 5.4. Members involved in the Complex Case Management services showed overall improvement in their PHQ scores, with more significant improvements noted the longer they participated in the program. Specifically, the average PHQ scores improved by 26% at 30 days, 35% at 60 days, and 31% at 90 days of receiving CCM services




**Evaluation of Effectiveness**

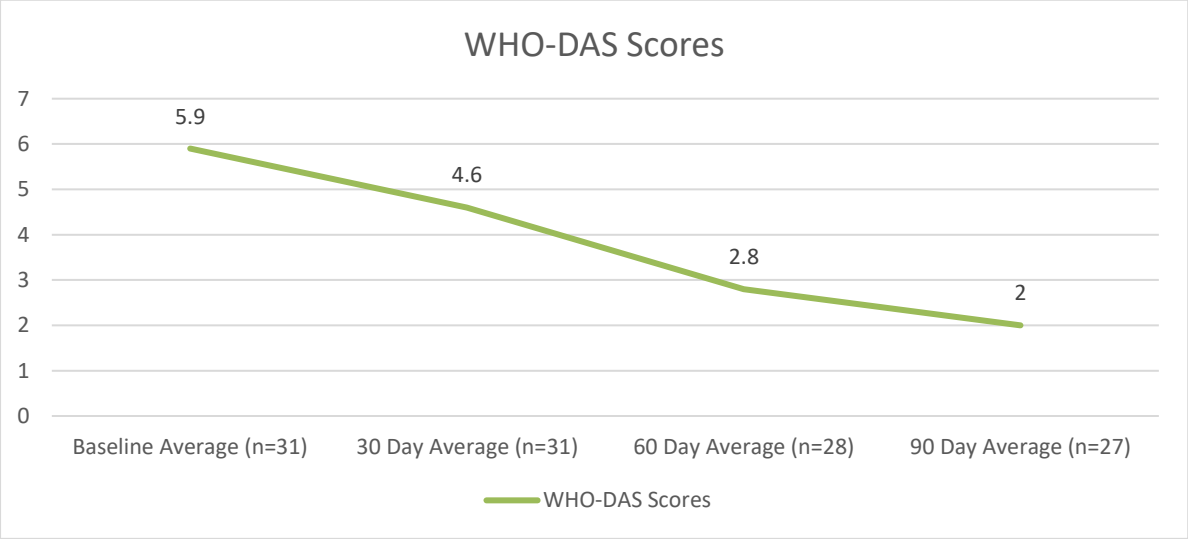
Out of 40 members, 32 were included in the denominator for the baseline PHQ scores. Seven members were excluded because their cases had not been open for 90 days. One member was not included due to being below the recommended age for PHQ assessments, which is 11 years and older. Additionally, six member cases remained active at the conclusion of FY2024 (after 10/31/2024). Among those assessed, 25 out of 26 members (96%) achieved the goal of a 20% improvement in PHQ scores from the start to the closure of CCM services. The initial and 30-day PHQ scores of members were reviewed to evaluate any improvements within the first 30 days of starting CCM services. Again, 32 out of 40 members were included in this analysis. Seven members were excluded for not being open for 90 days, and one member was not included due to age. The average PHQ score decreased from the baseline to the 30-day mark, indicating an improvement in scores within the first month of CCM services.

**Causal Analysis**

Although we achieved our goal of a 20% improvement in PHQ scores in the first year, we will continue to monitor whether this improvement is consistent over time to determine if we should significantly increase or retire this goal. Overall, members who participated in the Care Coordination Model (CCM) for at least 30 days experienced a significant improvement in their scores. Specifically, there was a 6% increase in 90-day PHQ scores from FY2025 compared to the scores from FY2023. We are continuously evaluating interventions that can enhance member outcomes and help us maintain this goal. Out of 26 members, 25 showed improvement in their PHQ scores from baseline to the end of CCM services, while one member's scores remained unchanged. We believe that our ongoing efforts—such as connecting members with behavioral health providers, arranging transportation, assisting with appointment scheduling, and providing appointment reminders—have contributed to exceeding our goal. CCM will continue to emphasize crisis plans, coordinate with members' care teams, provide education on symptom management, and connect members with peers for additional support.

**WHO DAS Scores**

During Fiscal Year 2024, data were collected to assess the quality of life of members using the World Health Organization's Disability Assessment Schedule (WHO-DAS). This assessment is integrated into the Complex Case Management (CCM) process and is conducted at the beginning of CCM services and every 30 days thereafter until the services conclude. A higher score on the WHO-DAS indicates a greater level of disability. The WHO-DAS evaluates six domains: cognition, mobility, self-care, interpersonal relationships, life activities, and participation. It is essential that practitioners administering this assessment are properly trained. A decrease in the WHO-DAS score signifies an improvement in the level of disability. WHO-DAS scores were collected during the CCM assessments at the start of services and again at 30, 60, and 90 days after beginning. Scores were also evaluated at the closure for members who participated in the CCM Program for at least 90 days. The baseline WHO-DAS scores for members ranged from 2 to 32, with an average score of 5.9. Members engaged in Complex Case Management services displayed overall improvement in their WHO-DAS scores, with enhancements becoming more pronounced the longer they participated in CCM services. Specifically, average WHO-DAS scores improved by 22% from the baseline at 30 days, 39% at 60 days, and 29% at 90 days of receiving CCM services.



**Evaluation of Effectiveness**

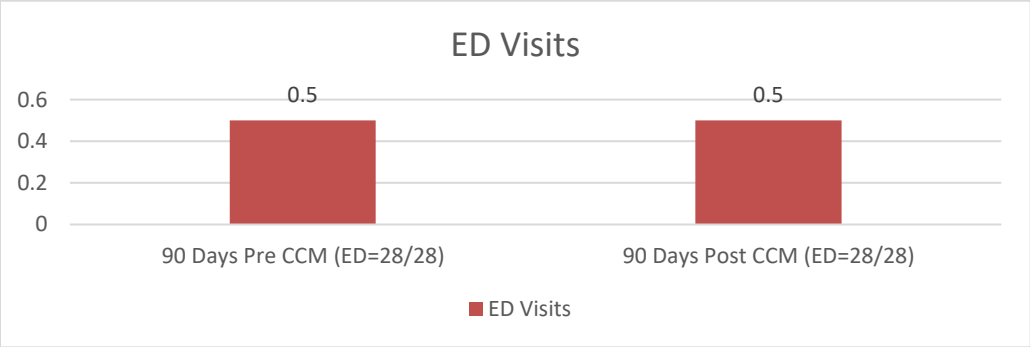
A total of 31 out of 40 members were included in the denominator for the baseline World Health Organization Disability Assessment Schedule (WHO-DAS) scores. Seven members were excluded from the denominator because their cases had not been active for at least 90 days. Additionally, two members were not included due to being under the recommended age for assessment; the WHO-DAS is suitable for individuals aged 18 and older. Furthermore, six member cases remained active at and after the end of FY2024 (after October 31, 2024). Among those assessed, 23 out of 25 members (92%) achieved the goal of a 20% improvement in their WHO-DAS scores from the beginning to the conclusion of the Chronic Care Management (CCM) services. The initial WHO-DAS scores of the members were also compared to their scores after 30 days of starting CCM services to determine whether any improvement occurred within the first month. Again, 31 out of the 40 members were included in this evaluation. Two members were excluded for being under the recommended age, while seven were not included due to their cases not being open for at least 90 days. The average WHO-DAS score decreased from baseline to the 30-day mark, indicating an improvement in the scores within the first 30 days of receiving CCM services.

**Causal Analysis**

We have successfully achieved our goal of a 20% improvement in WHO-DAS scores for the first year; however, we will continue to evaluate whether this improvement can be sustained over time. Members participating in the CCM program for at least 90 days have shown notable improvements in their WHO-DAS scores. Specifically, there was a 44% improvement in the 90-day WHO-DAS scores between FY2024 and FY2023. Out of 25 members, 23 experienced improvements in their WHO-DAS scores from baseline to the conclusion of CCM services, while two members' scores remained unchanged. CCM continuously assesses all members for physical limitations and ensures they have the necessary support, such as durable medical equipment, therapeutic services, and CLS services, to maintain their independence. Additionally, CCM assists members in transitioning to higher levels of care when needed.

**Emergency Department Utilization and Hospital Admissions**

DWIHN analyzed member Admission, Discharge, and Transfer (ADT) alerts along with claims data to assess the use of Emergency Departments and hospital admissions. This analysis focused on the 90 days before and the 90 days after members began participating in CCM services, specifically in FY2024. Overall, due to the small population size, there was no significant change in Emergency Department utilization when comparing the 90 days prior to the start of CCM services with the 90 days following the initiation of these services. On average, members had 0.5 Emergency Department visits during both the 90 days before and the 90 days after starting CCM services.



**Evaluation of Effectiveness**

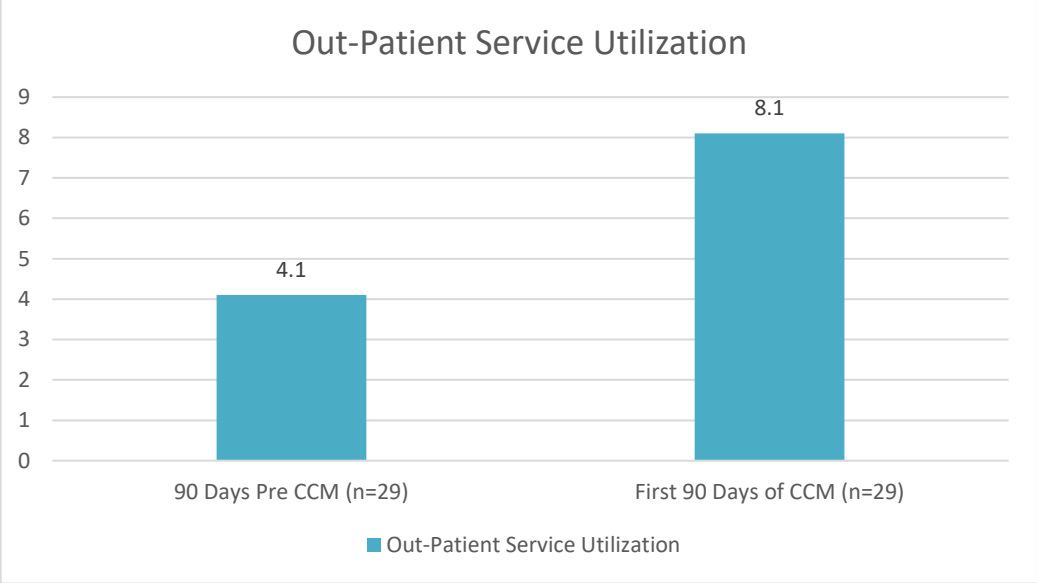
Among the 8 members who utilized the Emergency Department (ED), 1 member exhibited high utilization during both time periods, which affected the overall average. Out of 40 active cases, 5 members were not included in this measure because they had not been enrolled in Chronic Care Management (CCM) services for at least 60 days by the report's date. Additionally, 1 member was excluded for not being enrolled in CCM services for 90 days. Furthermore, 6 members were not counted in the denominator due to their CCM cases remaining active, with closures expected after October 2024 during the review period. Additionally, 20 members were excluded from the denominator because they did not have any Emergency Department visits within 90 days of starting CCM services. Out of the 8 members, 2 (25%) achieved the goal of a 10% decrease in the number of Emergency Department visits from the 90 days prior to their enrollment in CCM services. Two members showed no change in ED visits, while 4 members experienced an increase in visits. DWIHN also tracks inpatient admissions for members participating in CCM services. Among the 40 active cases, 6 members were excluded from the denominator for the same reasons mentioned earlier—they were still active cases with expected closures after October 2024. Additionally, 5 members were excluded for not being enrolled in CCM services for at least 60 days. Notably, 28 members did not have any inpatient hospitalizations, and only 1 member experienced a hospitalization within 90 days of starting CCM services. As a result, inpatient admissions could not be evaluated for FY24 as a goal, given that there was only one CCM member hospitalized.

**Causal Analysis**

When evaluating the data, we recognized that we had a small dataset reviewed for this goal. Out of a total of 8 eligible members, only 2 (25%) achieved the goal of a 10% reduction in Emergency Department visits. Four members experienced an increase in Emergency Department visits from 90 days prior to starting Complex Care Management (CCM) services to 90 days after beginning the program, while 2 members showed no change during this period. To help meet the 10% reduction goal for FY2025, the Complex Care Management team will provide more education to members about crisis support and available services upon program enrollment. This aims to reduce Emergency Department utilization. In addition to discussing Crisis Plans with members, Complex Case Managers will also offer education on medical and behavioral health management after a member's first Emergency Department visit while enrolled in the program. Educational materials will cover medication management, the importance of attending appointments with providers, follow-up care, and symptom management. Furthermore, Complex Case Managers will continue to round in designated hospitals to provide additional support.

**Utilization of Out-patient Services**

DWIHN conducted an analysis of member claims data to assess the utilization of outpatient behavioral health services. This analysis compared the 90 days prior to participation in Care Coordination Management (CCM) services with the 90 days following the initiation of CCM services. The focus was on members who were enrolled in CCM for at least 60 days before closure. The average number of outpatient behavioral health services utilized during the 90 days before starting CCM services was 4.1. After beginning CCM services, the average number of outpatient behavioral health services rose to 8.1. This represents a 51% increase in service utilization within the first 90 days of participating in CCM services.




**Evaluation of Effectiveness**

A total of 29 members were included in the analysis of out-patient behavioral health services for the 90 days prior to the start of CCM services and the 90 days following the initiation of CCM services. These members had been enrolled in CCM for at least 60 days by the time of closure. Five members were excluded from the analysis because they were not enrolled in CCM for at least 60 days. Additionally, 6 members were not included due to their CCM cases still being active, with closures occurring after October 2024 at the time of review. Out of the 29 members analyzed, 25 (86%) achieved the goal of a 10% increase in out-patient behavioral health services when comparing the 90 days prior to starting CCM services with the 90 days following the start of these services. Two members showed no change, as they attended the same number of out-patient behavioral health appointments in the 90 days before and after starting CCM services. However, two members experienced a decrease in the number of out-patient behavioral health services attended during the same time frame. DWIHN also tracks the number of members who attended two or more out-patient behavioral health appointments within 60 days of starting CCM services and who remained in CCM for at least 60 days, with closures occurring by October 2024. Out of the 29 members, 26 (90%) attended two or more out-patient behavioral health services within 60 days of starting CCM services.

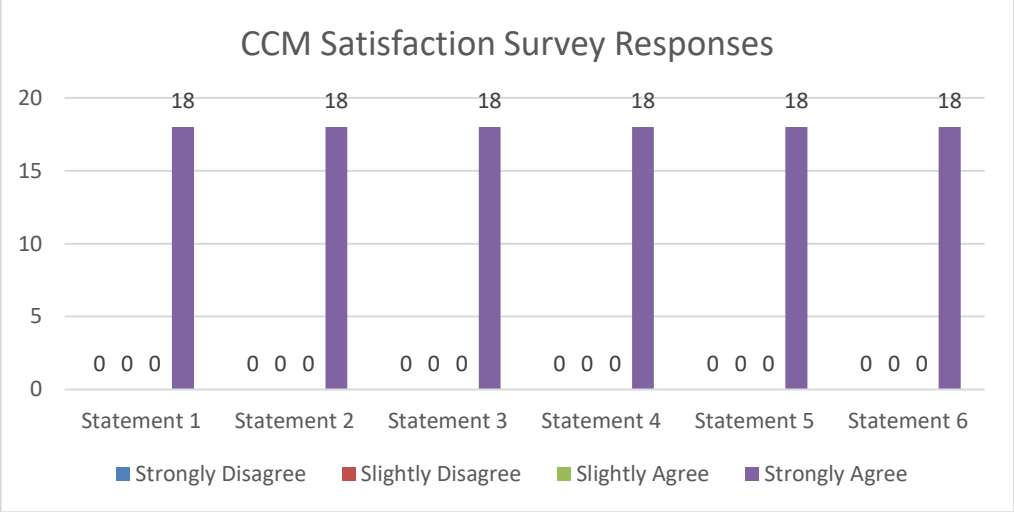
DWIHN measures the number of members who attended two outpatient behavioral health appointments within 60 days of starting CCM services, provided they participated in CCM for at least 60 days and closed their cases by October 2024. Out of 29 members, 26 (90%) attended two or more outpatient behavioral health services within 60 days of starting CCM services. Five members were excluded from this measure because they were not enrolled in CCM services for the required 60 days at the time of the report. Additionally, six members were not included in the denominator because their CCM cases were still active and would close after October 2024 at the time of the review. DWIHN also measures the number of members who attended two outpatient behavioral health services within 60 days of the closure of CCM services. Out of 22 members who were eligible to participate in two outpatient services after their CCM case closure, 16 members (73%) attended two or more services. Five members were excluded from this measure for not being enrolled in CCM services for 60 days by the time of the report. Seven members were not included because their cases had not been closed for at least 60 days at the time of review, and six members were excluded from the denominator because their CCM cases were still active and would close after October 2024 at the time of the review.

**Causal Analysis**

For FY24, we achieved our goal of a 10% overall improvement in Outpatient Behavioral Health visit attendance. This target was established in 2021, a year in which we experienced a 1.5% decrease in this measure from FY2023 to FY2022. DWIHN surpassed our goal of a 10% increase in participation in two or more behavioral health services within 60 days of starting CCM services. Notably, 25 out of 29 members saw an increase in outpatient visits within the first 90 days of starting CCM services, and 26 out of 29 members attended two or more outpatient visits within 60 days of beginning CCM services. Additionally, 16 out of 22 members attended two or more outpatient visits 60 days after the closure of their CCM services. Complex Case Managers continue to work on reducing barriers for members to promote greater stability and continuity in both behavioral and medical care. They collaborate with members to reconnect with or establish connections to their Primary Care Physicians and Behavioral Health Service Providers. Furthermore, Complex Case Managers assist members in organizing and establishing systems to help them remember their outpatient appointments, such as setting reminders and keeping organized calendars. They also provide resources and education to encourage ongoing participation in outpatient visits even after CCM program closure. In addition, Complex Case Managers work closely with members and support staff—Case Managers, Support Coordinators, Therapists, etc.—to help schedule future appointments after CCM has ended to encourage attendance.

**Satisfaction Surveys**

Satisfaction surveys were made available to all members following the conclusion of Complex Case Management (CCM) services. Members were informed that participation in these surveys was optional. However, they were strongly encouraged to provide feedback regarding their experiences with the CCM services. This input is valuable in assessing the effectiveness of the services and identifying areas for improvement. During the designated survey period, a total of 40 cases were initiated for CCM services. Out of this number, services were closed for 34 members. It is important to note that of these 34 closed cases, 5 members were enrolled in the program for less than 60 days, and unfortunately, 1 member passed away during the service period. As a result, satisfaction surveys were not distributed to either of these groups. This left us with 28 members who were eligible to receive the satisfaction surveys. Out of these, 18 members completed and returned their surveys, resulting in a completion rate of 64%. Our target is to achieve a satisfaction rate of 85%, which emphasizes our commitment to enhancing our services based on member feedback. The Satisfaction Survey is constructed with 6 statements that participants can evaluate using a Likert Scale, which includes the response options of Strongly Disagree, Slightly Disagree, Slightly Agree, and Strongly Agree. In addition, there is an optional section at the end of the survey where members can provide written comments. Responses marked as ‘Strongly Disagree’ and ‘Slightly Disagree’ signify dissatisfaction, while responses categorized as ‘Slightly Agree’ and ‘Strongly Agree’ reflect positive satisfaction with the services received. The insights garnered from these surveys will guide us in making informed decisions to enhance the quality of care delivered through our CCM services.




**Evaluation of Effectiveness**

Starting from FY2024, we increased the overall satisfaction rate from 80% to 85%. We exceeded our goal, with members reporting a remarkable 100% satisfaction in all returned surveys. However, we continue to face challenges in reaching our members, as many are not responding to our outreach attempts or have changed or disconnected their phone numbers. The rate of survey returns decreased from FY2024 to FY2023, with FY2024 reflecting the highest satisfaction rates and FY2023 showing the highest return rates. CCM offers an electronic Satisfaction Survey for members, but many do not complete it electronically. Barriers to completing the electronic survey may include members lacking access to email, difficulties logging into their accounts, and issues with remembering passwords. To address these challenges, Complex Case Managers will be encouraged to discuss survey completion incentives with members before case closure. We will continue to provide multiple options for completing the Satisfaction Survey and increase outreach efforts to enhance completion and return rates.

**Comparison to Previous Reviews**

The results of the analysis for the Complex Care Management (CCM) services associated with FY2024 were compared to the outcomes from the analyses of FY2023 and FY2022. This detailed comparison focused specifically on several key metrics, including Patient Health Questionnaire (PHQ) scores, World Health Organization Disability Assessment Schedule (WHO-DAS) scores, rates of hospital admissions, levels of engagement in behavioral health services, and findings from Satisfaction Surveys. At the baseline assessment, the PHQ scores for FY2023 were notably lower than those for FY2024. In contrast, FY2022 exhibited the highest baseline PHQ scores among the three. When examining WHO-DAS scores, FY2024 demonstrated lower values not only at baseline but also at the 30, 60, and 90-day follow-up periods compared to previous fiscal years. Conversely, during the evaluation period for FY2022, both the PHQ and WHO-DAS scores reached their highest levels at baseline, as well as at the 30, 60, and 90-day marks, when compared to previous fiscal years. Importantly, the average scores for both the PHQ and WHO-DAS consistently showed a decline as participants engaged more deeply in CCM services over the course of the three fiscal years. Throughout the analysis, it was observed that the number of members achieving a 10% reduction in their PHQ scores increased as we progressed from the data associated with FY2023 to that of FY2022. In contrast, the WHO-DAS scores exhibited a decline during the same period. Starting with the data from FY2024, the objective for both the WHO-DAS and PHQ assessments was elevated to a goal of achieving a 20% reduction. As a result of this initiative, an impressive 96% of participating members successfully met the PHQ goal, while 92% achieved the WHO-DAS goal. This achievement highlights the effectiveness of the strategies employed, and we plan to continue monitoring and comparing these outcomes against the new goals in subsequent fiscal years. Over the past two fiscal years, we noted that only one member was admitted for inpatient care within 90 days of initiating CCM services. Unfortunately, due to insufficient data, we were unable to evaluate inpatient admission rates specifically for FY2024 and FY2023. This analysis underscores the importance of continued data collection and monitoring to better assess the impact of CCM services on hospital admissions in the future.

**Access Call Center**

The call center serves as a vital resource for our community, playing an essential role in connecting individuals with mental health services and support for substance use disorders (SUD). Each day, we receive a significant volume of calls from people in need, ranging from those seeking immediate emotional support to others looking for information about available treatment options and ongoing resources. In addition to individual callers, we also facilitate communication with in-network providers and key community organizations, including local hospitals and foster care agencies. This collaboration is crucial, as it allows us to provide a more integrated approach to care. From the moment a community member reaches out to our DWIHN Access Call Center Representatives, we prioritize their well-being. Each call is carefully monitored to ensure that callers feel heard and supported. Once initial information is gathered, calls are efficiently transferred to experienced screeners who have expertise in mental health, SUD, and related resources. These specialists are trained to conduct thorough assessments and offer tailored referrals, ensuring that every caller receives the comprehensive assistance they need to navigate their circumstances effectively. Through this dedicated approach, we reinforce our commitment to delivering essential services and fostering a healthier community.

**Qualitative Analysis and Trending of Measures**

The tables and descriptions presented below offer a comprehensive overview of the Access Call Center's performance for the fiscal year 2023-2024. In addition to highlighting key metrics from this year, the data also includes a comparative analysis with the previous fiscal year, 2022-2023. This comparison aims to provide insights into trends, improvements, and areas that may require further attention, helping stakeholders understand the Call Center's effectiveness and service delivery over the two-year period.

| Fiscal Year | Queue | Incoming Calls | Calls Handled | % Calls Abandoned (Dropped, Disconnected, Hang Up) | Avg Speed to Answer | Avg Call Length | % of Calls Answered | Service Level |
|---|---|---|---|---|---|---|---|---|
| 2023-2024 | Call Reps | 200,422 | 187,190 | 4.00% | :26 secs | 5.30 mins | 93.00% | 78.15% |
| 2022-2023 | Call Reps | 263,832 | 205,240 | 3.45% | :28 secs | 4:57 mins | 96.83% | 82.73% |

For Fiscal Year 2023-2024, the Access Call Center successfully managed a total of 187,190 incoming calls, reflecting the growing demand for services. Below is a detailed breakdown of the various types of calls received. A total of 41,037 calls were directed to the SUD services, accounting for 22.0% of all calls received. The average handling time for these calls was 17 minutes, indicating a focused effort to address the specific needs related to substance use challenges. The Mental Health services received 22,733 calls, which represented 12.0% of the total. The average handle time for these inquiries was longer at 22 minutes, reflecting the complexity and sensitivity of mental health issues addressed by the staff. Other Requests are the largest category, encompassing 123,420 calls (66.0% of the total), includes a variety of requests. This category covers provider inquiries, requests for information and referrals to community programs and services, follow-up calls for screenings, and coordination of hospital discharge appointments. Additionally, this category includes enrollments in various programs such as Infant Mental Health, Foster Care, Targeted Case Management/Personal Care Workers (TCW/PCW), Hospital Inpatient services, and related processes. Transfer calls to other departments, including Crisis services, Protocall, Office of Refugee Resettlement (ORR), Customer Service, and Grievance handling, are also included in this segment. This comprehensive handling of diverse call types demonstrates the Access Call Center's commitment to providing essential support and information to the community it serves.

During the first three quarters of the year, the Access Call Center experienced a decline in its average service level, which fell below the established standard of 80%. Recognizing the importance of maintaining high service standards for customer satisfaction and operational efficiency, the management team implemented several strategic measures to address this issue. One of the primary steps taken was to increase the frequency of performance monitoring. This involved not only regular assessments of service levels but also a more in-depth analysis of call metrics and customer feedback. By gaining a clearer understanding of the specific factors contributing to the lower service levels, the management team was better equipped to make informed decisions. In conjunction with enhanced monitoring, staffing levels were also adjusted as necessary. This included reallocating resources to peak times when call volume was highest, as well as adding additional team members during particularly busy periods. These staffing adjustments were crucial in ensuring that the call center could adequately handle customer inquiries without long wait times. As a result of these combined efforts, service levels showed significant improvement over the subsequent quarters: 1st Quarter (76%), 2nd Quarter (77%), 3rd Quarter (77%) and 4th Quarter (81%). By the end of the year, the Access Call Center successfully exceeded the 80% service level benchmark, demonstrating the effectiveness of the management team's proactive approach to performance improvement and commitment to delivering excellent customer service. Enhanced monitoring has now become a standard part of daily management practices, ensuring ongoing accountability and continual progress.

**Appointment Availability**

The appointment availability report provides a comprehensive overview of the appointments scheduled after an eligibility screening conducted by the Access Call Center. This screening process is specifically designed for individuals seeking critical services related to Serious Mental Illness (SMI), Serious Emotional Disturbance (SED), Developmental Disabilities (DD), Applied Behavior Analysis (ABA), and substance use disorders (SUD). Additionally, the report encompasses a summary of appointments scheduled for individuals being discharged from hospitals, all coordinated through the Access Call Center. The primary objective of this initiative is to ensure that routine intake appointments are arranged within a maximum of 14 days following the completion of the eligibility screening. Similarly, the report aims to schedule follow-up appointments within 7 days after a patient's discharge from the hospital. The Access Call Center manages this scheduling process, considering the availability and capacity of Clinical Responsible Service Providers (CRSP), who are essential in providing timely and effective services to those in need. During the fiscal year 2023-2024, data indicates a positive trend in appointment availability for both Mental Health/Intellectual and Developmental Disabilities (MH/IDD) intake and substance use disorder (SUD) intake. Specifically, the average availability of appointments rose by approximately 3% from the first quarter to the fourth quarter of the fiscal year. Of note is the significant increase in the availability of hospital discharge appointments, which improved from 71% in the first quarter to 89% in the fourth quarter. This upward trend reflects the ongoing efforts and collaborative initiatives underway.

The partnerships among the DWIHN Access Call Center, the DWIHN Utilization Management (UM) department, DWIHN hospital liaisons, and Community Self-Help and Recovery Programs (CSRPs) are pivotal in the appointment coordination process. When the Access Center identifies that an appointment is unavailable within the designated 7-day or 14-day timeframe, staff members first reach out to CSRPs to assess whether they can accommodate the individual in need. If CSRPs are unable to provide an appointment, the Access Center will proceed to schedule the earliest available time slot for the individual and will instruct the provider to reach out to the member should an earlier appointment become available. Furthermore, the Call Center is engaged in a thorough fourth-quarter analysis to evaluate the additional appointments offered by CSRPs. This analysis aims to identify opportunities for enhancing appointment availability and streamlining the scheduling process. In the fourth quarter alone, two new CSRPs were welcomed into the network, and many existing providers reported successful recruitment of additional staff to better meet the demands of clients. These developments signify a proactive approach to increasing service capacity and ensuring timely access to necessary care for individuals seeking assistance.

**Clinical Operations**

Detroit Wayne Integrated Health Network (DWIHN) has made significant progress in expanding access to integrated healthcare services across the DWIHN network. These integrated models include Behavioral Health Home (BHH), Substance Use Disorder Health Home (SUDHH), and Certified Community Behavioral Health Clinic (CCBHC) services.

Health Homes provide behavioral and physical health care coordination to treat the person holistically, and help people navigate the healthcare system. In 2024, DWIHN increased its Behavioral Health Home enrollment by 28.5%, serving 807 members, which is the highest enrollment of a PIHP in the State of Michigan. In addition, the Michigan Department of Health and Human Resources (MDHHS) transitioned Opioid Health Homes (OHH) into Substance Use Disorder Health Homes (SUDHH) by expanding eligible diagnosis. These eligible diagnoses include stimulant use and alcohol use disorders. This diagnosis expansion has led to 130 new enrollments, for a total of 663 enrollees. Most of the new enrollees cited an issue with alcohol use disorder.

This was a big year for the Certified Community Behavioral Health Clinic (CCBHC)State Demonstration expansion. CCBHC's are an integrated healthcare model that provides increases timely access to services to all people regardless of insurance, level of care, geography, or ability to pay. In 2024, DWIHN CCBHC certified providers in Wayne County expanded from a single provider to six (6) providers. This expansion has resulted in 12,333 members receiving CCBHC services. The DWIHN CCBHC team provided technical assistance to all six (6) of these providers in their initial onboarding and FY24 recertification with MDHHS.

In 2024, DWIHN established a clinical outpatient clinic (DWIHN Community Care Clinic) in Detroit that provides integrated care services that align with the CCBHC model of practice. DWIHN used heat mapping, member demographic data, and Medicaid Health Plan information to determine additional clinic site locations as well. Clinic services include psychiatry, therapy, case management, and peer/recovery support services. DWIHN has applied to be a part of the MDHHS CCBHC State Demonstration and has received full CCBHC certification starting January 1, 2025. DWIHN is currently awaiting approval from the Centers for Medicare and Medicaid (through MDHHS) for DWIHN to be added as a State CCBHC Demonstration provider.

**Crisis Services**

The Crisis Services Department plays a crucial role in ensuring that all members have access to the full range of care provided by DWIHN within the framework of the Crisis Continuum Service System. During Fiscal Year 2023 (FY23), we experienced a significant uptick in service requests: adults saw an increase of 2%, while the demand for services among children rose by 4% compared to the previous fiscal year. This growing demand highlights the critical need for effective crisis intervention and support services. Moreover, we are pleased to report improvements in diversion rates for both adults and children throughout this same period. These advancements can be largely attributed to enhanced and more effective communication across various stakeholders, including the provider network, DWIHN Liaisons, and Clinically Responsible Service Providers (CRSPs). This collaborative approach has allowed us to ensure that members are placed in the least restrictive environments possible, which is essential for their ongoing recovery and well-being. However, we also noted a significant increase in inpatient admissions during FY23—9% for adults and a staggering 41% for children—compared to the prior fiscal year. This dramatic rise in admissions suggests that there is still an urgent need for crisis services. At the same time, we must address the concerning trend in recidivism rates for those requiring inpatient hospitalization. Although recidivism increased throughout the third quarter of the fiscal year, a positive trend emerged in the fourth quarter, indicating some effectiveness in our interventions.

To address these challenges, the Crisis Services team is committed to working closely with CRSPs to ensure that all members are seen by care providers within 72 hours of their admission to an inpatient facility. This prompt attention is vital for initiating appropriate treatment. Additionally, we are focused on ensuring that pertinent member information is consistently forwarded to inpatient treatment teams upon their admission, which will help facilitate a more coordinated and effective approach to care. Recognizing the importance of seamless transitions, the Crisis Services Department is also dedicated to fostering better collaboration with Access, Utilization Management (UM), as well as Adult and Children's Initiatives and Residential services. DWIHN's goal is to enhance the coordination of member information to support effective discharge planning processes. To further strengthen these initiatives, we will implement a new requirement mandating that screening agencies notify CRSPs at least 90% of the time when a member is referred. This will ensure timely communication and intervention. Moreover, CRSPs will be expected to make a minimum of five attempts to re-engage members who have been identified as recidivistic within a 60-day period. By prioritizing these efforts, we aim to reduce recidivism rates and improve overall member outcomes in our crisis services program.

**Crisis Care Center**

The Detroit Wayne Integrated Health Network (DWIHN) Crisis Care Center officially opened its doors in the spring of 2024, strategically located in the heart of downtown Detroit. This state-of-the-art facility is designed to provide a comprehensive range of crisis intervention and stabilization services tailored to meet the needs of both children and adults. Among its key features are fifteen dedicated residential beds specifically for adult crisis care, ensuring that individuals experiencing severe mental health challenges receive immediate and effective support in a safe environment. In addition to the Crisis Care Center, DWIHN has ambitious plans for the future, including the establishment of a regional integrated behavioral healthcare campus set to debut in 2025. This innovative facility will not only offer physical health services but also deliver integrated behavioral health services, thereby addressing the multifaceted needs of individuals in the surrounding communities and counties. Furthermore, there are plans in progress to open a third crisis center in the downriver area, expanding DWIHN's capacity to serve individuals in more locations.

As we look to the future, DWIHN remains committed to prioritizing the needs of children and enhancing services for families. The organization is dedicated to achieving this through continual innovation, the integration of technology, and robust community engagement initiatives designed to promote better mental health outcomes. The Crisis Services Department has recently undergone significant enhancements, including the introduction of dispatch services for Requests for Service (RFS). This new system is crucial for conducting Pre-Admission Review (PAR) screenings for both adults and children who present to emergency departments. Historically, the process involved the DWIHN Access Center contacting contracted PAR providers for children in the community, while adult requests were directed to COPE directly. The implementation of the PAR Dispatch Team streamlines this process by efficiently receiving calls and coordinating with designated screening entities to ensure timely completion of PARs. Since the launch of the PAR Dispatch Department on November 1, 2024, the team has fielded an impressive total of 2,536 calls. Out of these, 1,343 calls have led to requests for services, which breaks down to 1,088 requests for adults and 255 requests for children. This data highlights the significant demand for crisis services and the vital role that the PAR Dispatch Team plays in facilitating timely access to necessary care.

**Downriver Care Center**

Efforts are currently being made to establish a third DWIHN Care Center in the Downriver area, aimed at enhancing access to mental health services for the community. The Facilities Department has developed comprehensive criteria that outline the specific needs for the facility, including size, accessibility, and necessary amenities, along with a detailed budget plan to ensure the project is financially viable. To facilitate this process, DWIHN is actively collaborating with an experienced consulting real estate broker who specializes in healthcare properties. Together, they are working to identify and evaluate various potential locations that align with the established criteria, ensuring that the new center will effectively serve the needs of the community while adhering to DWIHN's standards of care.

## Quality Pillar

**Provider Network**

DWIHN collaborates with a network of over 400 providers and contractors to deliver comprehensive services to individuals in need. Each year, the dedicated performance monitoring staff conducts thorough reviews of these providers, aiming to ensure the safety, health, and well-being of all individuals served by the organization. To maintain high standards, the Quality Improvement (QI) team plays a crucial role in assessing compliance with both federal and state regulations. This includes oversight of the MI Health Link demonstration project, which integrates physical and behavioral health services for Medicaid beneficiaries. The QI team employs a variety of evaluation methods, including detailed desk reviews that analyze documentation and performance metrics, on-site assessments that involve direct observation and interaction, verification activities to confirm the accuracy of reported information, and claims verification to ensure appropriate billing practices are followed. In cases where performance does not meet established standards, DWIHN has protocols in place to implement additional oversight. This may involve heightened scrutiny, corrective action plans, and compliance enforcement strategies designed to enhance the quality of services provided. The organization is committed to minimizing risks associated with service delivery and ensuring that individuals receive the necessary care and support. Furthermore, Community Mental Health Services Program (CMHSP) organizations and substance use disorder (SUD) providers that fail to demonstrate acceptable levels of performance may face additional oversight. This can include targeted interventions and support to help these providers improve their services and maintain compliance with regulations. DWIHN remains vigilant in its efforts to uphold a high standard of care and ensure the best possible outcomes for the individuals it serves.

**Quantitative Analysis and Trending of Measures**

During the fiscal year 2024 (FY 2024), the Performance Monitoring Team undertook an extensive engagement with 318 contracted service providers. This initiative involved a meticulous examination of 707 case records and an assessment of the qualifications and credentials related to 1,349 staff files. The evaluation process was comprehensive, incorporating a detailed analysis of both administrative files and case records to ensure that we adhere to the highest standards of care and service delivery in our programs. Recognizing the importance of a diverse range of services, we broadened the scope of our evaluations to include not only traditional behavioral health services but also crucial sectors such as substance use disorder (SUD) treatment and prevention services, services for individuals with autism, B3/(i)SPA providers, and various inpatient hospital settings. This expansion allowed us to implement a robust quality assurance framework that addresses the unique challenges and standards relevant to each type of service provider. Among the SUD providers evaluated, 20 demonstrated compliance with the required standards, which signifies their steadfast commitment to delivering quality care. Conversely, 9 providers were identified as falling below the critical compliance threshold of 95%. This outcome underscores the necessity for targeted improvements in these areas to elevate care standards. In the realm of autism services, we noted a total enrollment of 2,483 youth during FY 2024, with 1,252 of them being newly enrolled.

A significant achievement was observed, as 88% of these newly enrolled youth commenced services within 14 days of their ABA authorization effective date. This performance surpassed the state goal of 70%, reflecting our effective operational strategies and the responsiveness of our service providers. For those providers who received scores below the 95% benchmark, we instituted a requirement for them to submit corrective action plans to address the identified deficiencies. To ensure these plans were effectively put into action, we conducted follow-up validation reviews. This approach is designed to support providers in making necessary adjustments and improvements. Furthermore, we proactively monitored trends and practices that could enhance quality outcomes through CRSP self-monitoring audits. Our performance monitoring staff diligently analyzed data derived from these self-reviews on a quarterly basis and provided tailored consultations to facilitate ongoing improvements. This continuous feedback loop reinforces our commitment to delivering the highest quality services and ensuring the best possible outcomes for all individuals we serve.

**Home and Community Based Services (HCBS) Monitoring**

During FY2024, we embarked on an extensive initiative to monitor compliance with Home and Community-Based Services (HCBS). This multifaceted approach encompassed two primary methods: conducting comprehensive case record reviews and performing in-depth onsite evaluations of the residential service providers' environments. Our case record reviews were meticulous, focusing on a range of criteria to ensure that all documentation accurately reflected the quality and effectiveness of the services being provided. We analyzed individual care plans, service delivery logs, and incident reports to assess whether they adhered to regulatory standards and best practices within the HCBS framework. Simultaneously, our onsite evaluations involved direct observations of the living conditions and support environments provided by residential service providers. We assessed factors such as the safety, accessibility, and overall quality of the facilities, ensuring that they met both regulatory requirements and the specific needs of the individuals being served. Collaboration was a cornerstone of our efforts; we actively engaged with a diverse array of provider settings offering HCBS and (i)SPA services. This partnership allowed us to align our monitoring activities with the standards established in the field, ultimately working towards the welfare and well-being of the members who depend on these essential services. In addition to examining established providers, we also evaluated new service providers seeking to contract with the Detroit Wayne Integrated Health Network (DWIHN). This process included rigorous environmental reviews to verify that all potential providers possess the necessary qualifications and resources to deliver high-quality services. These comprehensive efforts are vital for maintaining and enhancing the standards of care and support for individuals receiving HCBS. By continuously monitoring compliance and fostering strong partnerships, we strive to create an environment that not only meets regulatory expectations but also promotes the dignity, autonomy, and quality of life of the individuals we serve.

**Verification of Services**

The additional monitoring of network providers included comprehensive verification activities and thorough reviews of Medicaid claims to ensure compliance and accuracy. For Fiscal Year 2024, the Medicaid Claims Review process was implemented, utilizing both virtual reviews and desk audits to facilitate a detailed evaluation of claims. In the first and second quarters of FY 2024, a total of 1,313 claims were randomly selected for verification, involving a careful examination of services provided by 212 distinct Medicaid providers. Of the claims selected, an impressive 1,303, or 99%, were successfully completed, while only 10 claims, representing 1%, were deemed incomplete. This high completion rate highlights the effectiveness of the review process.

Moving into the third and fourth quarters of FY 2024, the review process continued with an increased total of 2,880 claims randomly selected for verification, involving 236 distinct providers. Of these audits, 2,880, or 90%, were successfully completed, while 196 audits, representing 10%, were not completed due to time constraints. During the review, several trends were noted, including issues with invalid IPOS (Individual Plan of Service) documents and direct care staff not being adequately trained on the members' IPOS.

Looking ahead to Fiscal Year 2025, the DWIHN plans to implement follow-up monitoring for providers who have been issued a Corrective Action Plan (CAP) and for those who have received repeated citations for non-compliance. This approach aims to ensure that providers address any identified issues promptly and maintain high standards of service delivery within the Medicaid framework.

**Opportunities for Improvement**

This year, we have made significant advancements in our approach to monitoring the performance of our network, which is crucial for evaluating the quality of care we provide. However, there remain several critical areas that require our attention to further improve our services. One key advancement has been the implementation of a comprehensive Integrated Biopsychosocial Assessment. This assessment is designed to evaluate not only the medical needs of our members but also their psychological and social circumstances, ensuring a holistic approach to care. In addition, we have enhanced staff qualifications through targeted training programs that equip our team with the skills necessary to deliver outstanding service. These efforts reflect our unwavering commitment to maintaining a high standard of care and meticulous attention to detail throughout the network. Despite these improvements, documentation practices remain a significant area for enhancement. We must refine our documentation processes to ensure full compliance with the Home and Community-Based Services (HCBS) Final Rule, which sets forth essential requirements for service delivery and accountability. Moreover, we need to focus on several additional areas to elevate our service quality. Care coordination must be improved to ensure that all team members are aligned and working collaboratively to meet our members' needs effectively. We also need to evaluate the extent and duration of the services we provide, ensuring they adequately reflect the individualized needs and preferences of each member. Member choice of providers is another critical factor. We must work to ensure that our members can select providers who best meet their preferences and needs, fostering a sense of autonomy and satisfaction.

Lastly, it is imperative that we provide Direct Support staff with targeted training that aligns with each member's Individual Plan of Service (IPOS). This training should focus on the specific goals and needs identified in the IPOS to ensure that staff are well-prepared to support our members effectively. By addressing these areas with intentional strategies and actions, we can continue to enhance our network's performance and, ultimately, the quality of care we deliver to our members.

**Critical/Sentinel, Unexpected Deaths, and Risk Reporting**

During the fiscal year 2023/2024, comprehensive training on Critical/Sentinel Events was delivered to the staff of Clinically Responsible Providers (CRSP) and Specialized Residential Providers within the DWIHN network. This initiative aimed to enhance staff understanding and compliance with critical reporting protocols. A total of 238 staff members engaged in this specialized training, which was conducted virtually through the Microsoft Teams platform to accommodate participants and ensure accessibility. In addition to the training sessions, the Quality Performance Improvement Team (QPIT) has been dedicated to offering continuous technical assistance to support CRSPs in fulfilling the Critical/Sentinel Event reporting requirements established by MDHHS. This framework focuses on five clearly defined categories deemed critical for reporting. QPIT also collaborates closely with the provider network to ensure effective remediation in four additional internal categories that are particularly relevant to the services offered by DWIHN. QPTI's responsibilities extend beyond training; they are tasked with reviewing and managing the Critical/Sentinel Event module within the Mental Health-WIN (MH-WIN) system. This team has also started to monitor and address remediation efforts in the new MDHHS-Clinical Risk Management (CRM) system, which allows for electronic submission of events for MDHHS staff review. When additional documentation or clarification is required, these requests are primarily managed by a registered nurse on the QPIT team, who works in conjunction with other team members. This collaborative approach adds a crucial layer of review, ensuring that all remediations are addressed within the timelines established by MDHHS. As part of our ongoing commitment to compliance, the Critical/Sentinel Event Guidance Manual has been revised to incorporate the latest MDHHS requirements. Furthermore, we are in the process of preparing for additional modifications and enhancements to the MH-WIN Critical/Sentinel Event module, aiming to streamline operations and improve its overall functionality. In FY 2023/2024, we have rolled out significant improvements to the data capture process for the CRM system, along with the introduction of several new reporting categories in anticipation of fiscal year 2024/2025. The newly identified reporting categories include Fall Risk, Crisis Stabilization, and Immediately Reportable Media Events, which enhance our capacity to track and report critical incidents effectively.

To improve the process surrounding sentinel events, the Sentinel Event Committee/Peer Review Committee (SEC/PRC) has implemented a streamlined procedure. This allows for a paper review by a qualified psychiatrist to approve the closure of death reports submitted by nursing staff, provided that a Death Certificate is submitted for examination. It is important to note that this streamlined process does not eliminate the requirement for a thorough Root Cause Analysis, which continues to be closely monitored by QPIT. This fiscal year saw no review conducted by Health Services Advisory Group (HSAG) regarding Critical/Sentinel Events. Nevertheless, our commitment to timely and efficient reporting to the Integrated Care Organizations (ICO) and the MDHHS-CRM system has been steadfast. Monthly meeting reviews have consistently met all established requirements. As we move forward, recommendations from both QPIT reviews and committee meetings are expected to play a crucial role in enhancing our practices and improving the quality of care within the network.

- Discontinuing the Care Academy as it did not produce the results that were expected. Staff referred were not followed, nor did they participate in the remediation process. The recommendation is to create a DWIHN authored training to address the specific remediations that have been identified by the QPIT and refer staff to take those trainings and tests in collaboration with the Detroit Wayne Connect (DWC) programs.
- QPIT will continue to work with the IT Department to upgrade the Critical/Sentinel Event module to swiftly notify DWIHN departments of significant risks reported by the CRSPs for all populations. Several modifications are required, as previously mentioned, as we move to the new fiscal year. Fortunately, the Fall Risk requirement will only require the QPIT team to update and enhance the remediation protocols that were developed through the HSAG PIP and to add the training component to DWC modules.
- FY 2023/24 QPIT re-established the role of the CRSP to secure Death Certificates for members given the smaller number of requests that would be made by the individual CRSP and their ability to secure copies within the 30-day MDHHS reporting timeframe. Unfortunately, the Provider Network was unable to master the process as it was designed causing yet another backlog for closing deaths in the fiscal year. The QPIT team re-examined the process and has instituted a stop gap measure with the assistance of Quality's Administrative Assistant monitoring and following up with acquiring Death Certificates that are delayed in submission.

**Quantitative Analysis and Trending of Measures**

In the fiscal year 2023/2024, the Quality Performance Improvement Team (QPIT) processed a total of 1,797 Critical and Sentinel Events. This figure represents a 3% decrease in the number of reported events compared to the previous fiscal year. Upon thorough analysis, the team has identified a significant issue: many events are not being reported as mandated by existing policies and contracts. This problem is particularly pronounced in the reports submitted to the Office of Recipient Rights, indicating a gap in compliance. Despite the team providing comprehensive training and developing a Guidance Manual aimed at facilitating accurate reporting, staff members have continued to make substantial errors when documenting Critical and Sentinel Events in the MH-WIN module. This year alone, 123 events were reported, but they did not meet the necessary reporting criteria, suggesting misunderstandings regarding what constitutes a reportable event. Additionally, 310 events lacked the sufficient documentation required for appropriate closure, resulting in Administrative Closures. This data points to a pressing need for improved training and clarity on reporting protocols. While the data collected over the year shows stability in reporting across nearly all categories, there is a concerning trend of low reporting rates, particularly in critical and high-risk areas, including fatalities. The accompanying chart highlights this issue, distinguishing between higher reporting rates (shown in green) and lower rates (shown in blue). Alarmingly, the analysis revealed significant under-reporting within the Provider Network, indicating that some providers are not fulfilling their reporting obligations.

To assist in addressing these discrepancies, the IT Department has developed a specialized dashboard designed to help identify providers who are under-reporting or failing to report entirely. This tool is intended to enhance oversight and accountability within the network. Looking ahead to the upcoming fiscal year, the Quality, Contracts, and Compliance departments plan to implement Corrective Action Plans aimed at improving compliance among providers. These plans may include sanctions for those who do not meet established compliance standards, ensuring that reporting requirements are taken seriously. Additionally, efforts are being made to resolve staffing challenges to improve the review and remediation process for providers identified as having reporting deficiencies. The QPIT is dedicated to fostering collaboration both internally within the organization and externally with partner agencies to address this systemic issue comprehensively. By working together, the team hopes to enhance the overall quality of reporting and improve safety standards across the network.

**Qualitative Five-Year Comparative Analysis of Data by Category**

| CATEGORY | FY 2023/2024 | FY 2022/23 | FY 2021/2022 | FY 2020/2021 | FY 2019/2020 |
|---|---|---|---|---|---|
| ARREST | 89 | 61 | 64 | 72 | 83 |
| Behavior Treatment | 211 | 73 | 88 | 61 | |
| Deaths | 393 | 444 | 492 | 551 | 731 |
| Environmental Emergencies | 16 | 85 | 57 | 79 | 38 |
| Injuries Requiring ER | 162 | 176 | 177 | 227 | 259 |
| Injuries Requiring Hospitalization | 33 | 39 | 35 | 47 | 70 |
| Medication Errors | 27 | 20 | 14 | 16 | 27 |
| Physical Illness Requiring ER | 254 | 210 | 216 | 975 | 634 |
| Physical Illness Requiring Hospitalization | 137 | 153 | 239 | 445 | 400 |
| Serious Challenging Behavior | 388 | 455 | 437 | 609 | 815 |
| Administrative | 86 | 104 | 96 | 77 | 173 |
| TOTAL | 1796 | 1817 | 1915 | 3159 | 3230 |

**Behavioral Treatment Review**

In FY2024, the Detroit Wayne Integrated Health Network (DWIHN) engaged Behavior Treatment Plan Review Committees (BTPRC) to conduct a comprehensive review of 1,597 Behavior Treatment Plans. This reflects an increase of 46 plans, corresponding to a growth of 1.02% compared to the previous year. The following data provides a detailed overview of the utilization of intrusive and restrictive techniques employed during treatment, the number of 911 calls and critical events that were reported, and the frequency of medication administration for each individual receiving these interventions. This analysis aims to enhance our understanding of treatment efficacy and safety considerations within our programs.

**Evaluation of Effectiveness**

DWIHN has proudly maintained full compliance with the PIHP Administrative Review Procedures for Behavior Treatment (B.1) for an impressive fifth consecutive year. This ongoing achievement has been thoroughly validated by comprehensive findings from the Michigan Department of Health and Human Services (MDHHS) during the recent Habilitative Supports Waiver 1915(c) review. This review is crucial as it assesses the overall effectiveness, quality, and compliance of behavioral health services currently provided to individuals in the community. The MDHHS review specifically recognized DWIHN's commitment to excellence in the management and delivery of behavioral treatment services. In addition to the MDHHS findings, the Health Services Advisory Group (HSAG) conducted an assessment that confirmed DWIHN's adherence to all critical elements required for the Behavioral Treatment Protocol Review Committees (BTPRCs). These committees play an essential role in establishing and maintaining rigorous standards of care for individuals with complex behavioral needs. By consistently meeting these standards, DWIHN demonstrates its unwavering commitment to providing high-quality care that meets the diverse needs of the population it serves.

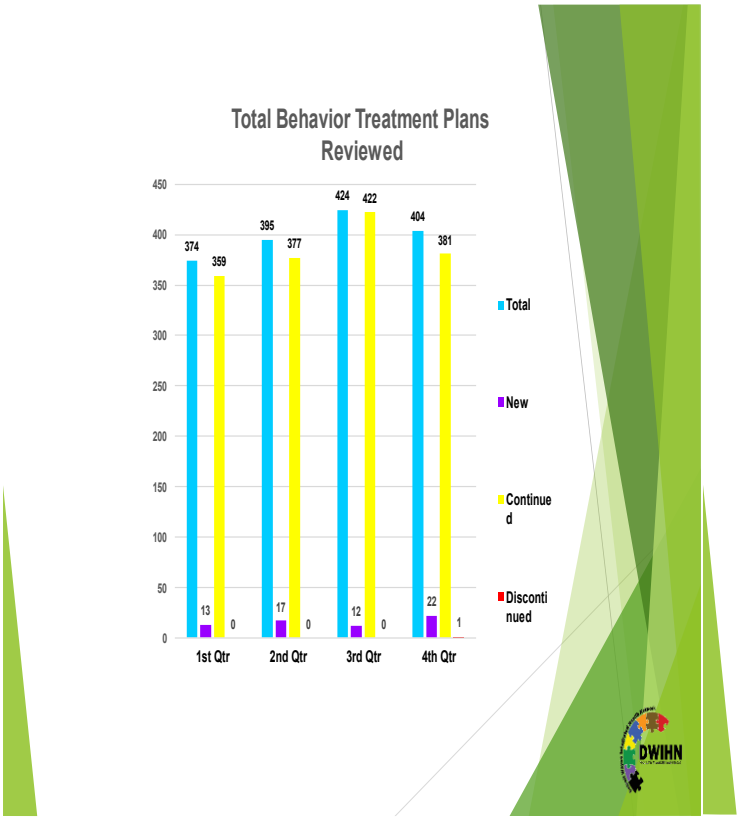
Throughout the fiscal year 2023-2024, DWIHN's Behavioral Treatment Advisory Committee (BTAC) staff were instrumental in offering specialized technical assistance to clinical teams involved in treating challenging behaviors. This support was extended to a wide array of partner organizations, including ACCESS Community Services, Community Living Services, Inc., Central City Integrated Health Network, Chitter Chatter Autism Services, Children’s Center, Inc., Gesher Human Services, The Guidance Center, Lincoln Behavioral Services, ProCare Unlimited, the Neighborhood Services Organization, Hegira Downriver, PsyGenics, Inc., Wayne Center, and the DWIHN Office of Receipt Rights and Residential Department. The purpose of this technical assistance was to enhance the understanding of and adherence to the technical requirements and protocols established within the BTPRC processes, which are critical for effectively managing and addressing challenging behaviors in individuals. Throughout the fiscal year, network providers showcased the complexity of cases involving severe behavioral challenges by presenting a total of fifteen intricate case studies to the BTAC. This collaborative approach allowed for a thorough review and evaluation of the strategies employed to address serious behavioral issues, providing beneficial insights for both the providers and the individuals receiving services. It created a platform for sharing best practices, discussing innovative solutions, and identifying potential areas for improvement, thus fostering a culture of continuous learning and development.

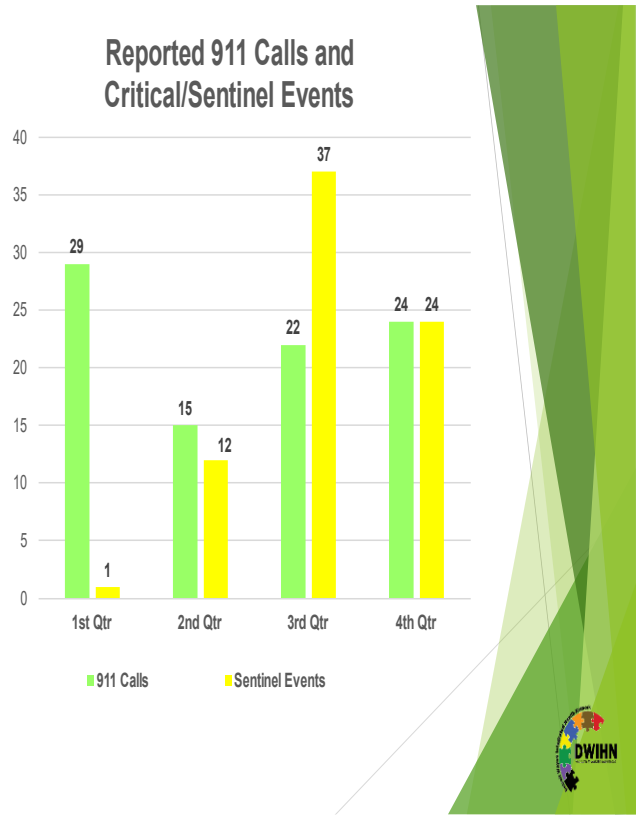
The BTPRC requirements remain integral components of the Outpatient and Residential contracts for FY 2023-2024, reinforcing DWIHN's commitment to delivering high-quality care to those in need. In addition to case presentations, DWIHN is diligent in monitoring system-wide trends related to BTPRCs. The organization submits detailed quarterly data analysis reports to MDHHS, which provide valuable insights into emerging patterns and issues within the behavioral health system. This thorough reporting process facilitates informed decision-making and ongoing system improvements. Moreover, the expertise of the DWIHN BTAC staff has been recognized through their reappointment to the MDHHS Behavior Treatment Advisory Group for a fifth consecutive year. This ongoing participation underscores DWIHN's dedication to influencing state-level discussions and policy-making efforts that aim to enhance behavioral treatment practices across Michigan. It reflects a commitment not only to local service delivery but also to contributing to broader systemic improvements in the behavioral health landscape. Through these comprehensive initiatives, DWIHN remains focused on ensuring that individuals with challenging behaviors receive the most effective and compassionate care possible. The organization strives to create an environment where effective treatment protocols are implemented, and individuals' unique needs are addressed in a person-centered manner. DWIHN's continued success in maintaining full compliance with the PIHP Administrative Processes of Behavior Treatment Review (B.1) was further validated during the April 2024 review conducted by MDHHS. This review emphasized DWIHN's unwavering commitment to excellence in behavioral treatment management. MDHHS specifically commended DWIHN for its quarterly BTAC reports, which not only demonstrated a comprehensive tracking system for behavior treatment outcomes but also featured visually engaging graphic illustrations that effectively conveyed essential data. This recognition highlights DWIHN's commitment to transparency and effectiveness in delivering behavioral health services, ultimately contributing to improved outcomes for individuals across the region.

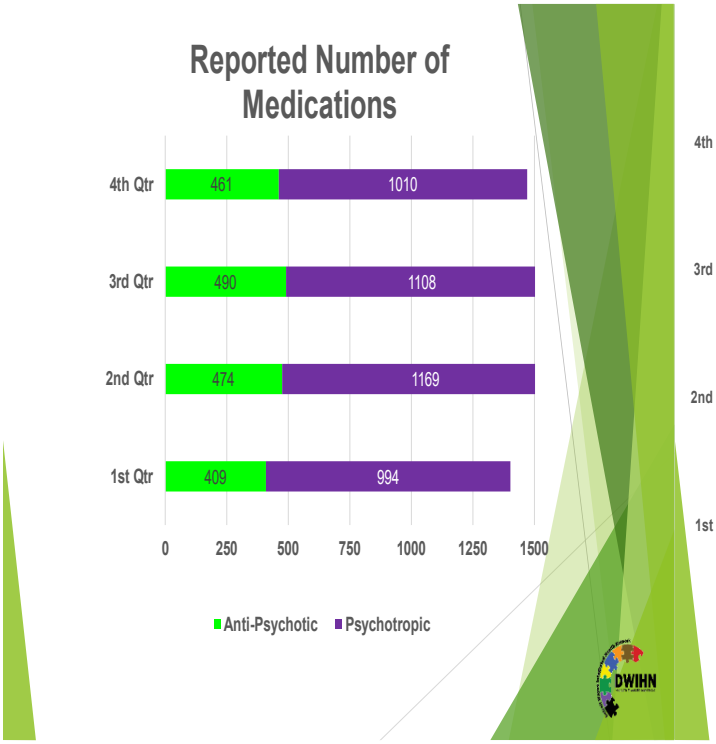
**Trends and Patterns**

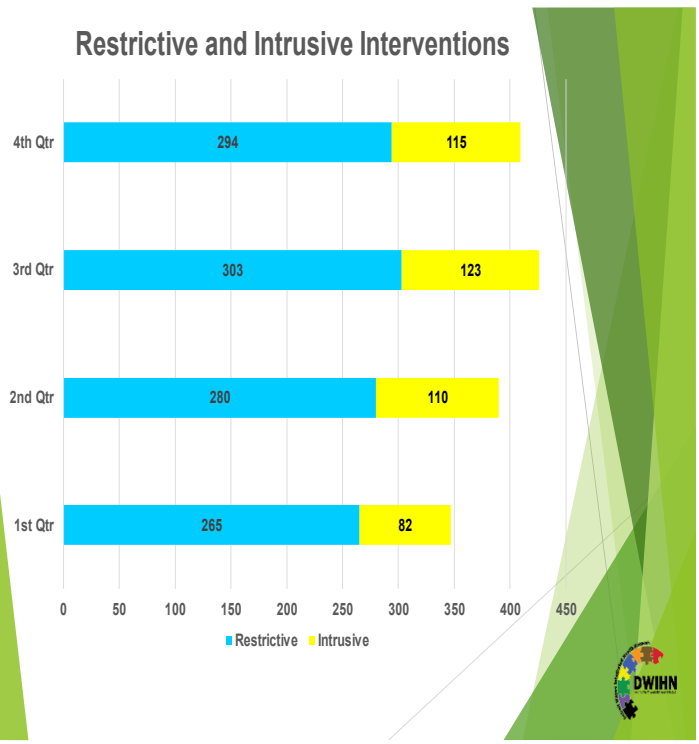
The collection and reporting of data concerning Behavior Treatment beneficiaries are currently inadequate, particularly regarding critical metrics such as 911 calls, deaths, emergency treatment incidents, and instances of physical management. This underreporting poses significant challenges for accurately assessing the effectiveness and safety of behavior treatment services. To improve this situation, the Detroit Wayne Integrated Health Network (DWIHN) is actively engaging with network providers to implement strategies aimed at enhancing data collection and reporting practices. One of the primary obstacles hindering accurate reporting is the lack of integration between the electronic health record systems used by the network's Behavioral Treatment Provider Review Committee (BTPRC) and the DWIHN's Patient Care Encounter (PCE) system (MHWIN). The current disconnection between these systems prevents seamless data sharing, which is crucial for ensuring that all relevant information is captured and reported in a timely manner. This integration issue significantly contributes to the underreporting of critical events such as 911 calls and other key indicators.

Another challenge is the incorrect categorization of reported data, which complicates the overall analysis and response to behavior treatment cases. To address this specific issue, the Behavior Treatment category has been activated within the Sentinel Events Reporting module of the MHWIN system. This initiative aims to standardize reporting procedures and improve the accuracy of the data collected on Behavior Treatment beneficiaries, thereby enhancing the organization's ability to monitor and evaluate outcomes more effectively. Furthermore, the training of staff in implementing behavior treatment plans has encountered difficulties, primarily due to a shortage of qualified clinical personnel. The requirement for staff to possess the credentials mandated by the Michigan Department of Health and Human Services (MDHHS) for BTPRC review has become increasingly challenging. The ongoing lack of such qualified professionals limits the capacity to provide essential training and oversight, which is crucial for maintaining high standards of care within the behavior treatment framework. The following charts illustrates the data collected and reported during FY2024.


Total Behavior Treatment Plans Reviewed
450
400
350
300
250
200
150
100
50
0
374
359
13
0
395
377
17
0
424
422
12
0
404
381
22
1
1st Qtr
2nd Qtr
3rd Qtr
4th Qtr
Total
New
Continued
Discontinued

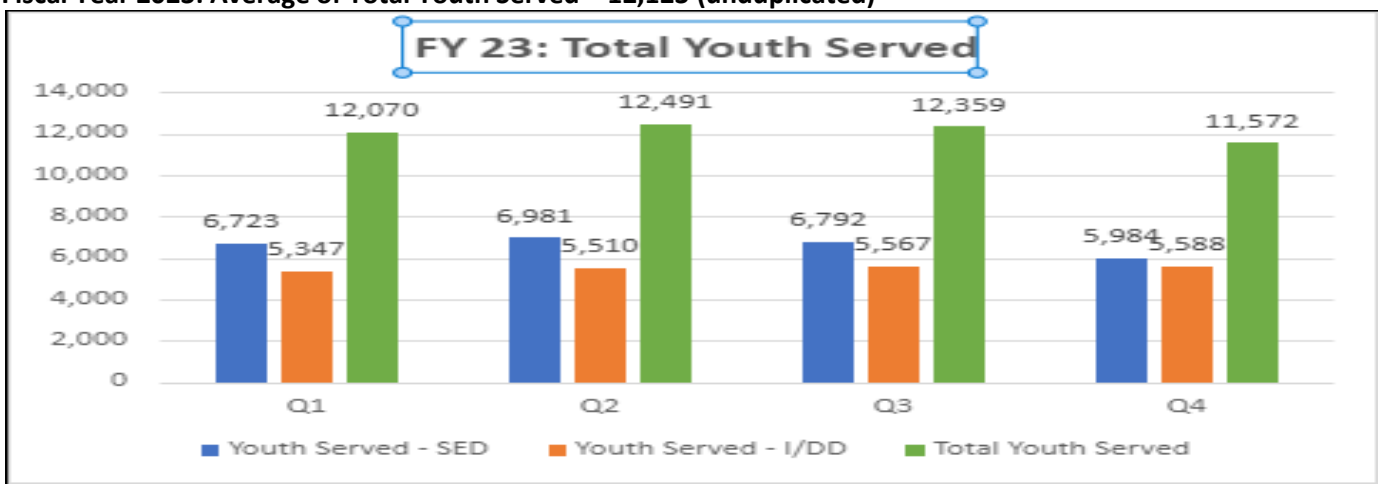

Reported 911 Calls and Critical/Sentinel Events
40
35
30
25
20
15
10
5
0
29
1
15
12
22
37
24
24
1st Qtr
2nd Qtr
3rd Qtr
4th Qtr
911 Calls
Sentinel Events


Reported Number of Medications
4th Qtr
461
1010
3rd Qtr
490
1108
2nd Qtr
474
1169
1st Qtr
409
994
0
250
500
750
1000
1250
1500
Anti-Psychotic
Psychotropic


Restrictive and Intrusive Interventions
4th Qtr
294
115
3rd Qtr
303
123
2nd Qtr
280
110
1st Qtr
265
82
0
50
100
150
200
250
300
350
400
450
Restrictive
Intrusive

**Children's Initiatives**

**Quantitative Analysis and Trending of Measures**
**Fiscal Year 2023: Average of Total Youth Served = 12,123 (unduplicated)**




The Michigan Department of Health and Human Services (MDHHS) has developed the MichiCANS screener and comprehensive assessment specifically for children and youth up to their 21st birthday. This innovative tool is designed to empower families and guide youth in their care planning processes. It aims to support several crucial areas, including Family-Driven and Youth-Guided Care Planning, Level-of-Care Decision Making, Quality Improvement Initiatives, Monitoring Outcomes of Services. As part of the MichiCANS initiative, Wayne County was chosen as a pilot site. In this capacity, the Detroit Wayne Integrated Health Network (DWIHN) collaborated with The Children Center to participate in the Soft Launch Project, which aims to test and refine the implementation of MichiCANS. In fiscal year 2024, the DWIHN Access Department successfully completed a total of **2,586 MichiCANS screenings. To enhance understanding and facilitate the implementation process, two informative MichiCANS Q&A sessions were conducted for providers and stakeholders. These sessions provided an opportunity for participants to discuss the initiative, ask questions, and share insights. Moreover, a comprehensive MichiCANS data report was created, outlining key findings and trends. New screening eligibility processes were established to ensure that all eligible children and youth have access to the necessary services. Service utilization guidelines were developed to outline best practices and facilitate optimal care. To further support providers and families, a dedicated webpage was created to offer resources related to the MichiCANS initiative. https://www.dwihn.org/Providers/MichiCANs

**Infant Mental Health and Early Childhood Services**

Infant Mental Health and Early Childhood Services Early Childhood Mental Health Services (ECMHS) are dedicated to promoting the healthy emotional development of very young children. These services aim to foster strong attachment relationships between infants, toddlers, preschoolers, young children, and their families. By focusing on the foundational relationships during early childhood, we can significantly reduce the risk of developmental delays and disorders. In fiscal year 2024, a total of **1,065 infants and toddlers** benefitted from these vital services, underscoring our commitment to supporting early childhood development. This number reflects our continuous efforts to provide accessible and effective mental health services for this vulnerable population. To further enhance our commitment to early childhood mental health, we have partnered with multiple service providers to deliver a variety of grants specifically designed for infants and toddlers. The following grants have been implemented:

- Infant and Early Childhood Mental Health Consultation Grant. This initiative focuses on providing consultation services to early childhood settings, equipping caregivers with the skills and knowledge needed to support the mental health of young children.
- Infant and Early Childhood Consultation Expansion Grant. This expansion aims to increase the availability of consultation services, reaching more families and early childhood programs in need.
- Infant and Early Childhood Consultation Home Visiting Grant. This grant supports home visiting programs that provide targeted early intervention services right within the family's home environment, ensuring personalized support.
- Baby Court Grant. This initiative focuses on improving outcomes for infants and toddlers involved in the child welfare system by ensuring they receive timely and effective mental health support.

**Opportunities for Improvement**

The Patient Health Questionnaire for Adolescents (PHQ A) is a vital screening tool utilized by healthcare providers specifically for young individuals aged 11 to 17 who have been classified with Serious Emotional Disturbance (SED). This comprehensive assessment aims to evaluate the presence and severity of symptoms related to suicidality and depression. Early identification of these symptoms is crucial, as it allows clinicians to implement targeted therapeutic interventions tailored to the needs of these youth right from the outset of their treatment. In addition to the initial assessment, the PHQ A is administered quarterly to monitor changes in the patient's mental health status over time. The goal for Fiscal Year 2024 (FY24) is to significantly enhance the completion rates for both the initial and quarterly PHQ A assessments. Increased completion rates are essential not only for improving individual treatment outcomes but also for ensuring that young patients receive the necessary support and care they require to manage their emotional and psychological well-being effectively.

**FY2024**

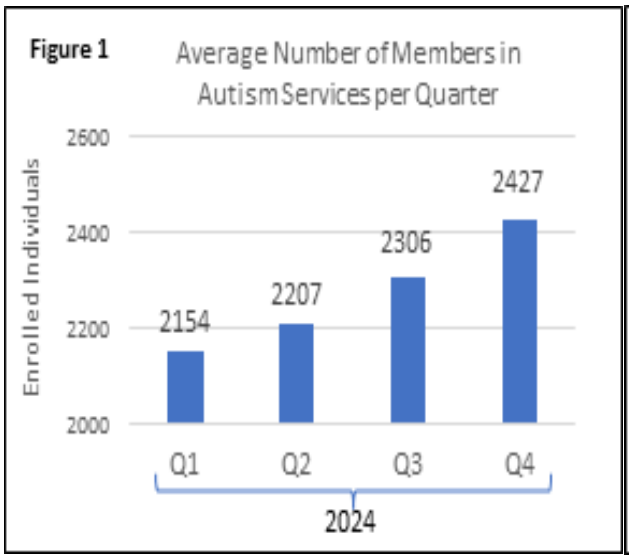
| **PHQ A (ages 11-17)** | **QTR. 1** | **QTR. 2** | **QTR. 3** | **QTR. 4** | **TOTAL** |
|---|---|---|---|---|---|
| **Intake Goal = 100%** | 99.60% | 99.99% | 100% | 99.50% | 99.70% |
| **Quarterly Goal = 95% (score at least a 10)** | 60.70% | 61.90% (+) | 63.90% (+) | 75.30% (+) | 65.40% |

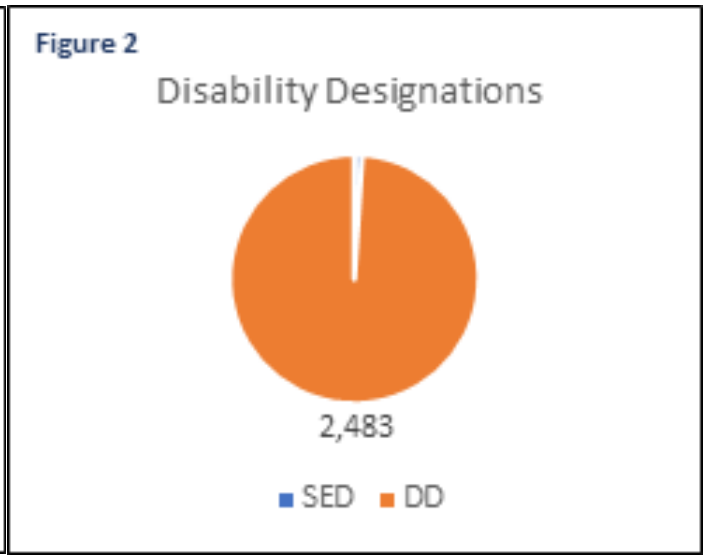
**Autism Services**

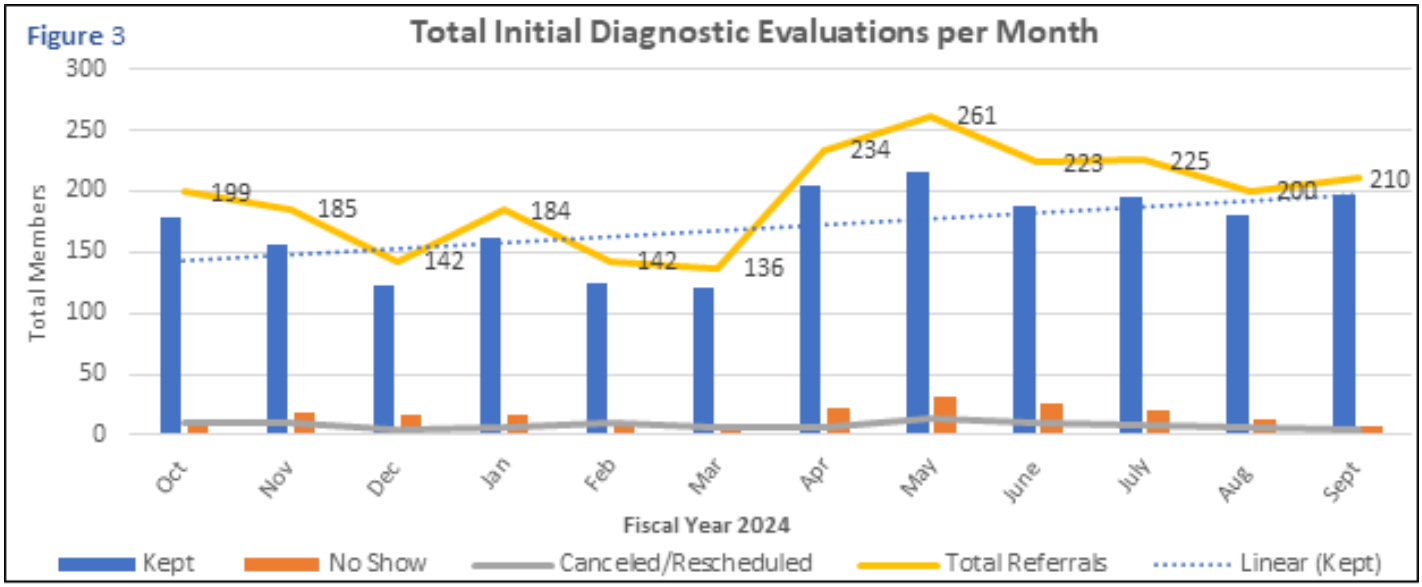
DWIHN provides Applied Behavior Analysis (ABA) services specifically designed for children and youth up to the age of 21 who have been diagnosed with autism spectrum disorder (ASD) and can medically benefit from these interventions. ABA is regarded as an evidence-based treatment that employs systematic techniques to teach essential skills and address challenging behaviors that may negatively impact an individual's ability to learn effectively. The primary focus of ABA therapy is on enhancing key areas such as communication, social skills, and the modification of repetitive behaviors, all of which are often prevalent in individuals with ASD. By fostering these skills, the therapy aims to promote better integration into the community and support personal development, ultimately enabling individuals to achieve their full potential and improve their overall quality of life. In the fiscal year 2024, DWIHN reported that a total of 2,483 youth was enrolled in the Autism Services program. Among these, an impressive 1,252 youth were newly enrolled, indicating a strong outreach and the increasing demand for these essential services. To provide a clearer picture of the program's demographics and performance, various visual aids accompany the report:

- Figure 1 presents the average number of children and youth who were actively enrolled in Autism Services, broken down by quarter. This data can help identify trends in enrollment and service usage over time.
- Figure 2 categorizes the members actively enrolled in Autism Services according to their disability designation. This breakdown shows that: - Serious Emotional Disturbances (SED) account for a minimal 0.01%, translating to 25 members. Intellectual Developmental Disabilities (IDD) constitute the vast majority at 99%, with 2,458 members participating in the program.
- Figure 3 illustrates the total number of referrals made to assess eligibility for Autism Services during the fiscal year 2024. This figure provides insight into the interest and need for assessment services, highlighting the essential role of DWIHN in providing support and determining qualification for ABA therapy. Overall, this detailed overview underscores DWIHN's commitment to serving the needs of youth with autism spectrum disorder and continuously improving access to vital therapeutic resources.

**Autism Service Enrollment**






**Goal: Improving Access to Applied Behavior Analysis (ABA) for Individuals with Autism Spectrum Disorders (ASD) ages 0-20 years of age covered by Medicaid in Wayne County**

DWIHN provides a comprehensive range of Autism Behavioral Analysis (ABA) services specifically designed for children and young adults, from birth to 21 years of age. ABA is a structured and evidence-based therapeutic approach that focuses on understanding and modifying behaviors associated with autism spectrum disorder (ASD). Our mission is to empower individuals with ASD to achieve meaningful improvements across various critical areas of their lives. Communication Skills. ABA techniques are designed to enhance both verbal and non-verbal communication abilities. We work closely with children to develop their skills in expressing their needs, wants, and emotions, leading to improved interactions with family members, peers, and educators. We implement strategies such as modeling, prompting, and reinforcement to encourage the use of language in everyday situations and facilitate better communication overall. Social Interaction.

The ABA program emphasizes the importance of social skills development. We focus on teaching children the essential components of social interactions, including taking turns, sharing, initiating conversations, and responding appropriately to social cues. Through structured play and social scenarios, we help children practice these skills in a supportive environment, thereby increasing their ability to form and maintain meaningful relationships with others. Reduction of Repetitive and Restrictive Behaviors. Many children with ASD exhibit repetitive movements or have intense, restrictive interests. The targeted interventions aim to reduce these behaviors and replace them with more adaptive alternatives. By using techniques such as functional behavior assessments and individualized behavior intervention plans, we address the root causes of these behaviors and help children engage in more flexible and constructive activities that enhance their overall daily functioning. At DWIHN, our dedicated team consists of highly trained professionals who tailor ABA strategies to meet the unique needs of each child. We recognize that every child is different, and we take great care to ensure our approaches are individualized and responsive. We engage with families throughout the process, providing support and guidance to create a collaborative and nurturing environment that fosters growth, development, and success for every child we serve.

**Quantitative Analysis and Trending of Measures**

Ensuring timely access to Applied Behavior Analysis (ABA) services is of paramount importance for eligible individuals with autism, aged 0 to 21 years, who are enrolled in Medicaid in Wayne County. These services play a critical role in providing the necessary support and therapeutic interventions for individuals on the autism spectrum. By focusing on behavior modification and skill development, ABA services aid in fostering essential life skills, improving communication, and enhancing overall quality of life for these individuals and their families. In December 2024, we are set to introduce a comprehensive initiative aimed at measuring the adequacy and effectiveness of autism services available within the community. This initiative will concentrate on a vital metric: the percentage of members who are able to initiate their ABA services within 14 days of the authorization date. Our baseline data analysis indicated a troubling trend—only 64.67% of eligible members were able to start their services within this critical 14-day timeframe. This delay in accessing necessary treatments can significantly impact the overall development and well-being of individuals with autism. To combat this challenge and improve service accessibility, we have established an ambitious target to ensure that at least 70% of eligible members commence their ABA services within the specified 14-day window. Setting this goal reflects our commitment to providing timely and effective care. In fiscal year 2024, we are excited to share that we achieved substantial progress toward this objective. On average, an impressive 88% of members were able to begin their ABA services within 14 days of receiving authorization.

This notable statistic not only surpasses our initial goal of 70% but also reflects a remarkable 23.58% improvement compared to the previous fiscal year. These advancements in access to ABA services underscore our dedication to enhancing the support and care available to individuals with autism. By facilitating timely initiation of services, we aim to ensure that eligible individuals receive the high-quality care they need to thrive, ultimately leading to better outcomes for both them and their families. Our continued efforts will focus on addressing barriers to access and fostering an environment where all eligible individuals can benefit from the transformative power of ABA therapy.

**Increase the number of eligible individuals who are receiving timely access to services within 14-days of being authorized**

| Reporting Period | Numerator | Denominator | Rate | Comparison Goal | Statistical Significance |
|---|---|---|---|---|---|
| FY 23 / Q1 | 28 | 48 | 58% | 70% | Below Goal |
| FY 23 / Q2 | 41 | 52 | 79% | 70% | Above Goal |
| FY 23 / Q3 | 40 | 70 | 57% | 70% | Below Goal |
| FY 23 / Q4 | 32 | 48 | 67% | 70% | Below Goal |
| **FY23 Total** | **141** | **218** | **64.67%** | **70%** | **Above Goal** |
| FY 24 / Q1 | 35 | 37 | 95% | 70% | Above Goal |
| FY 24 / Q2 | 43 | 51 | 84% | 70% | Above Goal |
| FY 24 / Q3 | 36 | 43 | 84% | 70% | Above Goal |
| FY 24 / Q4 | 75 | 83 | 90% | 70% | Above Goal |
| **FY24 Total** | **189** | **214** | **88.25%** | **70%** | **Above Goal** |

**Evaluation of Effectiveness**

During Fiscal Year 2024, a comprehensive range of interventions was strategically implemented to enhance timely access to Applied Behavior Analysis (ABA) services for individuals in need. To achieve this, a Request for Qualifications (RFQ) was carefully crafted and posted to solicit a diverse list of qualified ABA providers within Wayne County. This effort not only broadened the provider network but also successfully added six new providers who met the necessary qualifications. Furthermore, the RFQ process confirmed at least ten additional potential providers who could be called upon if demand increased. As a result of these initiatives, the provider network concluded the fiscal year with a total of 21 ABA active ABA providers, while 1 ABA providers exited the network. This growth resulted in 58 separate service locations across various areas in Wayne County, significantly increasing the availability of ABA services for families in the region. In addition to expanding the provider network, the Autism Department was proactive in facilitating a series of educational presentations aimed at enhancing understanding of autism services among stakeholders. These presentations included targeted training sessions on autism services policy and offered technical assistance tailored to the needs of autism providers.

To further support educational efforts, the Autism Department developed and added ten new educational videos to the Detroit Wayne Connect training website. These videos covered a broad spectrum of behavioral analytic principles, aiming to empower both providers and families with valuable knowledge. To streamline access to care, the Autism Department's website was revamped, now featuring an updated list of ABA provider contact information. This enhancement is designed to facilitate quicker coordination of care, helping families connect with services swiftly and efficiently. Moreover, the Autism Service Policy underwent a thorough revision to ensure compliance with updated state requirements. Despite the intensified focus on enabling members to receive ABA services within 14 days of authorization approval, the Autism Department remained committed to advocating for the initiation of ABA services within 90 days of referral, recognizing the critical nature of timely intervention. Lastly, the network was enriched with a variety of specialized training opportunities for autism providers, covering essential topics and best practices to improve the overall quality of care delivered within the community. The details of these training sessions are outlined below:

| Training Title | Date | Number of Attendees |
|---|---|---|
| Autism Spectrum Disorder & ABA Therapy | April 20, 2023 | 65 |
| Infant Mental Health Autism Training | April 24, 2023 | 10 |
| Genetics in Autism/Treatment | May 12, 2023 | 37 |
| Celebrating the Unique Abilities of Autism | May 25, 2023 | 25 |
| Choice Matters: Compassion, Empathy, and Perspective Taking in Treatment | June 1, 2023 | 38 |
| Jump Start Behavior Change | June 22, 2023 | 30 |
| ASD Radio Interview | July 10, 2023 | 15 |
| Using Behavior Assessment Data to Choose Effective Treatment | August 23, 2023 | 23 |
| Developing and Writing Better Treatment Plans | September 13, 2023 | 31 |

**Identified Barriers**

- Difficulty identifying ABA Service Providers with availability.
- ABA Service Providers have minimal to no afternoon availability.
- Difficulty identifying the support coordinator or case manager to request authorizations.
- Difficulty receiving consistent responses from the CRSPs.
- Delay with CRSPs completing the annual Individual Plan of Service (IPOS).
- Delay with CRSPs submitting ABA authorizations for approval.
- Delay with CRSPs responding to returned authorizations.
- Delay with CRSPs providing IPOS training to BCBA/BT.
- Lack of capacity to provide autism services within the provider network and staffing shortages.
- Low pay rate for behavioral technicians compared to commercial insurance rates.
- Implement ongoing case monitoring system and notices to ensure each case is moving through the benefit in a streamlined process.
- Review utilization of ABA services with ABA Providers and discharging when members have completed treatment goals.

**Opportunities for Improvement**

- Increased communication and coordination in the network about recruiting appropriate professionals and timely initiation of treatment.
- Updated DWIHN's Autism Service Utilization Guidelines (SUGs) to increase supervision for behavior technician staff ratio.
- Added an Autism Support Specialist position to improve review of approval for diagnostic evaluation reports.
- Remove barriers to service access by streamlining processes and educating the network and community on accessing Autism Services.
- Review utilization of ABA services with ABA Providers and discharging when members have completed treatment goals.

**Performance Improvement Projects (PIPs)**

The DWIHN Departments have been actively pursuing a variety of process improvement initiatives aimed at enhancing the overall quality of care. Among these initiatives, several are formalized as Quality Improvement Projects (QIPs). These projects are diligently overseen by two key groups: the Improving Practices Leadership Team, which provides strategic direction, and the Quality Improvement Steering Committee, which ensures that the projects align with organizational goals and standards. The guidance provided for all QIPs focuses on several critical areas to drive success. Firstly, there is an emphasis on enhancing the identification of both outcome and process measurements. This involves developing clear metrics to evaluate the effectiveness of interventions and ensuring that data collection processes are robust and reliable. Additionally, the teams are encouraged to utilize Health Effectiveness Data and Information Set (HEDIS) measures, which provide standardized performance measures used to assess the quality of care within the healthcare system. HEDIS measures allow for benchmarking against industry standards and can highlight areas requiring attention and improvement. Another important focus is the implementation of meaningful and measurable interventions. This entails designing interventions that are not only impactful but also quantifiable so that their effectiveness can be assessed over time. In this context, the applications of cause-and-effect tools are vital for analyzing progress. These tools help to identify the root causes of issues and to track the outcomes of implemented changes systematically. Overall, the clinical care improvement projects are specifically targeted at enhancing member outcomes. By focusing on these structured areas of guidance, the DWIHN Departments aim to deliver higher quality care that meets the needs of their members more effectively. The projects include various initiatives that will be detailed further in subsequent communications.

**Goal: Improving the Attendance at Follow up Appointments with a Mental Health Professional after Hospitalization for Mental Illness**

Access to the public mental health system is critical for ensuring that individuals can obtain the support they need. Quick and convenient access is not only a matter of convenience but fundamental for effective treatment. Delays in conducting clinical and psychological assessments can lead to a worsening of mental health symptoms, increased emotional distress, and can severely impact an individual's daily functioning and quality of life. One important measure of access to care is the duration of time between a service request and the point at which a qualified professional conducts a clinical assessment. This time frame can significantly influence the trajectory of an individual's mental health treatment. In the United States, statistics from 2020 indicate that approximately 20.3% of adults engaged in some form of mental health treatment, which encompasses various services, including counseling, therapy sessions, and prescription medications. This indicates a significant but incomplete response to the needs in the population. For individuals diagnosed with schizophrenia, the situation is particularly concerning, as the rate of readmission to psychiatric hospitals ranges from 40% to 50% within just 12 months following discharge from previous hospitalization. This high readmission rate suggests that many individuals are not receiving the continued care and support they need to stabilize their condition after discharge.

Depressive disorders also play a considerable role in readmission rates, although the exact percentages can vary based on numerous factors, including treatment interventions and individual circumstances. Mental health challenges are more widespread in the United States than commonly perceived. The U.S. Department of Health and Human Services reports that one in five American adults has faced a mental health challenge at some point in their lives. Furthermore, one in 20 Americans is living with a serious mental illness, including conditions such as schizophrenia, bipolar disorder, or severe depression. This reality underscores the critical importance of accessible mental health care services, which are essential for helping individuals manage their mental health conditions effectively. Despite the recognized need for mental health support, a staggering statistic reveals that over half of the adults with mental illness in the U.S.—an estimated total of about 27 million individuals—do not receive the necessary treatment. This gap in care highlights the urgent need for improvements in access to mental health services, as well as the importance of public awareness and stigma reduction to encourage individuals to seek help when needed. Addressing these barriers is vital for ensuring that more people can obtain the support required to lead healthier and more fulfilling lives.

**Quantitative Analysis and Trending of Measures**

Follow-up care after hospitalization plays a critical role in enhancing patient outcomes and overall healthcare quality. It involves continued monitoring of the patient's health status, which is vital for identifying any complications early on. This proactive approach not only facilitates timely medical interventions but also significantly contributes to patient satisfaction, as individuals feel supported and cared for even after leaving the hospital. Therefore, healthcare professionals and organizations should prioritize the implementation of comprehensive follow-up care strategies to improve recovery rates and reduce the likelihood of readmissions. In 2024, the Detroit Wayne Integrated Health Network (DWIHN) conducted an in-depth review of the baseline data regarding the follow-up after hospitalization measure within the Healthcare Effectiveness Data and Information Set (HEDIS). This review included a thorough evaluation by the Improving Practice Leadership Team (IPLT), which aimed to assess DWIHN's current performance and identify areas for improvement. Following this assessment, it was decided that DWIHN would benchmark its follow-up care performance against specific targets established by the State of Michigan. These benchmarks reflect the state’s commitment to improving healthcare delivery and have set ambitious goals: a follow-up rate of 79% within 7 to 30 days for children aged 6 to 17 and a target of 58% for adults aged 18 and older.

DWIHN has resolved to use these state metrics as comparison goals to gauge its effectiveness in delivering timely follow-up care post-hospitalization. As part of this initiative, the follow-up rates achieved by DWIHN in 2024 are expected to highlight the organization's performance in relation to the established benchmarks, providing valuable insights into the effectiveness of its post-hospitalization care strategies and identifying opportunities for continued enhancement in patient care delivery. These rates illustrate DWIHN's current performance compared to the state's established goals.

- **For children aged 6-17****
  - 30-day follow-up: 62.27%
  - 7-day follow-up: 42.70%
- **For adults aged 18-64**
  - 30-day follow-up: 49.67%
  - 7-day follow-up: 31.21%
- **For individuals aged 65 and older**
  - 30-day follow-up: 33.72%
  - 7-day follow-up: 18.60%

**Goal: Improving Adherence to Antipsychotic Medications for Individuals with Schizophrenia**

Schizophrenia is a complex and chronic mental disorder that profoundly affects a person's thinking, emotions, and behaviors. It is characterized by a range of symptoms, including hallucinations (seeing or hearing things that are not present), delusions (strongly held false beliefs), and significant cognitive impairments that can hinder daily functioning. The disorder typically emerges in late adolescence or early adulthood, affecting individuals across various demographics and backgrounds. Antipsychotic medications are the cornerstone of treatment for schizophrenia. These medications are designed to help manage and mitigate the symptoms of the disorder, ultimately leading to improved quality of life for those affected. Various types of antipsychotics are available, and they can vary in effectiveness and side effects from person to person. Despite their benefits, a significant challenge remains: many individuals do not consistently adhere to their medication regimens. Adhering to prescribed antipsychotic medications is essential for several reasons. Consistent use helps prevent relapses, which are periods when symptoms worsen or re-emerge. Additionally, maintaining adherence can significantly reduce the frequency of hospitalizations, leading to better health outcomes and reduced disruption to a person's life. Studies have shown that non-adherence to treatment can be alarmingly high, with rates reaching up to 60%. This non-adherence can lead to more severe symptoms, an increased risk of relapse episodes, and ultimately higher healthcare costs due to emergency interventions and hospital stays. In Michigan, the prevalence of schizophrenia is estimated to be around 2.22% of the population. This percentage corresponds to approximately 50,830 individuals living with the disorder. Within this group, around 2.45% (or about 15,598 members) are affiliated with the Detroit Wayne Integrated Health Network (DWIHN), as reported by the CC 360 database. This data highlights the significant number of individuals who may struggle with non-adherence to treatment and underscores the need for targeted interventions to support their mental health needs and improve adherence to prescribed medications.

**Quantitative Analysis and Trending of Measures**

Enhancing medication adherence is essential for achieving improved health outcomes and significantly reducing healthcare costs. This is particularly important for individuals diagnosed with schizophrenia, as consistent adherence to antipsychotic medications plays a vital role in the effective management of their condition and the enhancement of their overall well-being. To support these individuals, it is crucial for healthcare providers to identify and understand the various factors that influence medication adherence. By implementing targeted strategies to overcome these challenges, providers can empower individuals with schizophrenia to achieve better health outcomes and an enhanced quality of life. Recently, the Detroit Wayne Integrated Health Network (DWIHN) conducted a comprehensive review of the 2024 baseline data pertaining to the antipsychotic compliance HEDIS measure. This evaluation included insights from the Improvement Practice Leadership Team (IPLT) committee, which played a key role in guiding the decision-making process. After careful analysis, it was concluded that DWIHN should benchmark its performance against that of Michigan Medicaid Health Plans. The benchmarking process is facilitated through Michigan's partnership with the Health Services Advisory Group, Inc. (HSAG), an organization that specializes in analyzing and comparing the performance of health plans relative to the Quality Compass National Medicaid percentiles. The recently published Michigan HSAG report revealed that the average results for antipsychotic management among health plans in 2023 stood at 66.28%. This figure not only reflects a commendable level of compliance but also exceeds the HEDIS 50th percentile, indicating that many health plans are effectively supporting their members in medication adherence. In stark contrast, DWIHN's baseline results for the 2024 antipsychotic medication adherence rate—derived from detailed data provided by Vital Data Technology, our National Committee for Quality Assurance (NCQA)-certified vendor responsible for managing and reporting our HEDIS results—were considerably lower at only 45.83%. This disparity underscores the urgent need for DWIHN to implement effective strategies to improve medication adherence among its members and better align its performance with state and national benchmarks.

**Goal: Improving Diabetes Monitoring for People with Schizophrenia and Bipolar**

The percentage of individuals aged 18 to 64 years who are diagnosed with schizophrenia, schizoaffective disorder, or bipolar disorder and are prescribed antipsychotic medication, alongside those who have had a diabetes screening test during the measurement year, serves as a critical healthcare metric. Annual diabetes screening is strongly recommended for individuals within this age group who are taking antipsychotic medications due to the increased risk of developing metabolic disorders, including diabetes. Screening can be conducted using a fasting glucose test or an HbA1c test, both of which measure blood sugar levels. It is essential that the results of these tests be accurately documented in the patient's medical records to ensure continuity of care and to inform future clinical decisions. This proactive approach is vital for early identification and effective management of diabetes risk among this vulnerable population, as many individuals with these mental health disorders may be less likely to receive routine health screenings. To enhance the monitoring of diabetes screening in patients with schizophrenia and similar conditions, consider implementing the following key interventions:

- Annual Screening: Establish a routine to schedule a diabetes screening test for these patients at least once a year. This regular screening helps in early detection of potential diabetes, allowing for timely intervention and management strategies to be put in place, thus reducing the risk of complications.
- Care Coordination: Promote effective communication and collaboration between behavioral health professionals and primary care physicians (PCPs) involved in the care of these patients. This includes actively requesting diabetes screening test results, sharing relevant clinical information regarding the patient's mental health status, and facilitating the scheduling of appointments for testing. By ensuring a holistic approach to the patient's health, the likelihood of successful diabetes management increases, leading to improved overall health outcomes. By emphasizing these key interventions, healthcare providers can significantly contribute to the well-being of individuals with schizophrenia, schizoaffective disorder, or bipolar disorder, ultimately helping to mitigate the risks associated with diabetes.

**Evaluation of Effectiveness**

When analyzing the member population with chronic conditions at the Detroit Wayne Integrated Health Network (DWIHN) in comparison to the broader statewide population in Michigan, several significant statistics emerge. The prevalence of schizophrenia in Michigan is estimated at 2.22%, translating to approximately 50,830 individuals affected statewide. In comparison, DWIHN reports a higher incidence rate of 2.45%, which corresponds to about 15,598 individuals receiving services through their network.

Regarding bipolar disorder, Michigan's statewide prevalence stands at 5.76%, indicative of 131,943 individuals. Conversely, DWIHN reflects a lower prevalence rate of 4.1%, accounting for around 26,136 individuals. Furthermore, when it comes to diabetes screening adherence, DWIHN currently shows a rate of 64.40%. This figure is considerably lower than the managed health plan (MHP) benchmark of 80.99%, highlighting a significant disparity in diabetes screening rates among the populations served. During Fiscal Year 2024, DWIHN achieved a compliance score of 64.40% for members aged 18 to 64 diagnosed with either schizophrenia or bipolar disorder who were prescribed antipsychotic medication and had undergone a diabetes screening test within the measurement year. This evaluation was part of a comprehensive review process that included feedback from the Improvement Practice Leadership Team (IPLT) committee, which aimed to assess the effectiveness of current practices and identify areas for improvement.

Considering the findings regarding diabetes screening compliance, DWIHN took proactive steps to benchmark its performance against other Michigan Medicaid health plans. The state of Michigan, in collaboration with the Health Services Advisory Group, Inc. (HSAG), conducts thorough analyses of the performance of Medicaid health plans, leveraging data from the Quality Compass National Medicaid percentiles. According to the HSAG report for Michigan, the average diabetes screening rate among Medicaid health plans in 2023 was 80.99%, positioning it within the 75th to 89th percentiles for HEDIS (Healthcare Effectiveness Data and Information Set) measures. To enhance their services and monitor progress effectively, DWIHN established this 80.99% benchmark for both diabetes screening and antipsychotic medication adherence in 2024. This allows DWIHN to critically compare its performance metrics with the average scores of nine distinct Michigan Medicaid health plans, thereby identifying best practices and opportunities for improvement in member care.

**Goal: Increasing Compliance with Antidepressant Medication adults 18 years and older with a diagnosis of major depression who were newly treated with antidepressant medication and remained on their antidepressant medications**

Effectively managing antidepressant medication is vital for the successful treatment of major depression. This process involves several key components to ensure that patients adhere to their prescribed medication regimen, which is critical for achieving the desired therapeutic outcomes. First and foremost, it is important to monitor patients for any side effects that may arise from the medication. This can include physical symptoms, emotional changes, or alterations in behavior. Regular check-ins and assessments can help identify any adverse effects early, allowing for timely interventions. In addition to monitoring side effects, healthcare providers should be prepared to adjust dosages based on individual patient responses. Some patients may require a higher or lower dosage to achieve the desired effect, and these adjustments should be made carefully and in consultation with the patient. Moreover, providing ongoing support is a crucial aspect of effective management. This can involve educating patients about their medication, addressing any concerns they may have, and encouraging open communication. Support groups or counseling can also be beneficial, as they offer patients a platform to share their experiences and challenges in managing their condition. Together, these strategies create a comprehensive management plan that enhances medication adherence and improves treatment outcomes for individuals suffering from major depression.

**Acute Phase Treatment**

- Goal: Reduce remission of depressive symptoms.
- Duration: Typically lasts 6-12 weeks.
- Importance: This phase aims to significantly reduce symptoms and restore normal functioning. Effective treatment during this phase can prevent the worsening of depression and lower the risk of suicide.

**Continuation Phase Treatment**

- Goal: Prevent relapse of depressive symptoms.
- Duration: Usually lasts 4-9 months after achieving remission.
- Importance: Maintaining the same treatment that was effective during the acute phase helps solidify the gains made and prevents the return of symptoms. This phase is crucial for ensuring long-term recovery and stability.

In the state of Michigan, a significant 12.98% of the population has been diagnosed with major depression, amounting to approximately 251,779 individuals affected by this mental health condition. Among these individuals, a notable subset—7.39% or around 47,116 people—are actively receiving services through the Detroit Wayne Integrated Health Network (DWIHN), as indicated by data from the CC 360 database. When it comes to medication adherence, studies show that, on average, only 50% of patients manage to follow their prescribed treatment plans consistently. This alarming figure highlights a widespread issue in chronic disease management that is documented by the Center for Disease Control in 2024. The implications of medication nonadherence are far-reaching and serious. Those who do not adhere to their treatment plans face higher rates of hospitalization, which can lead to longer recovery times and increased strain on medical facilities. Furthermore, patients experiencing nonadherence often encounter suboptimal health outcomes, which include worsening of existing health conditions, increased rates of morbidity (incidence of disease), and even mortality. In terms of financial impact, nonadherence places a tremendous burden on the U.S. healthcare system, with annual estimated costs ranging between $100 billion and $300 billion. These costs stem not only from increased hospital admissions and the need for additional medical interventions but also from the broader implications of treating advanced or neglected health issues. Addressing medication adherence is thus crucial not only for improving individual patient outcomes but also for enhancing the overall efficiency and effectiveness of the healthcare system.

**Evaluation of Effectiveness**

The average medication adherence score in the United States is currently 79 out of 100, which translates to a C+ grade in academic terms. This statistic highlights a significant issue in patient care, as only 24% of patients are able to achieve an A grade for full adherence to their prescribed medications. According to recent data from Vital Data, the Detroit Wayne Integrated Health Network (DWIHN) has reported compelling findings regarding medication adherence among its members for the year 2024. Specifically, during the acute phase of treatment, only 730 out of 2,045 members—approximately 35.7%—stayed on their prescribed medications. This low adherence rate during the initial treatment phase indicates the need for targeted interventions to support patients. Conversely, the adherence rates observed during the continuation phase are more promising. In this phase, an impressive 1,835 out of 2,045 members—about 89.7%—maintained adherence to their medication regimens for 80% or more of the treatment period. This improvement emphasizes the value of ongoing support and monitoring in enhancing medication adherence.

The importance of medication adherence cannot be overstated, particularly when it comes to managing chronic conditions such as depression. Proper adherence to antidepressant medications is crucial not only for managing symptoms effectively but also for enhancing overall patient outcomes. Research has shown that poor adherence can lead to unfavorable health outcomes, increased hospitalizations, and higher healthcare costs. By better understanding the various factors that influence patient adherence—such as side effects, mental health status, and social determinants of health—healthcare providers can implement effective strategies to address these challenges. This, in turn, can help individuals suffering from depression achieve improved health, enhanced well-being, and a better quality of life. In fiscal year 2024, DWIHN specifically reported that 35.70% of its members aged 18 and older, who had been prescribed an antidepressant, adhered to their treatment for 6 to 12 consecutive weeks. Additionally, a smaller subset—10.27%—managed to continue their antidepressant treatment for a significant duration of at least 4 to 9 months. Recognizing the need for improvement, DWIHN undertook a comprehensive review of baseline data concerning its antidepressant medication compliance as part of the Healthcare Effectiveness Data and Information Set (HEDIS) measures. This review was conducted in collaboration with the Improving Practice Leadership Team (IPLT) to analyze and strategize based on performance metrics. To further enhance its performance, DWIHN decided to benchmark its adherence rates against those of other Michigan Medicaid health plans. The Michigan Department of Health collaborates with Health Services Advisory Group, Inc. (HSAG) to assess the effectiveness of Medicaid health plans in relation to national standards, utilizing the Quality Compass National Medicaid percentiles for comparison.

According to the HSAG report for Michigan, the average effectiveness rates for Medicaid health plans in 2023 were notably 66.93% for the acute phase treatment rate, which exceeds the HEDIS 75th percentile. Furthermore, the effective continuation phase treatment rate for the same year stood at 50.71%, placing it above the 50th HEDIS percentile. Considering these findings, DWIHN established specific benchmarks for both the acute and continuation phases of medication adherence in 2024. These benchmarks are designed to enable DWIHN to assess its performance against the average scores of nine other Michigan Medicaid health plans, ultimately aiming to improve patient outcomes and adherence rates across the board. The ongoing commitment to enhancing medication adherence is essential for optimizing healthcare delivery and ensuring that patients receive the best possible care.

## Workforce Pillar

The mission of the Detroit Wayne Integrated Health Network (DWIHN) Innovation and Community Engagement (ICE) is centered on driving innovation through deliberate and strategic program development, as well as advancing workforce capabilities across our extensive provider network. We are wholly committed to promoting recovery, building resilience, and enhancing community wellness. Our approach focuses on connecting individuals to vital treatment resources, while also offering ongoing support through various educational outreach and engagement initiatives designed to empower our communities.

During the fiscal year 2023-24, we successfully organized and facilitated a total of 100 live training events and conferences. Of these events, 60 were conducted in-person, allowing for direct engagement and networking opportunities, while 40 were hosted virtually, providing access to those who preferred or required remote learning options. Throughout the year, we recorded a total of 4,283 attendees who participated in these training sessions, reflecting a strong interest in professional development within the behavioral health community. In conjunction with our in-person events, the usage of DWC's online training portal, Detroit Wayne Connect, has seen remarkable growth. In fiscal year 2023-24 alone, over 12,000 unique users logged onto the site. These users completed a staggering 188,036 instances of required online training and another 188,550 instances of supplementary training courses. This surge in participation signifies the vital role of accessible education and training resources in supporting the advancement of knowledge and skills within the provider network.

Moreover, we received 54 applications for Continuing Education Units (CEUs), which are vital for recognizing completed training activities. These applications covered a wide range of training sessions, conferences, seminars, and other educational opportunities organized by DWIHN and affiliated organizations within our provider network, emphasizing our commitment to maintaining a high standard of professional development. We provide a comprehensive range of training opportunities through our online platform, Detroit Wayne Connect. This continuing education platform is specifically designed for stakeholders in the behavioral health workforce, offering valuable resources and courses tailored to meet the needs of professionals in the field. To access the platform and explore available training options, please visit dwctraining.com. Additionally, we offer specialized substance use disorder (SUD) Trainings, which can be found on the Improving MI Practices website. These trainings are designed to enhance the skills and knowledge necessary for effectively addressing substance use challenges within our communities. For more information, please visit **www.dwihn.org**.

## Workforce Development and Retention

In FY2024, ICE focused on sustaining the centralized training program in collaboration with local and national educational institutions. The efforts resulted in continuing to provide comprehensive training to student learners in various settings to engage in integrated healthcare across the lifespan. During FY2024, more than 58 behavioral health students completed a field practicum within our provider network to develop competent behavioral health professionals who are qualified mental health and child mental health professionals. Retention efforts have included advocacy with the National Health Service Corporation to develop approved sites within our community to be eligible for consideration for student loan repayment. We were granted this approval designation which will allow us to recruit and retain staff with this incentive. DWIHN planned and coordinated the 10th Annual Trauma Conference there were 294 attendees, who participated in various workshops that identified trauma as a public health concern that impacts the emotional and physical wellness of individuals. Throughout the year, partnering organizations offered specific evidence-based trauma-informed continuing education training, Cognitive Behavioral Therapy, Trauma Empowerment Model (TREM), for 271 individuals.

The 3rd Annual Self-Care Conference was held. The theme was Empowering Wellness and Resilience in Behavioral Health Professionals and was held and saw 124 attendees. The conference offered concepts about the importance of self-care, mental health, wellness, nutrition, physical wellness, and relationships. During FY 24, ICE increased continuing education training about co-occurring disorders. We hosted the annual Co-Occurring Disorder Mini Conference and a 2-day Co-Occurring Disorder Workshop Series on September 25 and 26. There were approximately 100 attendees who learned about the symptoms of co-occurring disorders, which include those associated with substance use problems and mental health conditions affecting an individual.

**Special Initiatives**

**Reach Us Detroit**

The Reach Us Detroit Therapy Line continues to be a critical support for Wayne County residents, effective in crisis prevention, crisis interventions, and referrals. This year, there were 1668 incoming/outgoing calls. The highest recorded calls for the year were in July 2024, with 235 calls. This connects with the numerous community losses that occurred. Significant increase in call volume, reflecting both media awareness and improved outreach. There is a clear progression of increasing support with an average call volume of over 100 calls each month.

**Mental Health Jail Navigator**

The Mental Health Jail Navigator referrals remain consistent, **87** individuals were referred and interviewed, met the criteria and were referred to various treatment providers, Genesis House III, Team Wellness Center and/or Christian Guidance Center. Currently, all individuals are being monitored and receiving jail navigation services.

**PIHP Veteran Navigator**

The Veteran Navigator program aims to strengthen partnerships and improve communication with the VA and community agencies. Key objectives include building awareness of the Navigator's role, streamlining referrals, and enhancing access to resources for veterans and their families. The Veteran Navigator provided support to 284 veterans.

**Detroit Police Department Co-Response Partnership**

Co-responders had **3707** encounters, four hundred fifty-nine (**459**) individuals received various resources for mental health, substance use, and homelessness when crisis transport was not needed. A team of 30 individuals organized by ICE offered behavioral health support in partnership with the co-response teams for the 2024 NFL Draft. Staff were available to provide resources, verbal de-escalation, and a display of partnership.

**Plans for enhancement and improvement**

Looking ahead, we remain focused on building upon this year's accomplishments to expand our reach and impact in Wayne County. Our commitment to innovation and comprehensive care will guide our efforts to improve access to mental health resources, enhance community safety, and strengthen resilience. Working closely with stakeholders, both internally and externally, we will continue to ensure individuals receive the support they need.

**Enhance Suicide Prevention Efforts**

Strengthen the Zero Suicide Initiative by further embedding the program's principles across the provider network and engaging additional community partners.

**Support the Justice-Involved Population**

The team will expand the Mental Health co-response program and further develop partnerships with law enforcement to improve outcomes for individuals with mental health needs in the justice system.

**Increase community engagement/support equitable access to care**

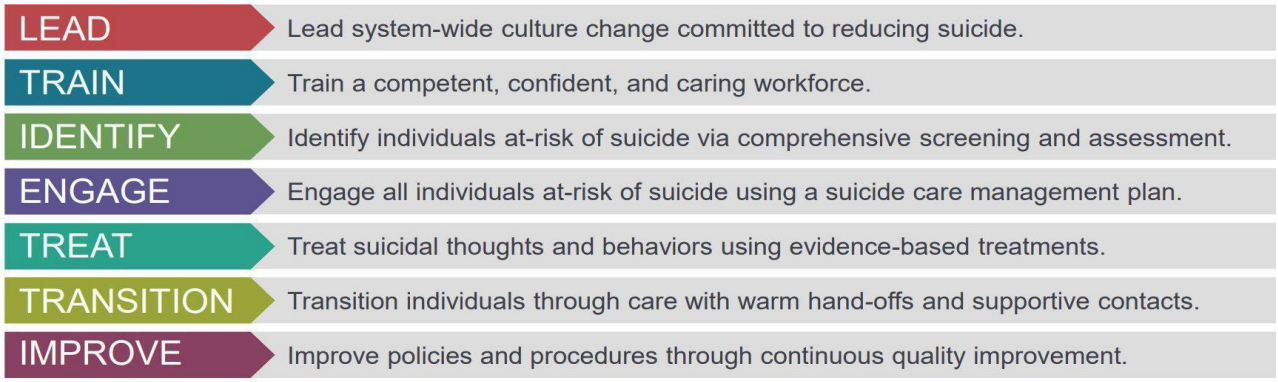
Launch our new mobile clinic to reach underserved communities, enhancing equitable access to healthcare services and ensuring comprehensive support is available for all individuals in Wayne County. We will continue efforts to advance comprehensive care, community safety, and mental health resilience throughout Wayne County.

**Zero Suicide Grant**

In FY2023, the Detroit Wayne Integrated Health Network (DWIHN) responded to the funding announcement issued by the Substance Abuse and Mental Health Services Administration (SAMHSA) for the Zero Suicide Initiative. We are pleased to announce that we received notification of our award on September 8, 2023. This grant will provide us with essential funding over the next five years, beginning on September 30, 2023. DWIHN's Zero Suicide Initiative is dedicated to the ambitious aim of eliminating suicides within Wayne County. Achieving this goal requires a fundamental cultural transformation within the healthcare system. We plan to accomplish this by implementing a comprehensive strategy that includes workforce training, which will equip providers with the necessary skills and knowledge to effectively identify and support individuals at risk for suicide. Additionally, we will conduct thorough screenings to ensure that we can identify those in need of assistance as early as possible. The initiative will also emphasize the implementation of evidence-based treatments that have been proven effective in reducing suicidal ideation and behavior. By employing these strategies and improving care management practices, we aim to create a support system that addresses the multifaceted nature of suicide risk. Setting the goal of zero suicides among individuals in our care is indeed a significant challenge that health systems across the country should be willing to accept. Although it may appear overwhelming or, in some cases, unattainable, we must consider the implications of setting a less ambitious target. Numerous healthcare systems that have embraced this comprehensive approach to suicide prevention have reported remarkable results, with some witnessing a reduction in suicide rates among their patients by as much as 70% to 80%.

The Zero Suicide Initiative holds a vital position within the broader framework of the National Action Alliance for Suicide Prevention. It highlights the critical need to transform healthcare delivery for individuals at risk for suicide by prioritizing safety and minimizing errors. By adopting and disseminating best practices in suicide care across health systems and among healthcare providers, we can foster an environment that significantly enhances the level of support and care available to those in need. Through collective efforts and commitment, we can work towards making suicide a rare occurrence rather than an accepted reality.

**Core Elements:**



**Substance Use Disorder**

**Recovery Incentive RI Pilot Imitative**

Stimulant use in Michigan has been escalating at a concerning rate, prompting serious public health concerns. In 2021, data revealed that 30% of overdose deaths involved the use of cocaine, while an additional 17% were associated with other stimulants such as methamphetamine and various amphetamines. This troubling trend highlights a significant gap in treatment options, as, unlike other substance use disorders (SUDs), there are currently no FDA-approved medications available specifically for the treatment of stimulant use disorders. Contingency Management (CM) has emerged as the leading evidence-based treatment for stimulant use disorder. This therapeutic approach reinforces positive behaviors by providing tangible rewards for treatment engagement and adherence. Notably, CM has also demonstrated effectiveness in treating opioid use disorder, offering a dual opportunity to address both public health crises simultaneously. To this end, SUD providers that offer outpatient, intensive outpatient, and/or partial hospitalization services and are licensed and certified to provide Medicaid services in specific Participating Integrated Health Plans (PIHPs) are eligible to participate in the RI Pilot Program.

This eligibility encompasses a range of facilities, including Narcotic Treatment Programs (NTPs), Opioid Health Home (OHH) providers, and Certified Community-Based Behavioral Health Clinics (CCBHCs) within the designated PIHP regions. This month, a total of fourteen providers are prepared to initiate the CM initiative, marking a significant step in tackling this substance use disorders. The principal aim of the RI Pilot Program is to explore innovative treatment solutions and collect valuable insights over a comprehensive two-year period. Participants will be involved in a series of structured activities and assessments that are purposefully designed to track their progress and measure various treatment outcomes. Throughout the duration of the pilot, regular evaluations will be conducted to ensure that established objectives are being met efficiently.

These evaluations will also allow for necessary adjustments to be made to enhance the overall effectiveness of the program. Beneficiaries participating in the program will have the opportunity to earn financial incentives for achieving negative urine drug tests and for actively engaging in the Contingency Management services provided. Individuals can potentially receive a total of up to $599 in incentives per calendar year, contingent upon their successful participation in the treatment protocol. The primary goals of the RI Pilot are centered around improving health outcomes for beneficiaries diagnosed with either Stimulant Use Disorder, Opioid Use Disorder, or a combination of both. The specific objectives include: - Increasing engagement and retention in treatment programs to ensure that beneficiaries remain involved in their recovery journey. - Reducing the number of emergency department (ED) visits by addressing issues that lead individuals to seek emergency care, thereby improving overall public health. - Decreasing the rate of repeated ED visits, which can indicate ongoing health crises and ineffective treatment strategies. - Lowering adverse health outcomes, such as overdose deaths and non-fatal overdoses, which pose significant risks to individuals struggling with substance use disorders. By focusing on these objectives, the RI Pilot Program aims to make a substantial impact on the landscape of stimulant and opioid misuse in Michigan, ultimately fostering healthier communities.

**Identified Barriers**

Current issues surrounding alcohol use among adults are multifaceted and significantly impact public health. Key concerns include involvement in traffic accidents, which is often exacerbated by impaired driving under the influence of alcohol. Additionally, liver disease remains a leading cause of mortality, with alcohol consumption being a major contributing factor. The opioid crisis has also led to an alarming rise in drug overdose deaths, further complicating the landscape of substance use. Furthermore, many individuals face significant barriers when trying to access treatment for substance use disorders (SUD), particularly those related to alcohol. Understanding the prevalence of these problems and identifying the obstacles to effective treatment are crucial steps toward mitigating the adverse effects of alcohol on this population.

To address these issues comprehensively, our strategy will include several key initiatives. First, we aim to establish partnerships with policymakers at local, state, and national levels to advocate for improved access to SUD treatment services. This includes pushing for funding that expands treatment options and support networks. Second, we will initiate community outreach programs that focus on educating the public about the realities of alcohol use and the associated stigma surrounding addiction. By providing accurate information and resources, we hope to foster a more supportive environment for individuals seeking help. Lastly, we will implement measures designed to ensure the equitable distribution of resources, specifically targeting underserved populations who may lack access to adequate support and treatment services. This multifaceted approach is designed to create a more robust and responsive framework for addressing alcohol-related issues within the community.

**Credentialing and Re-Credentialing**

DWIHN's Credentialing and Re-Credentialing procedures provide a comprehensive framework for assessing the qualifications of physicians and other licensed healthcare professionals affiliated with the organization. This includes those who are either employees of the provider network or contracted service providers within the Detroit Wayne Integrated Health Network (DWIHN). In addition to licensed professionals. To maintain high standards of practice, DWIHN's credentialing processes are designed in strict accordance with the Michigan Department of Health and Human Services (MDHHS) guidelines. These guidelines govern various aspects of the credentialing cycle, including initial credentialing, re-credentialing, re-certification, and reappointment of healthcare practitioners. The evaluation of qualifications for both physicians and licensed behavioral healthcare practitioners is conducted through a detailed assessment process outlined in DWIHN's Credentialing and Re-Credentialing Policy. This policy ensures that not only are the required standards met, but they are also consistently applied across all providers within the network. DWIHN is committed to upholding its accountability to its community by ensuring that all organizational providers directly contracted, including those serving within the Behavioral Healthcare system, adhere to these relevant standards.

Practitioners in these programs are subject to both the Credentialing and Re-Credentialing Policy and the Organization Credentialing Policy, which together establish robust criteria for maintaining quality care. To further ensure the reliability of these procedures, DWIHN conducts both quarterly and annual audits of the Credentialing Verification Organization (CVO). These audits aim to evaluate the efficacy of the CVO's system controls and review their operational policies and practices. As part of this evaluation, DWIHN samples 5% of the clean files that have been prepared for the Virtual Review Committee and conducts a comprehensive review of 100% of the unclean files. Moreover, practitioners retain the right to address and correct any erroneous information that may appear in their applications. This provision is clearly outlined in the Credentialing/Recredentialing Policy, which underscores DWIHN's commitment to transparency and fairness in the credentialing process. By fostering an environment where practitioners can rectify inaccuracies, DWIHN ensures the integrity of its credentialing system, and the quality of care provided to the community.

**Quantitative Analysis and Trending of Measures**

Medversant Technologies functions as the designated Credentials Verification Organization (CVO) for the Detroit Wayne Integrated Health Network (DWIHN). In this capacity, their primary responsibility is to perform comprehensive primary source verification of healthcare practitioners' credentials. This verification process is crucial for maintaining the integrity, safety, and quality of healthcare services provided by various organizations within the DWIHN network. In Fiscal Year 2024, a significant milestone was achieved with 674 practitioners obtaining credentialing for the first time. This accomplishment signifies their eligibility to deliver healthcare services within the network, which is essential for ensuring that qualified professionals are available to meet the healthcare needs of the community. Additionally, the recredentialing process is an important aspect of the quality assurance system. During the same fiscal year, 316 practitioners successfully underwent this process, which involves a thorough review of their qualifications and credentials. This ensures that their professional standings are current and compliant with the established standards of practice. The DWIHN network itself includes a noteworthy total of 145 settings that have been fully credentialed. This means that these settings have met all the necessary operational, legal, and regulatory standards required to provide high-quality healthcare. Moreover, 37 of these settings have successfully completed the recredentialing process, which further emphasizes their ongoing commitment to compliance with the evolving requirements imposed by regulatory bodies and the network. In conclusion, the overall figures for Fiscal Year 2024 present an encouraging picture: a total of 990 practitioners have been credentialed or recredentialed, along with 182 settings that have completed the credentialing processes. These results reflect the dedication of both Medversant Technologies and the DWIHN to maintain and promote high standards in healthcare credentialing and verification, ultimately ensuring that the network can deliver safe, effective, and quality care to those it serves.

**Evaluation of Effectiveness**

DWIHN initiated its Annual Provider Survey on October 2, 2024, distributing it to a total of 283 providers. This comprehensive survey is part of DWIHN's commitment to evaluate and enhance its services. In addition to this, the Annual Practitioner Satisfaction Survey was also disseminated on the same date to 1,925 practitioners, with the results of this survey currently pending analysis. Both surveys have been meticulously revised to include approximately 34 detailed questions. These questions are designed to cover a wide range of topics that pertain to DWIHN's various operational departments, which include Credentialing, Claims, Managed Care Operations, Quality Management, and Utilization Management. This ensures that all critical aspects of DWIHN's operations are addressed comprehensively. The surveys focus on five key areas of assessment:

- Effectiveness in Meeting Contractual Obligations. Evaluating how well DWIHN fulfills its commitments to providers, ensuring that all contractual requirements are met consistently.
- Support for Providers. Assessing the level of assistance offered to providers in effectively addressing the needs of our consumers and members, which is vital for maintaining quality care.
- Responsiveness to Provider Concerns. Measuring DWIHN's ability to promptly and effectively respond to the concerns raised by providers, which is essential for fostering a collaborative relationship.
- Identification of Gaps or Deficiencies. Identifying any shortcomings within DWIHN's operational framework that could hinder the quality-of-service delivery, thereby enabling targeted improvements.
- Opportunities for Improvement. Highlighting areas where enhancements can be made, or corrective actions may be necessary to elevate DWIHN's performance and service quality.

**Opportunities for Improvement**

- Continue to build and maintain a strong working relationship with our network providers.
- Perform a network assessment to identify the needs of our members, including the addition of new providers and the evaluation of existing providers' locations and services.
- Provide ongoing technical assistance to our providers and keep them informed of all updates from MDHHS.
- Ensure provider compliance by monitoring insurance and licensing, conducting thorough quarterly reviews, hosting biannual meetings, and arranging both announced and unannounced face-to-face visits.
- Support the credentialing team in expanding the number of providers that require credentialing.

## Finance Pillar

The mission of the Office of Finance is to establish and uphold robust financial controls that are essential for safeguarding the Authority's assets. This mission is carried out in strict accordance with generally accepted accounting principles (GAAP) and all applicable laws and regulations. The Office of Finance plays a critical role in the management, tracking, and accurate reporting of the Authority's financial transactions, utilizing our comprehensive Enterprise Resource Planning (ERP) system. This system not only streamlines processes but also enhances the accuracy and efficiency of financial reporting. Furthermore, the Office of Finance is dedicated to developing advanced reporting tools and dashboards that cater to the diverse needs of both internal and external stakeholders. By providing timely and relevant financial data, the office empowers stakeholders to make informed, data-driven decisions that align with their strategic objectives. The DWIHN Finance department encompasses several key functions, including but not limited to:

- Accounting - Responsible for accumulating and reporting on the financial position of DWIHN.
- Accounts Payable - Processes all payments for DWIHN, excluding payroll.
- Auditing and Grants - Provides oversight for the financial reporting process, the audit process, DWIHN's internal controls, and compliance with laws and regulations. - **
- Budget - Establishes a framework for managing DWIHN's assets, cash flows, income, and expenses.
- Financial Systems - Maintains a financial management system with strong internal controls to monitor compliance, ensuring the integrity of DWIHN's financial information and the safety of its assets.
- Fiscal Informatics and Analytics - Aids in establishing and enhancing data-driven and informed operational and management strategies, methods, processes, and systems. Manages and coordinates analytics and informatics projects related to costs, utilization, revenues, eligibility, and other financial and risk-related data. Payroll - Ensures that DWIHN pays its employees accurately and on time.
- Purchasing and Procurement - Manages and coordinates the acquisition of goods and services, including requisition processing, commodity code tracking, and bid specifications. Assists with contract management and the issuance of purchase orders.

**Cultural and Linguistic Needs**

Creating a diverse and inclusive workplace culture is of utmost importance in today's globalized society. Such a culture not only enhances employee recruitment and retention but also fosters loyalty, drives innovation, and improves overall performance. Understanding the three fundamental indicators of inclusion—equality, openness, and belonging—can help organizations build a stronger foundation for diversity. Equality in the workplace involves ensuring fairness and transparency across various aspects such as compensation, recruitment practices, promotion opportunities, and access to resources. It means that every employee is treated justly and has equal opportunities to succeed, regardless of their background. This fosters an environment where everyone can thrive, motivating individuals to contribute fully without the fear of bias or discrimination. Openness denotes a workplace culture where all employees are treated with respect and dignity. It requires ongoing efforts to eliminate biases, discriminatory practices, and microaggressions that can undermine employee morale and hinder collaboration. An open environment encourages employees to express their thoughts and ideas without hesitation, knowing that they will be heard and respected. This kind of culture nurtures trust and collaboration among team members at all levels. Belonging extends beyond mere inclusion; it signifies a deep sense of community within the workplace. It involves creating an atmosphere where individuals from diverse backgrounds feel comfortable sharing their perspectives and talents. When employees experience a genuine sense of belonging, they are more likely to feel valued for their unique contributions, which leads to increased engagement, creativity, and team cohesion.

Additionally, addressing cultural and linguistic needs is crucial for fostering effective communication, promoting equity, and ensuring inclusivity in diverse settings. When employees have access to information and resources in their preferred languages, misunderstandings are minimized. This not only aids in meaningful engagement but also builds stronger relationships and trust among colleagues and management. Recognizing and addressing these cultural and linguistic needs is a demonstration of respect for the diverse identities, traditions, and values present within the workplace. By doing so, organizations create an environment where everyone feels acknowledged and appreciated. In turn, this fosters a positive organizational culture that attracts and retains top talent, enhances collaboration, and drives business success. Overall, investing in diversity and inclusion is not merely a best practice; it is essential for thriving in the modern workplace.

**Diversity, Equity, and Inclusion**

The Diversity, Equity, and Inclusion (DEI) department at DWIHN is a vital component of the organization, dedicated to ensuring that all individuals receive equitable, culturally competent, and linguistically appropriate services tailored to the needs of the diverse populations within Wayne County. The DEI team actively works to identify and address the unique cultural and linguistic requirements of the community, promoting inclusivity, respect, and accessibility throughout every aspect of healthcare delivery. To achieve these objectives, the DEI team provides comprehensive training for staff and healthcare providers focused on enhancing cultural awareness, understanding implicit bias, and exploring other critical topics. This training equips staff to effectively serve individuals from a variety of backgrounds, ensuring that care is personalized, respectful, and sensitive to the unique needs of every patient. Additionally, DWIHN takes significant steps to support individuals with limited English proficiency. By providing access to interpretation and translation services, DWIHN removes language barriers, allowing all patients to engage fully with healthcare providers and receive the care they deserve. In its commitment to fostering an equitable community, DWIHN has established a DEI Coalition consisting of providers and community stakeholders.

This Coalition was formed to advocate for equity at all levels and to create an inclusive community for the 123,000 individuals DWIHN serves who face behavioral health challenges throughout Wayne County. The Coalition involves collaborative efforts among various community members and organizations, emphasizing the importance of diverse perspectives in addressing healthcare disparities. DWIHN has also partnered with the National Disability Institute to participate in the Detroit Alliance for Access and Assets, previously known as the Coalition on the Intersection of Disability, Race, Ethnicity & Poverty.

This initiative aims to facilitate meaningful conversations around intersectionality while dismantling unintentional silos that can obstruct the development of holistic and practical solutions to the complex economic challenges encountered by individuals of color with disabilities. By promoting collaboration among key stakeholders, this Coalition seeks to bridge the gap between organizations that serve individuals with disabilities, those offering financial empowerment services, and organizations focused on the needs of communities of color. Furthermore, DWIHN is an active participant in the Planning Committee for the Wayne State University (WSU) Detroit Community Health Equity Alliance (D-CHEA). This committee addresses a broad spectrum of health concerns, including those affecting Middle Eastern and North African (MENA) communities, immigrant health, LGBTQ health, and Black health and racial equity. Together, the committee members aim to inform and develop innovative initiatives that promote health equity, particularly in Detroit's persistent poverty areas, where many residents have experienced long-term economic challenges. Through collaborative efforts, D-CHEA seeks to enact community-level changes that foster health-promoting opportunities, healthy behaviors, and improved overall wellness for all community members.

## Advocacy Pillar

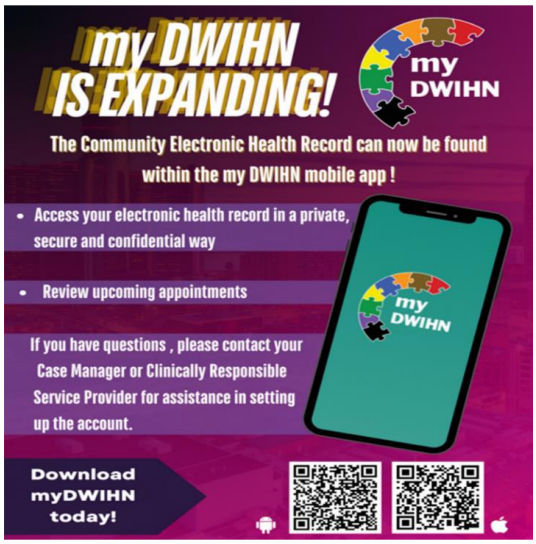
### Advocacy and Engagement

The DWIHN Constituent's Voice Advisory Group received the 2024 CMHA Partners in Excellence Award. This award recognizes those who have, in the process of utilizing community mental health services, enhanced the perception of those services and their recipients within the community. This award was presented during the CMHA 2024 Fall Conference.

### Community Outreach

The department attended 197 community outreach and engagement events during FY'23-24. DWIHN has developed a community mobile app titled myDWIHN. The myDWIHN app allows you to find out information about mental health, substance use disorder, disability, and children's resources. It also allows you to find any one of our 400 service providers. The myDWIHN app is available to be downloaded by anyone.

The Community Electronic Health Record has been improved through the valuable feedback and contributions from the individuals we serve. This expansion not only incorporates their insights but also aims to better meet their needs and enhance the overall quality of care provided within our community.




**Social Media Outreach**

DWIHN's social media accounts are growing with an increase in impressions across all channels. DWIHN utilizes Facebook, Instagram, Twitter, Snapchat Tik-Tok and YouTube to get its messaging across all platforms. It also streams educational messaging on Snap Chat, Spotify and Pandora.

Through FY'23-24 our Google Business Profile collected 11,554 profile interactions, interactions are when people call, message, ask for directions or more. Also, 24,870 people viewed our business profile on google, 56% of users viewed on their desktop resulting in our business profile to be shown in 11,009 searches. The following keywords were used that showed our business profile in the search, DWIHN (3,446), mental health services, Detroit (721), Wayne County Community Mental Health (555), DWCTraining (438), Wayne County Mental Health (422).

DWIHN is also actively elevating mental health awareness on social media by sharing informative content, engaging narratives and fostering a supportive online community. Through strategic and compassionate messaging, DWIHN is creating a digital space that encourages dialogue, educates the public, and helps reduce the stigma associated with mental health challenges.

**Community Outreach/DWIHN/Youth United/Youth Move Detroit**

During FY'23- '24, DWIHN was a participant in several important events, such as "Stronger Together:
A Community Chat About Preventing Domestic Violence" and a conversation addressing the disruption of the narrative surrounding youth suicide and mental health.

In November and December, DWIHN actively engaged in various outreach initiatives including a Game Night at the Michigan Science Center, dedicated to exploring the impact of gaming on mental health. Additionally, DWIHN hosted "Let's Talk Mental Health" with social media influencer Randi Rosario, fostering open discussions on mental health issues.

**Self-Management Performance Improvement**

DWIHN also offers the My Strength app free of charge. This app allows you to access videos and great information about self-care, depression, anxiety, and much more. There are almost 5,000 subscribers which are mostly females ages 35-64. Most people access the app daily with depression and anxiety being the top two most searched topics.

**Ask the Doc**

DWIHN's Chief Medical Officer Dr. Shama Faheem continues to educate the public with her bimonthly newsletter and videos containing information about mental health-related questions that are sent in by staff, stakeholders, and people we serve, etc. This past year, we added our Medial Director of Crisis Services, Dr. Dalia Mammo to the videos as well. This information is sent to Providers, stakeholders and posted on the DWIHN website and social media. The Communications Team has also moved the newsletter to a digital format visit **AskTheDoc@dwihn.org/.**

**DWIHN Website**

Website sessions increased by an impressive 109% when compared to the previous year, totaling 27,701 sessions. The number of users entering via social media saw a growth of 321%**.** Facebook was the top social media platform driving the most users to the website. Paid ads brought in the highest percentage of users at 38%. The top pages (excluding the home page) were "substance use disorders" with 10,177 views, this is significant as The SUD page recorded over 10K sessions just for the month of April 2024.

"For Providers" with 4,937 views, and "Programs and Services" with 879 views. User engagement varied across pages, with "Contact Us" having the highest average session duration of 2 minutes and 41 seconds.

Members, Stakeholders and Providers can access DWIHN's website to view member handbooks, provider directory, access to services, reports, annual evaluation, policies, and procedures. For more information on the DWIHN website, please visit the link https://dwihn.org.

The Persons Point of View newsletters continued to be published quarterly. In addition, monthly video announcements on trending topics were featured on YouTube and reached 341 (86%) individuals.


CALL OUR 24-HOUR HELPLINE

1-800-241-4949

**Sharing Information**

DWIHN produces and distributes quarterly newsletters specifically tailored for our members and providers. The main objective of these newsletters is to ensure that members are well-informed about the latest developments regarding programs and services available to them. In addition, we aim to keep providers updated with critical information surrounding regulatory changes, recent reports, and the contractual requirements that may affect their operations within our network. Through these newsletters, the Quality Improvement unit routinely shares a variety of important information. This includes updates on quality assurance initiatives, emerging best practices in service delivery, changes in healthcare policies, and resources for improving patient outcomes. Our goal is to provide comprehensive insights that support both members and providers in navigating the evolving healthcare landscape effectively.

- Quality Improvement Steering Committee (QISC)
  - QISC Agenda
  - QISC Minutes
- Quality Assurance Performance Improvement Plan (QAPIP)
  - QAPIP Description Plan FY2019-2021
  - QAPIP Description Plan FY2021-2023
  - QAPIP Description Plan FY2023-2025
- QAPIP Annual Evaluation
  - QAPIP Annual Evaluation FY2017
  - QAPIP Annual Evaluation FY2018
  - QAPIP Annual Evaluation FY2019
  - QAPIP Annual Evaluation FY2020
  - QAPIP Annual Evaluation FY2021
  - QAPIP Annual Evaluation FY2022
  - QAPIP Annual Evaluation FY2023
  - QAPIP Annual Evaluation FY2024
- Home and Community Based Services (HCBS)
  - For HCBS Questions please E-Mail to **Quality@dwihn.org** and **HCBSInfor.PIHP@dwihn.org.**

**DWIHN Accreditation**

DWIHN is thrilled to announce that we have successfully achieved full accreditation from the National Committee for Quality Assurance (NCQA). This accomplishment represents a significant milestone in our ongoing commitment to providing exceptional services and care to our community. The journey to accreditation was rigorous and required the collective dedication and collaboration of all our departments. Through this process, we gained valuable insights and learned important lessons that will not only enhance our current practices but also drive our continuous improvement efforts moving forward. The NCQA recognized our organization's key strengths, which include effective leadership, comprehensive patient care strategies, and a strong focus on quality improvement initiatives.

We are proud of these achievements and are committed to maintaining the high standards expected of us as we strive to deliver the best possible outcomes for those we serve.

- A highly dedicated and knowledgeable staff that prioritizes quality care
- A robust Utilization Management (UM) denial process backed by thorough documentation
- An exemplary Case Management program supported by detailed records
- Comprehensive staff file reviews and preparation practices
- An annual population assessment conducted by our Integrated Health Department
- Well-structured documentation of clinical Quality Improvement Projects, marked by rigorous study design and actionable analysis
- A holistic and comprehensive Quality Program

While DWIHN proudly celebrates its recent achievements, we also recognize the importance of identifying and addressing areas for improvement within our operations. Specifically, we see opportunities to enhance several critical components, including our utilization management policies, which govern how we assess and allocate resources effectively; our annual planning processes, which guide our strategic initiatives; the adequacy of our provider network, ensuring that we have a diverse and accessible range of services; credentialing practices that verify the qualifications of our providers; and the delegation agreements that define roles and responsibilities between our organization and external partners. To tackle these challenges, we have made significant efforts in developing targeted work plans that are currently being implemented. These plans include detailed assessments of our existing practices, stakeholder engagement, and the establishment of key performance indicators to track our progress. By focusing on these areas, we are committed to continuously improving our operations and striving for excellence in every aspect of the services we provide to our community.

**External Quality Reviews**

The Prepaid Inpatient Health Plan (PIHP) is subject to thorough external quality reviews by the Health Services Advisory Group (HSAG) to ensure adherence to all regulatory requirements stipulated in its contract with the Michigan Department of Health and Human Services (MDHHS). These reviews play a crucial role in assessing the PIHP's performance and operational compliance. During these evaluations, HSAG identifies any findings that indicate potential areas for improvement. Such findings are carefully analyzed and subsequently integrated into the Quality Assurance and Performance Improvement Plan (QAPIP) Work Plan for the upcoming year. This proactive approach ensures that the PIHP continually enhances its service delivery and meets the evolving needs of its members. HSAG performs three distinct reviews each year, each focusing on a specific aspect of quality assurance:

- Performance Improvement Project (PIP): This review evaluates the effectiveness of the PIHP's initiatives aimed at improving health outcomes for members and enhancing the quality of care provided.
- Performance Measure Validation (PMV): This assessment validates the accuracy and reliability of the performance measures reported by the PIHP, ensuring that the data reflects true performance levels.
- Compliance Monitoring Review: This review examines the PIHP's compliance with all relevant regulations and contractual obligations, ensuring that it operates within the established guidelines and maintains high standards of care.

**Performance Improvement Project (PIP)**

During the validation process for FY2022, the Detroit Wayne Integrated Health Network (DWIHN) launched a comprehensive Performance Improvement Project (PIP) specifically designed to address and reduce the racial disparities observed in follow-up care for African Americans within seven days following their discharge from a psychiatric inpatient unit. This initiative is closely aligned with the mandates established by the Centers for Medicare & Medicaid Services (CMS), which focus on enhancing quality outcomes in healthcare—particularly concerning the quality, timeliness, and accessibility of services provided to patients. Recent data analyses have underscored a significant disparity in the rates of follow-up care between the Black or African American populations and their White or Caucasian counterparts. The overarching goals of this project are twofold: firstly, to increase the percentage of eligible Black or African American members who successfully receive a follow-up visit with a qualified mental health practitioner within seven days of discharge due to mental illness; and secondly, to eliminate the identified disparities in care while ensuring that the performance levels for White or Caucasian populations remain consistent. Timely follow-ups care post-discharge is critical to establishing a seamless transition between inpatient treatment and ongoing outpatient care. This transition is essential for ensuring that members receive the necessary support and services to aid in their recovery.

Evidence suggests that effective follow-up care can substantially decrease the likelihood of repeat hospitalizations, thereby improving overall patient outcomes. African Americans represent the largest demographic served by DWIHN, constituting 56.84% of the total population. In conjunction with supporting statewide initiatives aimed at reducing racial and ethnic disparities in healthcare, DWIHN actively reports state performance measures to the Michigan Department of Health and Human Services (MDHHS). These measures pertain to both 7-day and 30-day follow-up care after behavioral health admissions, with a statewide goal set at 95%. Additionally, the target for readmission rates is established at a maximum of 15%. DWIHN's readmission rates have demonstrated notable trends over recent years, with rates recorded as follows: 19.67% in 2020, 16.82% in 2021, 16.23% in 2022, 16.08% in 2023, and a slight increase to 17.08% in 2024.

These performance measures are critically important, as they not only reflect the quality of care provided but also contribute significantly to how DWIHN is evaluated over time. By focusing on improving follow-up care within seven days after inpatient behavioral health admissions for African Americans, DWIHN aims to have a positive impact on these state performance measures, ultimately enhancing our annual evaluation by the state. This initiative underscores DWIHN's commitment to promoting equitable healthcare access and outcomes for all members of the community, particularly those from historically underserved populations.

**Quantitative Analysis and Trending of Measures**

In FY2023, DWIHN successfully achieved full compliance, scoring 100% in all reportable areas for the Health Services Advisory Group (HSAG) Performance Improvement Project (PIP). This project specifically aims to reduce the racial disparities faced by African Americans in accessing follow-up care within seven days after being discharged from a psychiatric inpatient unit. The overarching goal of the PIP is to implement effective interventions and continuously measure outcomes to ensure that significant improvements are not only made but also maintained over time. To that end, the next scheduled reporting and remeasurement period for DWIHN's PIP to HSAG will encompass data collected from January 1, 2024, to December 31, 2024. As part of the initiative, specific interventions have been identified to assist in achieving these goals. DWIHN is committed to transparency, and data related to these interventions and outcomes will be shared with the provider network to foster collaboration and enhance the quality of care provided.

**Evaluation of Effectiveness**

In FY2024, the preliminary data collected for the period of January to December 2024 indicates a notable decrease in racial disparity. Specifically, the percentage decreased from 4.51%, which represents the baseline data recorded from January to December 2021, to 4.46%, reflecting a reduction of 0.05 percentage points. This decline demonstrates the effectiveness of ongoing initiatives aimed at addressing and reducing racial inequalities. Moving forward, efforts to further close the racial disparity gap will continue in FY2025, as stakeholders remain committed to fostering equity and inclusivity within the community.

**Identified Barriers**

Members frequently encounter difficulties in managing their appointment schedules, leading to instances where they either forget to make appointments or neglect to remember those they have already scheduled. This lack of organization can significantly impact their access to necessary services. In addition, transportation challenges further complicate the situation. Some members may struggle to arrange their own transportation through Medicaid vendors, while others face issues when a Medicaid transportation provider fails to arrive on time for their scheduled pick-up. This can result in missed appointments and hinder access to crucial care. Moreover, there is a significant stigma associated with mental health issues among the African American community. Many individuals within this population experience apprehension and fear about seeking mental health support. This reluctance often stems from a historical lack of trust in medical professionals, particularly when it comes to mental health treatment. Concerns about receiving inadequate care or being misunderstood can prevent individuals from pursuing the help they need, ultimately contributing to a cycle of unaddressed mental health challenges.

**Opportunities for Improvement**

- Identify and implement various methods to effectively remind members of their upcoming appointments. This could include automated phone calls, text message alerts, and email notifications. Additionally, ensure that follow-up appointments are scheduled before patients are discharged from care to streamline their continued treatment.
- Increase resources and develop solutions that assist members in getting to their medical appointments. This may involve partnerships with local transportation services, providing information on public transit options, or offering shuttle services for those who need assistance.
- Develop a range of educational materials that cover various health topics, including appointment preparation, treatment options, and health management strategies. These resources should be distributed widely, using both online platforms and physical handouts, to ensure all members have access to vital information.
- Educate and encourage healthcare providers to prioritize respect and compassion in their interactions with members. Training sessions should emphasize the importance of acknowledging members' feelings, perspectives, and individual experiences during appointments to create a more supportive and understanding environment.
- Launch public education campaigns aimed at increasing awareness about mental health issues and combating stigma. This can include community workshops, informational sessions, and partnerships with local organizations to provide educational presentations that inform the public and promote mental health resources.

**Performance Measures Validation (PMV)**

The primary goal of performance measure validation is to thoroughly evaluate the accuracy of performance indicators that are reported by Prepaid Inpatient Health Plans (PIHPs). This process involves a systematic review to determine how closely these indicators align with established state specifications and reporting requirements. By assessing the quality and reliability of the reported data, stakeholders can ensure that the indicators effectively reflect the performance of PIHPs in delivering health services. This validation process not only enhances transparency and accountability but also informs necessary improvements in healthcare delivery and ensures compliance with state regulations.

**Quantitative Analysis and Trending of Measures**

In the fiscal year 2024 (FY24), HSAG undertook a comprehensive evaluation of the performance indicators reported by the Detroit Wayne Integrated Health Network (DWIHN). This assessment focused on the accuracy and integrity of the data submitted during the designated reporting cycle, which spanned from October 1, 2023, to December 31, 2024. After thorough analysis, DWIHN was awarded a remarkable compliance score of 100%. This achievement marks the fourth consecutive year that DWIHN has maintained full compliance, demonstrating its commitment to adhering to established standards without necessitating any Plans of Correction (POC). This consistent performance reflects the organization's dedication to quality and effective service delivery in the community.

**Evaluation of Effectiveness**

DWIHN consistently meets all required reporting areas by accurately providing performance indicator data. This demonstrates that the organization's systems and processes are effectively designed to capture critical data elements. These elements are essential for calculating performance indicators that align with the expectations outlined by the Michigan Department of Health and Human Services (MDHHS) and the relevant codebook. DWIHN's commitment to data integrity and compliance ensures that it not only adheres to regulatory standards but also continuously improves its performance measurement capabilities.

**Identified Barriers**
None identified.

**Opportunities for Improvement**
HSAG recommends that we continue our focused improvement efforts related to indicator #2 to meet or exceed the 50th percentile benchmark. Achieving this benchmark is essential for ensuring that individuals receive timely and accessible treatments and supports. Timely assessments play a pivotal role in engaging clients and facilitating person-centered planning, which is critical for their overall well-being. To support these efforts, we should maintain our existing provider and internal workgroups. These groups will convene regularly to assess our progress in enhancing performance measure rates and refining data collection processes. By collaborating across teams, we can create a shared understanding of our goals and strategies. Furthermore, it is essential to closely monitor performance trends and identify low-performing areas within our organization. This involves conducting detailed assessments not just at the level of individual providers but also analyzing performance across core member demographics. By examining these systemic patterns, we can pinpoint specific challenges and opportunities for improvement. To effectively address the issues of low performance, our workgroups will be tasked with identifying root causes. By analyzing the underlying factors, we can disseminate best practices and elevate the quality of care provided. This knowledge sharing will empower providers to implement effective strategies tailored to their unique contexts.

Moreover, HSAG recommends that our Quality Improvement (QI) team expands its auditing process by reviewing a larger sample of exceptions prior to submitting quarterly rates to the Michigan Department of Health and Human Services (MDHHS). This thorough review will ensure that all exceptions are justified, appropriate, and well-documented in the Mental Health-WIN (MH-WIN) system, thereby reinforcing the integrity of our submissions. By taking these steps, we can enhance our overall performance and the quality of services we offer to our clients.

**Compliance Review**

The Compliance Review is designed to ensure adherence to the standards set forth in *42CFR* and the contractual obligations established by DWIHN. This review is particularly focused on the standards detailed in *42CFR* §438.358(b)(1)(iii), along with relevant requirements specified by state contracts. The Compliance Review evaluates a total of 13 distinct program areas, referred to as standards, which are critical for maintaining quality and compliance in service delivery. In the first year of the review cycle, HSAG conducts an in-depth examination of the first six standards, assessing various components such as operational effectiveness, service quality, and adherence to regulations. Following this, in the second year, HSAG shifts its focus to the remaining seven standards, ensuring that all aspects of compliance are thoroughly evaluated over the two-year period. This systematic approach not only helps in identifying areas that require improvement but also reinforces the commitment of DWIHN and its partners to maintain high standards of service and compliance with applicable laws and regulations.

**Quantitative Analysis and Trending of Measures**

In FY2024, DWIHN attained a compliance score of 88%, indicating strong adherence to the required standards. The accompanying table offers a comprehensive overview of the results from the compliance review conducted on FY2024. Each individual element that necessitated a corrective action plan is listed, along with its status, which is categorized as either Complete or Not Complete. This detailed breakdown allows for a clearer understanding of specific areas where improvements were made and highlights any aspects that still need attention for full compliance.

**Summary of Standard Compliance Scores**

| Standard | Total Elements | Total Applicable Elements | Number of Elements | | | Total Compliance Score |
|---|---|---|---|---|---|---|
| | | | *M* | *NM* | *NA* | |
| Standard I—Member Rights and Member Information | 24 | 22 | 18 | 4 | 2 | **82%** |
| Standard III—Availability of Services | 20 | 18 | 17 | 1 | 2 | **94%** |
| Standard IV—Assurances of Adequate Capacity and Services | 11 | 9 | 9 | 0 | 2 | **100%** |
| Standard V—Coordination and Continuity of Care | 16 | 15 | 15 | 0 | 1 | **100%** |
| Standard VI—Coverage and Authorization of Services | 23 | 22 | 17 | 5 | 1 | **77%** |
| **Total** | **94** | **86** | **76** | **10** | **8** | **88%** |

**Evaluation of Effectiveness**

DWIHN achieved an overall compliance score of 88 percent, reflecting a strong adherence to a variety of federal and state requirements regarding healthcare service delivery. This score illustrates the organization's commitment to maintaining high standards within its operations. The Michigan Department of Health and Human Services (MDHHS) and the individual Prepaid Inpatient Health Plans (PIHPs) leverage the insights and findings gathered from compliance reviews to accomplish several key objectives:

- Evaluate Healthcare Services: They assess the quality, timeliness, and accessibility of the healthcare services provided by the PIHPs to ensure that members receive the necessary support in a prompt and effective manner.
- Identify and Implement Interventions: The organizations focus on identifying areas where quality can be improved. They develop and implement system interventions designed to enhance service delivery and monitor these initiatives to track their effectiveness over time.
- Assess Performance Processes: Current performance processes are evaluated to determine their effectiveness and efficiency. This assessment helps identify strengths and weaknesses in their operations.
- Plan for Sustainability and Enhancement: Based on evaluation results, activities are planned and initiated to sustain successful performance processes and enhance areas that may have room for growth.

**Identified Barriers**

During the compliance review, opportunities for improvement were identified specifically in the areas concerning Member Rights and Member Information, as well as Coverage and Authorization of Services. These program areas received performance scores below 90 percent, highlighting the need for targeted interventions and strategies to elevate their performance and better serve the members.

**Utilization Management**

The Annual Utilization Management (UM) Program for Fiscal Year 2024 is available in a separate document. The Detroit Wayne Integrated Health Network (DWIHN) holds the responsibility of ensuring that the UM Program adheres to all relevant federal and state laws, as well as contractual obligations. This program is an integral part of the organization's Quality Assurance and Performance Improvement Plan (QAPIP), which is designed to promote high standards of care and continuous improvement within the service delivery framework. To support its UM initiatives, DWIHN is mandated to maintain a comprehensive written Utilization Management Program Description. This document outlines the specific procedures and methodologies for assessing medical necessity criteria and delineates the processes involved in the review and approval of mental health and substance use disorder services. It serves as a foundational guide to ensure consistent and fair assessment of service utilization. In addition, DWIHN is responsible for producing an Annual Utilization Management Program Evaluation report, which serves several critical functions:

- Assessment of Program Goals: This evaluation will examine the extent to which the goals set for the Utilization Management Program have been achieved, providing insight into the program's effectiveness.
- Evaluation of Utilization Reports: The report will critically analyze data related to both overutilization and underutilization of services, identifying trends and potential areas for intervention.
- Opportunities for Quality Enhancement: Through this evaluation, DWIHN will pinpoint specific opportunities to improve the quality and efficiency of the Utilization Management processes, promoting better outcomes for individuals served.
- Management of Clinical Review Processes: The evaluation will focus on optimizing the clinical review process to enhance operational efficiency, ensuring that evaluations are completed in a timely manner without compromising quality.
- Effective Implementation of Clinical Protocol: The report will assess how well clinical protocols are being implemented across the organization, ensuring that best practices are followed and that they align with established guidelines. Overall, this thorough evaluation will not only ensure compliance with legal and regulatory standards but also foster a culture of excellence in the delivery of mental health and substance use services within the community.

**Adequacy of Quality Improvement Resources**

The Quality Improvement (QI) Unit is spearheaded by a Director of Quality Improvement, who is responsible for developing and overseeing the unit's strategic initiatives. This unit is supported by two full-time Quality Administrators who assist in the execution of various projects and objectives aimed at enhancing the quality of services provided by DWIHN. The QI Director collaborates closely with the DWIHN Senior Leadership team to align quality improvement strategies with organizational goals. This partnership ensures that quality improvement initiatives are integrated into the overall mission of DWIHN. Additionally, the Director engages actively with the Quality Improvement Steering Committee (QISC), which plays a crucial role in guiding and monitoring the progress of quality improvement efforts throughout the organization. A significant aspect of the QI Unit's work involves a partnership with DWIHN's Information Technology (IT) Unit. This collaboration is essential for the implementation of the Quality Assurance and Performance Improvement Plan (QAPIP), which outlines the framework for quality improvement activities. The IT Unit is tasked with providing comprehensive data analysis and management services that are critical for assessing organizational performance. These services support various functions including business modeling, strategic planning, and the execution of targeted quality initiatives. The IT Unit's responsibilities extend to managing business operations which encompass the development and maintenance of databases tailored for quality improvement projects. They also offer consultation and technical assistance to ensure that quality improvement strategies are data-driven and effective.

To effectively support QAPIP projects, the IT Unit conducts intricate data analyses that help identify areas for improvement. These analyses involve statistical examinations of outcomes data to ascertain the significance of any changes occurring within the organization. They delve into large data sets to extract insights and investigate the underlying causes or contributing factors of performance outliers—instances where performance deviates markedly from established benchmarks. Moreover, the IT Unit employs correlational analyses to explore potential relationships between various variables that may affect performance outcomes. This multifaceted analytical approach enables them to discern patterns and insights that are pivotal for informed decision-making. Ultimately, the findings from these comprehensive data analyses culminate in the generation of detailed reports, informative summaries, actionable recommendations, and visual representations (such as charts and graphs). These outputs not only facilitate communication with stakeholders but also serve to enhance the effectiveness of Quality Improvement Activities, driving DWIHN toward greater success in its quality improvement endeavors.

The chart below presents a detailed overview of the internal staff members who are part of the Quality Improvement Steering Committee (QISC). It includes their respective titles, which reflect their roles within the organization, as well as the percentage of their time allocated to quality improvement activities. This information highlights the team's commitment to enhancing the quality of services and processes, showcasing the diverse expertise and dedication of each member.

| Title | Department | Percent of time 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 | 50% |
| 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 | 50% |
| Practitioner Participation | Provider Network | 100% |

**Overall Effectiveness**

An extensive evaluation of the DWIHN's Quality Improvement (QI) Work Plan for FY2024 has been conducted. This comprehensive evaluation consisted of a detailed review of trended results for various QI measures over a specified timeframe, allowing for in-depth comparisons against established performance objectives. It also included both quantitative and qualitative analyses of the completed and ongoing QI activities. Overall, substantial improvements were achieved across the planned QI initiatives, which encompass both clinical and service-related aspects. Additionally, several programs specifically aimed at enhancing member safety have been successfully implemented. The Quality Improvement Steering Committee (QISC) and the Program Compliance Committee (PCC) Board have thoroughly reviewed and formally approved the 2024 Quality Assessment and Performance Improvement Plan (QAPIP) Evaluation, in addition to the FY2024 Work Plan (refer to Attachment A for details). The implementation of the FY2024 QI Work Plan has proceeded as intended, following the established timeline and objectives. The indicators assessed in this plan span a broad spectrum, including metrics related to the quality of clinical care, quality of service delivery, and safe clinical practices. These QI initiatives are directly relevant to the needs and preferences of Wayne County residents, and they align closely with DWIHN's overarching mission and vision. Furthermore, DWIHN's organizational structure and resource allocation have proven adequate and effective in supporting the QI process. To determine the quality of available resources, DWIHN evaluates the percentage of key activities that have been completed alongside the associated goals that have been achieved. Following a thorough review of the Quality Program's performance, DWIHN has concluded that it possesses sufficient staffing resources to meet current program goals, which prioritize highly educated and trained personnel. DWIHN conducted a comprehensive assessment of data integrity, personnel capabilities, and software functionality to ensure that its health information system can efficiently collect, analyze, and integrate essential data for the effective implementation of the Quality Improvement (QI) program.

The IT department at DWIHN has successfully designed, rigorously tested, and implemented the Provider Risk Matrix dashboard, which is based on measurable scientific goals tailored for CRSP providers. Moreover, a new Business Intelligence platform, utilizing Microsoft Power BI, has been introduced. This platform allows DWIHN to effortlessly connect its diverse data sources and disseminate information among staff and providers, thereby enabling them to concentrate on delivering high-quality care efficiently. Additionally, the IT department has successfully deployed a nationwide, NCQA-accredited Care Coordination platform that supports the calculation of HEDIS measures, facilitating effective partnerships with health plans to manage both Behavioral and Physical Health services comprehensively. The Chief Medical Officer (CMO) of DWIHN serves a pivotal role by chairing the Quality Improvement Steering Committee (QISC), in collaboration with the Quality Improvement Administrator. As the designated senior official, the CMO bears the responsibility for the successful implementation and oversight of the Quality Assessment and Performance Improvement Plan (QAPIP). DWIHN actively promotes the utilization of evidence-based practices and adheres rigorously to nationally recognized standards of care. To maintain high standards of care, clinical practice guidelines are reviewed biennially and require formal approval from the CMO.

Beyond this, the Chief Medical Officer participates in several crucial committees that contribute to the overall improvement of clinical practices and patient safety. These committee roles underscore the CMO's commitment to enhancing the quality of services provided and ensuring that DWIHN meets its performance objectives while addressing the needs of the communities it serves

- Improving Practices Leadership Team (IPLT)
- Critical Sentinel Event Committee
- Death Review Committee
- Peer Review Committee
- Behavior Treatment Advisory Committee (BTAC)
- Credentialing Committee
- Cost Utilization Steering Committee
- Compliance Committee

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**Analysis**

DWIHN is confident that there is sufficient engagement and consultation from practitioners involved in the Quality Program to successfully meet its objectives. This collaboration ensures that all perspectives are considered in the program's evaluation and improvement process. At this time, no changes to the program are anticipated for fiscal year 2025, indicating a commitment to maintaining the current framework and practices in place.

**Committee Structure**

Upon a thorough evaluation of the structure of the Quality Improvement (QI) program committee, it becomes evident that the participation and involvement of the Detroit Wayne Integrated Health Network (DWIHN) committees are more than adequate. Each member of the committee consistently attends meetings and actively contributes to discussions and initiatives during Quality Improvement Steering Committee (QISC) meetings. This level of engagement highlights the dedication of DWIHN to fostering a culture of quality improvement. Furthermore, DWIHN's commitment to enhancing quality is reflected across all levels of the organization, from leadership to frontline staff, ensuring that quality improvement initiatives are embraced universally. The existing governance structure effectively supports strategic oversight and aligns with important organizational initiatives, which facilitates the delivery of comprehensive guidance. This alignment is crucial for DWIHN as it works diligently towards achieving its defined goals and objectives. Given this strong foundation and effective collaboration, no changes are anticipated for FY2025. The current setup is deemed optimal for continuing to promote excellence in quality improvement practices throughout the organization.

**Practitioner Participation**

DWIHN is committed to incorporating substantial feedback from practitioners in our ongoing Quality Improvement and Safety Committee (QISC), as well as through the Quality Operations Workgroup and various ad hoc provider advisory workgroups formed as needed. This active participation highlights the collaborative efforts between our extensive provider network and practitioner leadership. Practitioners play a crucial role in all stages of program development, including the planning, design, implementation, and evaluation processes. Their involvement encompasses rigorous data collection and analysis, ensuring that all programs are grounded in evidence-based practices. This comprehensive approach helps to effectively manage the health and wellbeing of the overall population, fostering collaboration with essential stakeholders such as health plans, care delivery systems, and community partners. Aside from their contributions to the QISC committee, DWIHN actively solicits practitioner input on various key initiatives, allowing for diverse perspectives to inform decision-making processes. We regularly assess the level of practitioner involvement to ensure that it meets our program objectives. Based on this evaluation, we are confident that the current level of engagement and consultation is sufficient to achieve the goals of our Quality Program. As a result, no changes are anticipated for FY2025.

**QI Program Effectiveness**

An extensive evaluation of the Quality Improvement (QI) program at the Detroit Wayne Integrated Health Network (DWIHN) has recently been completed. This comprehensive assessment involved a multi-faceted approach, including a thorough review of trends in QI measures over time, a detailed comparison of performance metrics against established strategic objectives, and both quantitative and qualitative analyses of various completed and ongoing QI initiatives. The findings from the evaluation indicate significant progress in the implementation of planned QI initiatives, which effectively addressed both clinical care and service delivery components. Notably, specific programs designed to enhance member safety were successfully launched and have shown positive outcomes. Furthermore, the assessment highlighted the effectiveness of the resources allocated to the QI program. This includes an evaluation of the QI Committee structure, the roles and responsibilities of subcommittees, the active participation of healthcare practitioners, and the engagement of leadership throughout the process.

These elements collectively affirm that the existing QI program framework is functioning well and producing the desired results. Consequently, no changes to the QI program structure are deemed necessary at this time. DWIHN's commitment to fostering a culture of continuous improvement is vital for achieving optimal health outcomes and ensuring a high-quality member experience. Looking ahead to 2025, DWIHN plans to persistently address, and tackle identified areas for enhancement, with a focus on providing the best possible experience for all members. This dedication to improvement underscores DWIHN's mission to deliver exceptional care and support to the communities it serves.

**Work Plan Goals and Objectives FY2025**

In Fiscal Year 2025, the QAPIP will focus on several key areas aimed at achieving continuous quality improvement in clinical care, service quality, and the overall experience of our members. Below are the detailed areas of focus:

- Maintain National Committee for Quality Assurance (NCQA) Accreditation. We will prioritize maintaining our accreditation from NCQA, which reflects our commitment to high-quality care and adherence to industry standards.
- Establish an Effective Crisis Response System and Call Center. We will establish a robust Crisis Response System and a dedicated Call Center that ensures timely and appropriate responses for individuals in crisis, providing immediate support and resources to stabilize situations effectively.
- Enhance Healthcare Services. A continued effort will be made to improve the quality, appropriateness, availability, accessibility, coordination, and continuity of health care services for our members. This includes evaluating and refining service delivery across the continuum of care to ensure that every member receives comprehensive and seamless care.
- Transition of Home and Community-Based Services Waiver. We will further advance the transition of the Home and Community-Based Services Waiver, ensuring that services are tailored to meet individual needs and promote independent living.
- Improve Member and Provider Satisfaction. We will actively seek to enhance satisfaction levels for both our members and providers through feedback mechanisms, outreach, and service improvements, ensuring that both groups feel heard and valued.
- Ensure a High-Quality Network. Rigorous credentialing and peer review processes will be employed to maintain a high-quality network of providers. We will also enhance our contracting processes to ensure that all service providers meet strict quality standards.
- Standardize Contracts and Monitoring Protocols. We will establish and revise regional standardized contracts and comprehensive monitoring protocols to assess provider performance in specialized areas, including autism services, fiscal intermediary services, specialized residential providers, and inpatient psychiatric units.
- Collaborate with Providers. DWIHN aim is to strengthen partnerships with service providers by sharing innovative ideas and implementing strategies that enhance care coordination and improve overall service quality, focusing on collaborative care models.
- Improve Member Outcomes, Satisfaction, and Safety. A dedicated approach will be taken to improve and manage the outcomes for our members, focusing on enhancing satisfaction and ensuring their safety through targeted initiatives and programs.
- Maintain Regulatory Compliance. DWIHN will ensure that our operations adhere to all state and federal regulatory requirements as well as accreditation standards, thereby maintaining our commitment to high standards of care.

- Cultural Competency and Diversity Initiatives. It is imperative that our organizational initiatives around cultural competency and diversity adequately reflect and meet the diverse needs of our members. We will continue to assess and improve these initiatives as part of our commitment to inclusivity.
- Statewide Training and Reciprocity Activities. DWIHN will address our regional role in statewide training programs and reciprocity activities aimed at enhancing provider performance monitoring, ensuring consistency in care standards across the board.
- Outreach for Children and Families. DWIHN will enhance our efforts to engage with children and families through active participation in community events, collaboration with schools, and partnership with child service providers. This outreach will focus on raising mental health awareness and improving access to vital services.
- Commitment to Safe Clinical Practices. DWIHN will demonstrate and communicate our commitment to improving safe clinical practices throughout our network, ensuring that all providers adhere to best practices and guidelines to safeguard our members.
- Support for Strategic Initiatives. DWIHN will support strategic planning initiatives to advance our status as a Certified Community Behavioral Health Home (CCBHC) and a Behavioral Health Home (BHH), while also expanding Opioid Health Home (OHH) provider services to better meet the needs of our community.
- Naloxone Training Programs. We will enhance training for a wide range of stakeholders, including providers, healthcare workers, jail staff, drug court personnel, community organizations, and our members, on the effective use of Naloxone as a lifesaving tool to reverse opioid overdoses. This comprehensive plan serves as the foundation for ensuring that we deliver high-quality care and services to all our members, fostering a healthcare environment that is safe, responsive, and focused on continuous improvement.

**Work Plan Summary and Work Plan FY 2024-2025**

DWIHN's Quality Improvement goals are systematically embedded into the organization and effectively communicated to all members through a comprehensive Work Plan. This plan delineates specific goals and measurable objectives that are the responsibility of individual departments, ensuring accountability and focused efforts. The organization actively engages in monitoring activities that encompass the evaluation of performance metrics, data analysis, and report generation. These insights are diligently reviewed by the Quality Improvement Steering Committee (QISC) and the Program Compliance Committee (PCC) on a quarterly basis. During these reviews, committee members analyze current processes and outcomes to identify potential areas for enhancement, ensuring that quality improvement remains a dynamic and ongoing priority. The combination of these reviews and the continuous implementation of Performance Improvement Projects (PIPs) serves as the cornerstone of the organization’s Work Plan. This structured approach supports and enhances the wide array of services provided by DWIHN, ensuring that they meet the highest standards of care and efficacy. Furthermore, DWIHN's quality-related initiatives are guided by the ever-evolving landscape of Behavioral Healthcare. The organization continually assesses its key strengths, such as dedicated staff and established protocols, while also recognizing opportunities for growth and advancement. These assessments inform our strategic decisions and help shape DWIHN’s overall approach to quality improvement in FY2024, ensuring that we remain responsive to the needs of our clients and the community.

**QAPIP Work Plan**
**FY 2023 - 2024 (October 1, 2023 through September 30, 2024)**

| 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. | There were no previously identified issues during FY2023. This goal will continue from FY2024. | In FY2024, the survey results were not available for analysis. We will prioritize addressing this goal and will 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 2023 - 2024 (October 1, 2023 through September 30, 2024)**

| 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, analyze the results to compare FY2023 and FY2024. Additionally, the results of the 2024 Practitioner Satisfaction Survey will be complied, 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, and a comparison of the data from the baseline period will be conducted during FY2024. | **Target goal was partially met**. In FY 2024, we met the 5% increase in practitioner response rate (26.5% ) compared to FY2023 (21.8%) The provider response rate decreased in FY2024 (26.1%) compared to FY2023 (38.8%). This goal will be continued 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 2023 - 2024 (October 1, 2023 through September 30, 2024)**

| 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 continue from FY2024. | **Target goal was met**. In FY 2024, a total of 107 grievances and 47 appeals were filed. Indicating a slight decline from fiscal year 2023. The number of issues increased with the main areas of concern the delivery of service, access to staff, access to service, and interpersonal and customer service. 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 2023 - 2024 (October 1, 2023 through September 30, 2024)**

| 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 established by MDHHS/NCQA for timely decision making in UM, along with adhering to the required timeframes and notification. Threshold is set at 90% . | There were no 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. | **Target goal was met.** DWIHN has recorded some of the highest rates of all the PIHPs in Michigan for PI#3. The overall rate for FY2024 was 90.17%. The rates for each subpopulation for year were as follows: 89.14% for SED, 92.55% for MI Adults, 82.54% for IDD Children, and 91.05% for IDD Adults. 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 FY2024. | **Target goal was met.** 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 2023 - 2024 (October 1, 2023 through September 30, 2024)**

| 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 FY2024. | **Target goal was met.** 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. | **Target goal was met.** DWIHN achieved an overall success rate of 95% or higher across all populations. 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 2023 - 2024 (October 1, 2023 through September 30, 2024)**

| 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. | **Target goal was not met.** In 2024, DWIHN's PI#2a overall population rate was 53.23%, while the standard rate was 57%. 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. | **Target goal was met.** DWIHN had some of the highest rates among all of PIHPs in Michigan for PI#3. DWIHN's overall rate for FY2024 was 90.17%, exceeding the standard of 87%. 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 2023 - 2024 (October 1, 2023 through September 30, 2024)**

| 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.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 a continue in FY2025. | **Target goal was met.** In FY 2024, DWIHN was able to see 98.25% of members for follow-up within 7 days of discharge from a psychiatric inpatient hospitalization 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.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 continue in FY2025. | **Target goal was met.** Standard met for all quarters. Total rate population (96.69%). 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 2023 - 2024 (October 1, 2023 through September 30, 2024)**

| 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.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. | **Target goal was partially met**. In 2024, PI#10 for children met the MDHHS standard of 15% or less in three quarters, with a rate of 11.80%. The adult population had a rate of 17.09%, exceeding the standard in all 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. |

**QAPIP Work Plan**
**FY 2023 - 2024 (October 1, 2023 through September 30, 2024)**

| 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.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 FY2024. | **Target goal was met**.. During FY2024, 96% of members improved their PHQ scores by 20%, and 92% improved their WHO-DAS scores by 20%. Additionally, 25% reduced emergency department visits by 10%.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 2023 - 2024 (October 1, 2023 through September 30, 2024)**

| 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 FY2024. | **Target goal was not met.** Recidivism in the adult population were not met for 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. |
| **Workforce Pillar** | | | | | | | |
| **Goal III. (Quality of Service)** | **Develop and maintain a Competent Workforce through the Credentialing and Re-Credentialing Process** | | | | | | |

**QAPIP Work Plan**
**FY 2023 - 2024 (October 1, 2023 through September 30, 2024)**

| 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 FY2024. | **Target goal was met.** 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 FY2024. | **Target goal was met.** In FY 2024, randomly selected 3,035 claims for verification. This represents a significant increase compared to the previous fiscal year. 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 2023 - 2024 (October 1, 2023 through September 30, 2024)**

| 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 FY2024. | **Target goal was met.** 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 FY2024. | **Target goal was met.** 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 FY2024. | **Target goal was met. T**his 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 FY2024. | **Target goal was met.** 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.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 FY2024. | **Target goal was met**. 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. |

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**FY 2023 - 2024 (October 1, 2023 through September 30, 2024)**

| 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.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 FY2024. | **Target goal was partially met.** During the waiver review, DWIHN met the administrative requirements but did not meet the standards for clinical case records in behavioral treatment. 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)** | | | | | | |

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**FY 2023 - 2024 (October 1, 2023 through September 30, 2024)**

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|---|---|---|---|---|---|---|---|
| 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. | **Target goal was not met**: From January 1 to December 31, 2024, the measurement rate for people aged 18 to 64 was 31.55%, which is 26.45% below our goal. This is a 2.43% increase from last year's rate of 29.17%. Complete data for 2024 will be available in April 2025. This goal will be continue 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 2023 - 2024 (October 1, 2023 through September 30, 2024)**

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|---|---|---|---|---|---|---|---|
| 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. | T**arget goal was not met**: From January 1 to December 31, 2024, the measurement rate was 47.99%, which is 18.29% below the goal and a 3.92% decrease from last year's 51.91%. Total data for 2024 will be available in April 2025. This goal will be continue 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. |

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**FY 2023 - 2024 (October 1, 2023 through September 30, 2024)**

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|---|---|---|---|---|---|---|---|
| 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. | **Target goal was not met**: From January 1 to December 31, 2024, the chronic condition measurement rate was 16.76%, which is 34% below our goal and 3% lower than last year's 19.64%. The acute condition measurement rate was 39.89%, 27.04% below the goal and down 3.99% from last year's 43.88%. Total 2024 data will be available in April 2025. This goal will be continue 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. |

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**FY 2023 - 2024 (October 1, 2023 through September 30, 2024)**

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|---|---|---|---|---|---|---|---|
| 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. | **Target goal was not met:** During reporting period January 1-December 31, 2024, measurement rate for diabetes monitoring is 68.47%. Rate was 12.52% points below goal and 6.47 percentage points below previous year (71.94%) Total 2024 data not available until April 2025. This goal will be continue 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. |

**QAPIP Work Plan**
**FY 2023 - 2024 (October 1, 2023 through September 30, 2024)**

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|---|---|---|---|---|---|---|---|
| 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. | The IPLT committee agreed to sunset the performance Improvement Project (PIP) in FY2024. This PIP has been discontinued, IPLT agreed to sunset PIP in FY2024. | 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.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. | No previous identified issue. This goal will continue from FY2024. | In FY2024, the data results were not available for analysis. We will prioritize addressing this goal 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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**FY 2023 - 2024 (October 1, 2023 through September 30, 2024)**

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|---|---|---|---|---|---|---|---|
| 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 from FY2024. | **Target goal was met.** 1st Qtr. (Oct 2023-Dec 2023) Measurement: 5% (Goal Met). 2nd Qtr. (Jan 2024-Mar 2024) Measurement: 4% (Goal met). 3rd Qtr. (Apr 2024-Jun 2024) Measurement: 4% (Goal Met). 4th Qtr. (Jul 2024-Sep 2024) Measurement:3% (Goal Met). This goal will be continue 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. | **Target goal was not met**: During period 1/1/23 - 12/31/23 Measurement 1 rating was 19.57%, 3.79% below the goal however a 2.62% increase from the previous year. Measurement 2 rating was 31.2%, 1.5% below the goal. During rating period 1/1/24 - 1/31/24 as of September 2024 Measurement 1 rating was 9.92% and Measurement 2 rating was 19.48% (results are preliminary). This goal will be continue 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. 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. | **Target goal was not met**: March 1, 2023, to February 28, 2024, Measurement 1 was rated at 61.25%, 2.3% above the goal. Measurement 2 was rated at 69.21%, 1.02% below the goal. As of September 2024, for March 1, 2024, to February 28, 2025, Measurement 1 is at 59.65%, 4.35% below goal. Measurement 2 at 71.43%, 4.57% below goal (preliminary results).This goal will be continue 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. 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 be continue in FY2024. | **Target goal was partially met.** Preliminary data shows a follow-up 37.63% rate for Black/African American members for FY2024. Disparity gap below the 4.51% at 4.46 (Preliminary)This could be the highest follow-up rate DWIHN has achieved for this population in many years, but it is still 2.37 percentage points below the 40.00% goal. This goal will be continue 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. |

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|---|---|---|---|---|---|---|---|
| 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 be continue in FY2024. | In FY2024, the data results were not available for analysis. We will prioritize addressing this goal and will continue 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.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). | **Target goal was partially met**: During rating period 10/1/2023 - 9/30/2024 Measurement 1 rating was 99.70%, 0.30% below the goal and remained the same as last year rate as well. Measurement 2 rate was 65.40%, 29.60% below the goal yet higher than last year rate. This goal will be continue 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 2023 - 2024 (October 1, 2023 through September 30, 2024)**

| 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. | **Target goal was partially met**: During rating period of 10/1/2023 - 9/30/2024 the rate was 88.25%, increase of 23.58% compared to rate of 64.67% during rating period 10/1/2022 - 9/30/2023. This goal will be continue 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 FY2024. | **Target goal was not met.** 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 2023 - 2024 (October 1, 2023 through September 30, 2024)**

| 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. | **Target goal was partially met**: DWIHN was required to submit a plan of correction to MDHHS as a result of findings from the annual waiver on-site review, which took place in April 2024. This plan outlines the specific actions DWIHN will take to address deficiencies identified. 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. |

**QAPIP Work Plan**
**FY 2023 - 2024 (October 1, 2023 through September 30, 2024)**

| 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. | **Target goal was met**: DWIHN received full 3-year NCQA reaccreditation. 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. |

**QAPIP Work Plan**
**FY 2023 - 2024 (October 1, 2023 through September 30, 2024)**

| 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. | **Target goal was met**: DWIHN preliminary data for calendar Year 2024 shows a disparity gap of 4.46%. The bassline data is 4.51%. The results were partially met due to preliminary data, and data the data for October - December will be finalized in March, 2025. 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 2023 - 2024 (October 1, 2023 through September 30, 2024)**

| 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 in FY2025. | **Target goal was partially met**: DWIHN received a compliance score of 88.0%. DWIHN was required to submit a Corrective Action Plan (CAP) for standards I, III and VI. 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 fourth quarter of FY-2025. |

**QAPIP Work Plan**
**FY 2023 - 2024 (October 1, 2023 through September 30, 2024)**

| 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 |
|---|---|---|---|---|---|---|---|
| | 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. | **Target goal was met**: Received a full compliance score of 100% with no Plan of Correction (POC). 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. |

**QAPIP Work Plan**
**FY 2023 - 2024 (October 1, 2023 through September 30, 2024)**

| 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. | **Target goal was met.** MDHHS needs assessment documents submitted as required. 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 2023 - 2024 (October 1, 2023 through September 30, 2024)**

| 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. 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 Improveme | 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. | **Target goal was met** | Present the QAPIP description to the QISC, PCC, and Full Board in the first quarter of FY2025. |
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| 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 (FY2024). This will continue into FY2025. | The goal is to comprehensively assess the performance metrics and outcomes of the preceding year. | Previous issues identified during FY2023-2024;Not all goals were achieved. This goal will continue in FY2024 - FY2025. | **Target goal was not met; 21 out of 40) 52.5% were met.** Partially Met: Goals that were not met or partially met will be continued in FY(2025) | Present the QAPIP description to the QISC, PCC, and Full Board in the first quarter of FY2025. |
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**QAPIP Work Plan**
**FY 2023 - 2024 (October 1, 2023 through September 30, 2024)**

| 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. 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 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 FY2024. Goal completion rate for FY2024 was 52.5% | **Target goal was not met.** | Present the QAPIP description to the QISC, PCC, and Full Board in the first quarter of FY2025. |
| **END** | | | | | | | |
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