Quality Improvement Steering Committee (QISC)
January 28, 2025
10:30am – 12:00pm
Via Zoom Link Platform
Agenda

I.	**Welcome**	**T. Greason**
II.	**Authority Updates**	**S. Faheem**
III.	**Approval of Agenda**	**S. Faheem/Committee**
IV.	**Approval of Minutes** ○ October 29, 2024	**Dr. Faheem/Committee**
V.	**QAPIP Effectiveness**	
	Integrated Health Care (IHC) ○ CCM Evaluation FY2024 ○ Population Assessment FY2024	**A. Bond**
	Utilization Management ○ UM Annual Evaluation FY2024	**M. Hampton**
	Quality Improvement ○ QAPIP Program Description (updated) FY2023-2025 ○ QAPIP Evaluation FY2024 ○ QAPIP Work Plan FY2025	**A. Siebert/T. Greason**

Quality Improvement Steering Committee (QISC)
January 28, 2025
10:30am – 12:00pm
Via Zoom Link Platform
Meeting Minutes
Note Taker: DeJa Jackson

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

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

2) Item: Authority Updates: Dr. Faheem shared the following updates: Expansion of CCBHC providers and the provisional certification of DWIHN, waiting for a final word from CMS. The Clinic has begun seeing patients, gradually increasing in volume. While progress has been made in hospital follow-ups and outpatient engagement, adult recidivism rates remain a challenge. Efforts continue to improve access to services, reduce ED visits, and ensure compliance with outpatient services.

3) Item: Approval of Agenda: Agenda for January 28th, 2025 Meeting Approved by Dr. Faheem and Committee.

4) Item: Approval of Minutes: QISC Meeting Minutes for October 29th, 2024 were approved by Dr. Faheem and Committee.

5) Item: QAPIP Effectiveness
Goal: Integrated Health Care

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

Discussion		
Ashley Bond, Integrated Health Care Manager, shared a discussed for approval the outcomes for the following reports: ***Complex Case Management Evaluation (CCM) FY2024*** The ultimate goals of DWMHA's/DWIHN's Complex Case Management (CCM) Program are to: **The ultimate goals of DWMHA's/DWIHN's Complex Case Management (CCM) Program are to:** • Improve medical and/or behavioral health concerns, increase overall functional status, and improve overall quality of life, as evidenced by a 20% improvement in PHQ scores and/or a 20% improvement in WHO-DAS scores at CCM closure. • To provide early intervention for members appropriate for Complex Case Management to prevent recurrent crises or unnecessary hospitalizations as evidenced by a 10% reduction in Emergency Department (ED) utilization and/or a 10% reduction in hospital admissions from 90 days before receiving CCM services to 90 days after receiving CCM services. • Participation in outpatient treatment increased, as evidenced by a 10% increase in outpatient behavioral health services from 90 days before receiving CCM services to 90 days after receiving CCM services. • Assist members in accessing community resources and obtaining a better understanding of the physical and/or behavioral health conditions, as evidenced by improved compliance with behavioral health and physical health appointments and decreased ED visits and/or inpatient admissions. • 85% or greater member satisfaction scores for members who have received CCM services. Ahsley discussed and reviewed each area of the CCM Evaluation to include the following: • PHQ Scores: • This assessment is embedded in the CCM assessments and is completed upon the start of CCM services and every 30 days thereafter until CCM services end • The higher the score on the PHQ-9/PHQ-A, the greater the symptoms of depression are present • WHO-DAS: • The WHO-DAS assessment is embedded in the CCM assessment and is completed when the assessment is completed at the start of CCM services and every 30 days thereafter until CCM services end • The higher the score on the WHO-DAS, the greater the level of disability. A decrease in the WHO-DAS score indicates an improvement in the level of disability • Emergency Department Utilization • DWIHN analyzed member Admission, Discharge, and Transfer (ADT) alerts and DWIHN claims data to measure utilization of the Emergency Department 90 days before participating in CCM services and 90 days after starting CCM services • Hospital Admissions		

• Only 1 member experienced hospitalization within 90 days of starting CCM services. Inpatient admits could not be evaluated for FY24 as a goal due to only one CCM member being hospitalized
 	
• **Utilization of Outpatient Services**
• DWIHN analyzed members' claims data for outpatient behavioral health service utilization 90 days before participating in CCM services and 90 days after starting CCM services.
• **Satisfaction Surveys**
• Satisfaction surveys were offered to members upon closure of Complex Case Management services. Members were informed that completion of the Survey was not mandatory but that they were encouraged to complete the Survey to provide feedback regarding their experience receiving CCM services
• The CCM FY2024 Evaluation also shared and covered the following information: Membre Comments, Comparison to Previous Reviews PHQ Scores, Goals Met for PHQ & WHO-DAS, Goals Met Emergency Department Utilization and Satisfaction Return Rates.
• **Areas of improvement**
  ○ Emergency Department Utilization
  ○ Increase in FUH appointment attendance (primary focus on African American Members)
  ○ Increasing member Satisfaction Survey return rates
  ○ Connecting members to Primary Care Physicians
  ○ Increasing CCM program enrollment by 20% by proactively engaging members from hospital recidivism, transition of care, inpatient, PHQ list, Foster Care, Foster care chronic condition list
 	
• **Population Assessment FY2024**
 	
• **Purpose***:*
  ○ DWIHN recognizes the importance of analyzing member data to ensure that our programs and services meet the diverse needs of our members. This information included gender, age, spoken primary language, ethnic background, disability designation, residency, and insurance.
  ○ We use this information to create appropriate topic and language materials, establish partnerships with other organizations serving ethnic communities, inform our vendors about specific ethnic and cultural needs, and develop competency training for staff.
  ○ This information is gathered annually
• **Primary Care Physician**
• During FY24, DWIHN provided services to a total of 75,574* members. This is a slight decrease of 64 (.08%) from FY23		

• Only 65.5% of members had an identified Primary Care Physician in FY2024. This is a decrease from 71% of members in FY2023 and 66% of members in FY2022 who had an identified Primary Care Physician. *(Table 1)* • ** Data derived from Power BI/Risk Matrix. Numbers are based on claims submitted by providers on members served* The following information was also shared and covered in the Population Assessment FY2024 Identified Primary Care Physician (Graph), Gender (Graph), Age (Graph), Age group/ member count (Graph), Race (Graph) Primary Language (Graph), Disability Designation (Graph), Residency (Graph), Unreported Primary Spoken Language, English Primary Spoken Language, Two or more Ethnic Backgrounds, Top 5 Behavioral Health Diagnosis Children 0-17, Physical Health Diagnosis for Children ages 0-17, Behavioral Health Diagnosis Adults 18 and Older, SPMI Diagnosis Adults 18+ • **Analysis of Complex Case Management Activities and Resources** ○ During FY25 CCM will focus on trainings that include material on substance abuse, prescription drug abuse and heroin overdose, supporting clients living with chronic pain, motivational interviewing in managing pain, case management for chronic pain, state of MI health coverage, state of MI picking a Medicaid plan and MIBridges, and trainings with the Detroit Alliance for Asthma Awareness Please see attachments “FY2024 CCM Evaluation.pptx” and “FY2024 Population Assessment.pptx” for additional information.		
Provider Feedback	**Assigned To**	**Deadline**
Questions: 1. On the numbers for statewide asthma, is everyone collecting the data? Also, for the social determinants of health? 2. Do we match or do we overlay these numbers with the numbers that public health sees on the same side? 3. What do you see as a barrier? 4. Do you go over crisis plans with them like the crisis plans that their providers have developed? Do you sort of go over during complex case management. Is that something that you discuss with them? 5. Do you know if any of the people enrolled in CCM are also connected with the DHHS benefits monitoring program? I was just curious if that's something that you're familiar with. 6. So, when you say hospital admission, are you talking about hospital admission during the enrollment, or before? 7. So how many of your members had a hospital admission before starting the program? 8. Are you only talking about behavioral health hospitalizations? Are you looking at all hospitalizations? 9. Dr. Faheem recommends the team identify members on antipsychotic medication with obesity and assess if they are receiving A1C checks. **Answers/Responses:** 1. Yes, they should be collecting it the same way. Different areas of Michigan have different social determinants of health, but Asthma is a statewide initiative right now, so they have been collecting that data from all counties.		

2. Some of the information is from different areas that focus on public health. We're getting it from both our sources and outside sources. 3. We had just a couple of members who had high numbers and a skewed average. We are working to provide education. Upon enrollment for CCM, we are educating members about our MCU. We are educating members about our Crisis Center, and we are providing them that information to see if that also helps reduce some of those ed visits. 4. Yes, we do review crisis plans as well as if we see that crisis plans are outdated. We are working with them and CRSPs, to make sure we have updated crisis plans, whether it's annually or after hospitalization. 5. I am not, but I am definitely interested in hearing more, so I'll reach out to you. 6. Hospital Admissions we're looking at Prior and During. We look at both. 7. We did not look at that data, going forward we can review. 8. For CCM, we're looking at all hospitalizations.		
Action Items	**Assigned To**	**Deadline**
Dr. Faheem and the QISC members approved the *Complex Case Management Evaluation (CCM) FY2024 and the* Population Assessment FY2024 as written.	Dr. Faheem and the QISC	January 28, 2025

5) Item: QAPIP Effectiveness
Goal: Utilization Management

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

Discussion		
Marlena Hampton, Director of Utilization Management, shared and discussed for approval the outcomes for the following reports: **Utilization Management Annual Evaluation FY2024:** Currently there are six (6) pillars in which the UM Evaluation is structured: • Customer Service • Quality • Advocacy • Talent Engagement • Access • Finance The following is a review of the Goal Status for each Pillar: • **Customer Service Pillar** ○ *UM Program Description Goal A:* Utilize Provider and Practitioner Satisfaction Surveys related to service access and Utilization Management, make recommendations for improvement regarding service provision, treatment experiences and outcomes. ▪ **2024 Goal Status: Partially Met** ○ UM Program Description Goal B: Enhance provider satisfaction by ensuring a more meaningful experience through use of customer service driven language to improve network relationships. ▪ **2024 Goal Status: Met** • **Quality:** ○ UM Program Description Goal I: Monitor the effectiveness of processes that promote clinical review procedures established from accrediting and regulatory agencies by evaluating the efficiency of targeted metrics during UM activities through interdepartmental collaboration. ○ UM Program Description Goal J: Provide oversight of delegated UM functions through use of policies that reflect current practices, standardized/inter-rater reliability procedures and tools,		

pre-service, concurrent and post-service (retrospective) reviews, data reporting (i.e. timeliness of UM decisions and notifications), outcome measurements and remedial activities.
    - **2024 Goal Status: Partially Met**

- **Advocacy:**
    - **UM Program Description Goal K:** Promote need for enhanced use of Social Determinants of Health in making clinical decisions within standardized guidelines as part of the clinical review process.
        - **2024 Goal Status: Met**
- **Talent Management (formerly Workforce) Pillar:**
    - *UM Program Description Goal H* - Assure fair and consistent UM/review decisions based on MCG, Local Coverage Determination (LCD), National Coverage Determination (NCD) and/or American Society of Addition Medicine (ASAM) medical necessity criteria by monitoring the application of the applied criteria and service authorizations for behavioral health services (including substance use disorders) using a standard inter rater reliability process system wide.
        - **2024 Goal Status: Met**
- **Access Pillar**
    - UM Program Description Goal C: Evaluate DWIHN's UM Program Description to assure effective and efficient utilization of behavioral health services identifying any barriers, analyzing metrics, utilization trends and quality of care concerns.
    - 2024 Goal Status: Partially Met
    - *UM Program Description Goal* D: Monitor the use of specialty behavioral health waiver programs: Autism- Spectrum-Disorder (ASD) benefit, Habilitation and Supports Waiver (HAB), Children's Waiver Program (CWP) and Serious Emotional Disturbances Waiver (SED) through the development and on-going review of DWIHN policies and procedures and monthly monitoring reports.
    - UM Program Description Goal E: Analyze other populations served, examining services received and services available to identify any gaps.
        - **2024 Goal Status: Met**
- **Finance Pillar**
    - UM Program Description Goal F: Promote collaboration and provide guidance to the system by identifying patterns of behavioral health service utilization by funding source and by monitoring over and underutilization of services using dashboards.
        - **2024 Goal Status: Partially Met**
    - UM Program Description Goal G: Develop a system that helps track over- and underutilization
        - **2024 Goal Status: Partially Met**

Please see attachment "DWIHN UM Program Evaluation FY2024.pptx" for additional information.

Provider Feedback	Assigned To	Deadline
None provided.		

Action Items	Assigned To	Deadline
Dr. Faheem and the QISC members approved the *Utilization Management Annual Evaluation FY2024* as written.		

5) Item: QAPIP Effectiveness
Goal: Quality Improvement

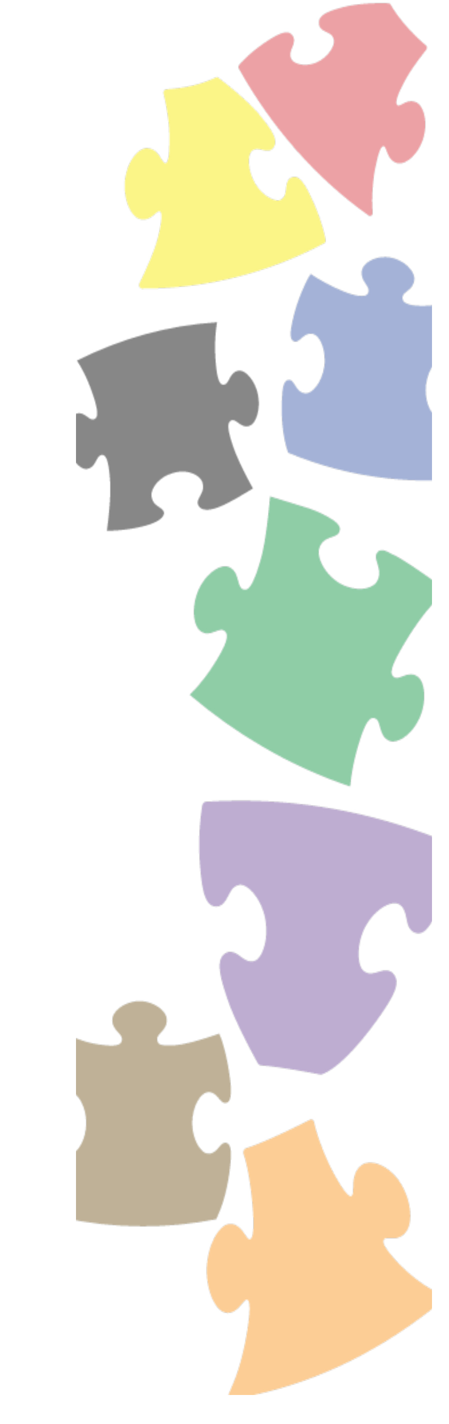
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems X Quality ☐ Workforce
NCQA Standard(s)/Element #: QI 1 CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Discussion		

April Siebert, Director of Quality Improvement and Tania Greason, Quality Improvement Administrator shared and discussed for approval the outcomes for the following reports:
QAPIP Program Description (updated) FY2023-2025
• Requesting the QISC Committee's approval for the revised QAPIP Description for FY 2023-2025, QAPIP Annual Evaluation FY 2024, and Work Plan FY 2025.
• The updated plan now includes more detailed information about our objectives, targeted strategies, expected outcomes, and metrics for measuring success.
QAPIP Evaluation and Work Plan FY2024
• The QAPIP Annual Evaluation FY 2024 is based on the six pillars that are identified in DWIHN's Strategic Plan.
• The QAPIP Annual Evaluation serves as a yearly report that is completed at the end of each fiscal year. It provides a thorough assessment of the performance outcomes from the previous year, analyzing how effective various initiatives and strategies were.
• In the Fiscal year 2024 Work Plan a total of 40 objectives were identified last year. Out of these, 21 objectives were fully met, 9 were not met, and 7 were partially met, and 3 were not evaluated due to a lack of available data.
• **Goals Met**:
  ○ MMBPI Performance Indicators
  ○ Complex Case Management
  ○ Performance Monitoring Activities
  ○ Performance Improvement Projects
  ○ Reducing the Call Abandonment Rate
  ○ HSAG
• **Goals Not Met**:
  ○ Performance Indicators PI#2
  ○ Recidivism
  ○ Performance Improvement Projects
  ○ Improving the availability of follow-up with Mental Health Professional with-in 7 days after Hospitalization
  ○ Adherence to Antipsychotic Medications for Individuals with Schizophrenia
  ○ Antidepressant Medication Management for People with a New Episode of Major Depression chronic and acute
  ○ Improving Diabetes Monitoring for People with Schizophrenia and Bipolar Disorder		

○ Children's Metabolic Screening for Children on Antipsychotics. ○ Follow up for Children on ADHD medication • **Goals Partially Met**: ○ PI#10 (Children) This was met 3 out of 4 quarters. ○ Performance Improvement Projects ○ 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 ○ PHQ-A Implementation ○ Decreasing wait for Autism Services ○ Behavior Treatment Review (Clinical Case Record Review) ○ HSAG Compliance (SFY 2024 Year 1 – 88% (CAP implementation). • **Goals Not Evaluated (No data)**: ○ ECHO Annual Satisfaction Surveys (Adult and Children) ○ Wellness/MySrength ○ PHQ-9 ○ The goals set forth in the 2023-2024 QAPIP Work Plan have reached a completion rate of 52.8%. This marks a decline compared to the completion rates noted in the previous fiscal year, indicating the need for a reassessment of strategies and efforts to ensure we meet our targets effectively. It is crucial to analyze the factors contributing to this decrease and implement measures that will help us improve progress moving forward. • **QAPIP Work Plan FY2025** ○ The objectives in the work plan that were not met or were partially met will be carried over to the work plan for FY 2024-2025. We will also continue with the goals that we achieved for continuous quality improvement. Please see attached handout "Final_QAPIP PP for QISC_1.27.25.pptx" for additional information.		
Provider Feedback	**Assigned To**	**Deadline**
None provided.		
Action Items	**Assigned To**	**Deadline**
Dr. Faheem and the QISC members approved the QAPIP Program Description (updated) FY2023-2025,QAPIP Evaluation FY2024 and the QAPIP Work Plan FY2025 as written. After approval from DWIHN's full board the QAPIP Program Description (updated) FY2023-2025, QAPIP Evaluation and Work Plan FY2024 and the QAPIP Work Plan FY2025 will be shared with Stakeholders, Providers and Members on DWIHN's website.	Dr. Faheem and QISC	February 28, 2025

New Business Next Meeting: February 25, 2025
Adjournment: January 28, 2025



FY2024 Complex Case Management Evaluation

Goals

- The ultimate goals of DWMHA's/DWIHN's Complex Case Management (CCM) Program are to:
- Improve medical and/or behavioral health concerns and increase overall functional status as well as improve overall quality of life as evidenced by a 20% improvement in PHQ scores and/or a 20% improvement in WHO-DAS scores at CCM closure.
- To provide early intervention for members appropriate for Complex Case Management to prevent recurrent crisis or unnecessary hospitalizations as evidenced by 10% reduction in Emergency Department (ED) utilization and/or 10% reduction hospital admissions from 90 days prior to receiving CCM services to 90 days after receiving CCM services.
- Increased participation in out-patient treatment as evidenced by a 10% increase in out-patient behavioral health services from 90 days prior to receiving CCM services to 90 days after receiving CCM services.
- Assist members to access community resources and obtain a better understanding of the physical and/or behavioral health conditions as evidenced by improved compliance with behavioral health and physical health appointments and decrease in ED visits and/or inpatient admissions.
- 85% or greater member satisfaction scores for members who have received CCM services.

PHQ

- Depression symptoms were measured using the Patient Health Questionnaire (PHQ-9) for adults and Patient Health Questionnaire- Adolescent (PHQ-A) for children under 18
- This assessment is embedded in the CCM assessments and are completed upon the start of CCM services and every 30 days thereafter until CCM services end
- The higher the score on the PHQ-9/PHQ-A, the greater the symptoms of depression are present
- A decrease in PHQ score indicates an improvement in symptoms of depression

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- Members baseline scores ranged from 0 to 11, with an average score of 5.4
- Members participating in CCM demonstrated an overall improvement in their PHQ scores, and the improvement increased the longer that the members participated in CCM services
- Average PHQ scores improved 26% from baseline at 30 days, 35% at 60 days and 31% at 90 days of receiving CCM services

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PHQ Scores

	Baseline Average (n=32)	30-day Average (n=32)	60-day Average (n=29)	90-day Average (n=28)
PHQ Scores	5.4	4	2.6	1.8

Y-axis: 0, 1, 2, 3, 4, 5, 6

Table 1

WHO-DAS

- The WHO-DAS assessment is embedded in the CCM assessment and is completed when the assessment is completed at the start of CCM services and every 30 days thereafter until CCM services end
- The higher the score on the WHO-DAS, the greater the level of disability. A decrease in WHO-DAS score indicates an improvement in level of disability
- WHO-DAS scores were gathered from the CCM assessments that were completed at the start of CCM services and at 30, 60, and 90 days after starting CCM services

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- Members WHO-DAS baseline scores ranged from 2 to 32, with an average score of 5.9
- Members participating in CCM services demonstrated overall improvement in their WHO-DAS scores, and the improvement increased the longer that the members participated in CCM services
- Average WHO-DAS scores improved 22% from baseline at 30 days, 39% at 60 days and 29% at 90 days of participating in CCM services

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WHO-DAS Scores

	WHO-DAS Scores
Baseline Average (n=31)	5.9
30 Day Average (n=31)	4.6
60 Day Average (n=28)	2.8
90 Day Average (n=27)	2

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Emergency Department Utilization

- DWIHN analyzed member Admission, Discharge and Transfer (ADT) alerts and DWIHN claims data to measure utilization of Emergency Department 90 days prior to participating in CCM services and 90 days after starting CCM services
- Members had an average of 0.5 Emergency Department visits during the 90 days prior to receiving CCM services and had an average of 0.5 Emergency Department visits during the 90 days after starting CCM services, displaying no change

Table 2

ED Visits

	ED Visits
90 Days Pre CCM (ED=28/28)	0.5
90 Days Post CCM (ED=28/28)	0.5

Table 3

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Hospital Admissions

- Only 1 member experienced a hospitalization within 90 days of starting CCM services. Inpatient admits could not be evaluated for FY24 as a goal due to only one CCM member being hospitalized.
- We will continue to monitor and evaluate for FY25 or if data reflects similar to the previous fiscal years goal will be retired.

Utilization of Outpatient Services

- DWIHN analyzed members claims data for out-patient behavioral health service utilization 90 days prior to participating in CCM services and 90 days after starting CCM services.
- The average number of out-patient behavioral health services during the 90 days prior to CCM services was 4.1 and the average number of out-patient behavioral health services after starting CCM services was 8.1, which amounts to a 51% increase in out-patient services utilization

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Out-Patient Service Utilization

	Out-Patient Service Utilization
90 Days Pre CCM (n=29)	4.1
First 90 Days of CCM (n=29)	8.1

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Outpatient Utilization additional timeframes

- DWIHN also measured the number of members who attended two out-patient behavioral health services within 60 days of starting CCM services and number of appointments attended 60 days after closure.
- Of the 29 members that were available to participate in 2 out-patient services after starting CCM services, 26 members (90%) attended two out-patient behavioral health services within 60 days of starting CCM services.
- Of the 22 members that were available to participate in 2 out-patient services after ending CCM services, 16 members (73%) attended two out-patient behavioral health services within 60 days of CCM case closure.

Satisfaction Surveys

- Satisfaction surveys were offered to members upon closure of Complex Case Management services. Members were informed that completion of the Survey was not mandatory, but that they were encouraged to complete the Survey to provide feedback regarding their experience receiving CCM services.
- Out of 34 members had Complex Case Management services closed during FY2024, 18 (64%) Satisfaction Surveys were completed and returned.

1. The Care Coordinator helped me understand the plan of care

2. The Care Coordinator assisted and supported me to get the care I needed

3. The Care Coordinator was attentive and helped me work through my problems

4. The Care Coordinator treated me with courtesy and respect

5. The Care Coordinator helped me eliminate barriers to connect me with Behavioral and Medical Health and Community Resources

6. I am satisfied with the Complex Case Management program

CCM Satisfaction Survey Responses

	Strongly Disagree	Slightly Disagree	Slightly Agree	Strongly Agree
Statement 1	0	0	0	18
Statement 2	0	0	0	18
Statement 3	0	0	0	18
Statement 4	0	0	0	18
Statement 5	0	0	0	18
Statement 6	0	0	0	18

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Member Comments

“Scherie was so supportive to help, work together as a team”

“Very helpful, very respectful. We like them.”

“Scherie went over and beyond her job. She truly is an asset to your company. She continues to offer her services to help my son, she is heaven sent”

“Scherie has helped me drastically. I’m now getting my teeth fixed and all the help mentally I’ve needed. Things I’ve needed to do for years. More help than family”

“Scherie works well with my case manager, and they are very helpful. They are kind and nice and make me feel better”

“Very attentive, and her concern was sincere. Scherie makes working with the organization a positive experience”

“She (Scherie) is very nice and attentive to my personal mental and physical needs that I need pertaining to my health”

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“Scherie helped me out a lot”

“Scherie has been available, dependable, a plethora of care & understanding. She has prevented me from going down the wrong path & has held my hand every step of the way”

“Very helpful, outgoing & easy to get along with. Made everything happen for me so far”

“I am extremely satisfied with my services”

“Very helpful, explained everything to me where I could”

“Everyone is kind & helpful. Working with me even if I’m not

Comparison to Previous Reviews PHQ

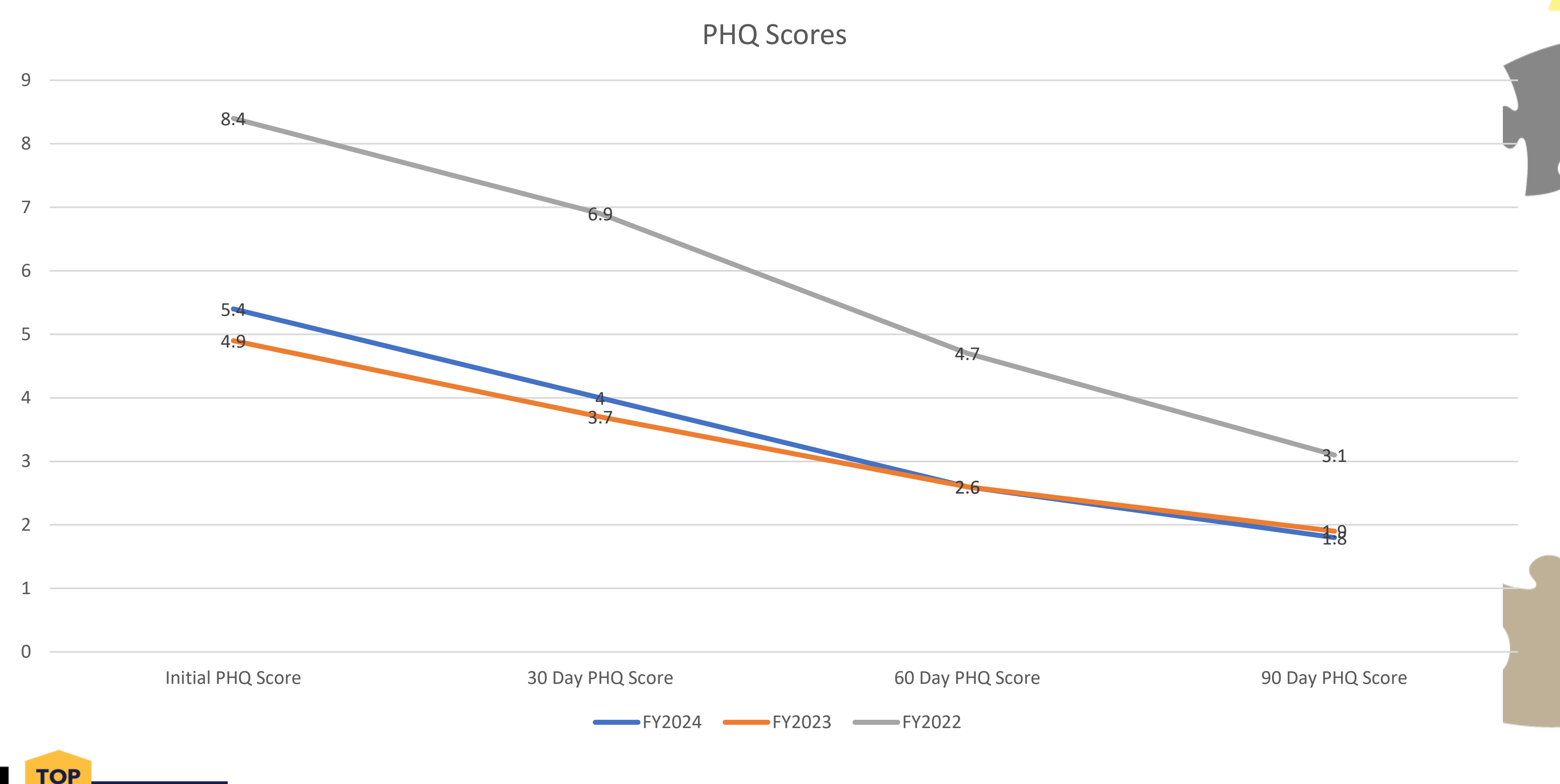

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Table 6

WHO-DAS

WHO-DAS Scores

	Initial WHO-DAS Score	30 Day WHO-DAS Score	60 Day WHO-DAS Score	90 Day WHO-DAS Score
FY2024	5.9	4.6	2.8	2
FY2023	6.2	5	3.6	3.5
FY2022	14.2	11.5	8.8	6.5

Table 7

Goals Met PHQ & WHO-DAS

PHQ and WHO-DAS Goals Met

	PHQ Goal Met	WHO-DAS Goal Met
FY2024 PHQ (25/26) WHO-DAS (23/25)	96%	92%
FY2023 PHQ (33/35) WHO-DAS (32/35)	94%	91%
FY2022 PHQ (42/46) WHO-DAS (45/46)	91%	97%

Table 8

Emergency Department

Emergency Department Utilization Goals Met

	ED Goals Met
FY2024 (ED 2/8)	25%
FY2023 (ED 8/17)	47%
FY2022 (ED 17/21)	80%

Table 9

Outpatient Services

Increase in Out-patient Behavioral Health Services

	Increase in Out-patient Behavioral Health Services
FY2024 (n=29)	86%
FY2023 (n=29)	69%
FY2022 (n=45)	69%

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Outpatient Services

Attended 2 Out-patient Behavioral Health Services within 60 days of starting CCM

	Attended 2 Out-patient Behavioral Health Services within 60 days
FY2024 (n=26/29)	90%
FY2023 (n=41/44)	93%
FY2022 (n=32/48)	66%

Table 11

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Outpatient Services

Attended 2 Out-patient Behavioral Health services within 60 days after closure

74%
72%
70%
68%
66%
64%
62%

FY2024 (n=16/22)	FY2023 (n=26/36)	FY2022 (n=32/48)
73%	72%	66%

Table 12

Satisfaction Surveys

Satisfaction Survey Return Rates

	Satisfaction Survey Return Rates
FY2024 (n=18)	64%
FY2023 (n=39)	88%
FY2022 (n=32)	55%

Table 13

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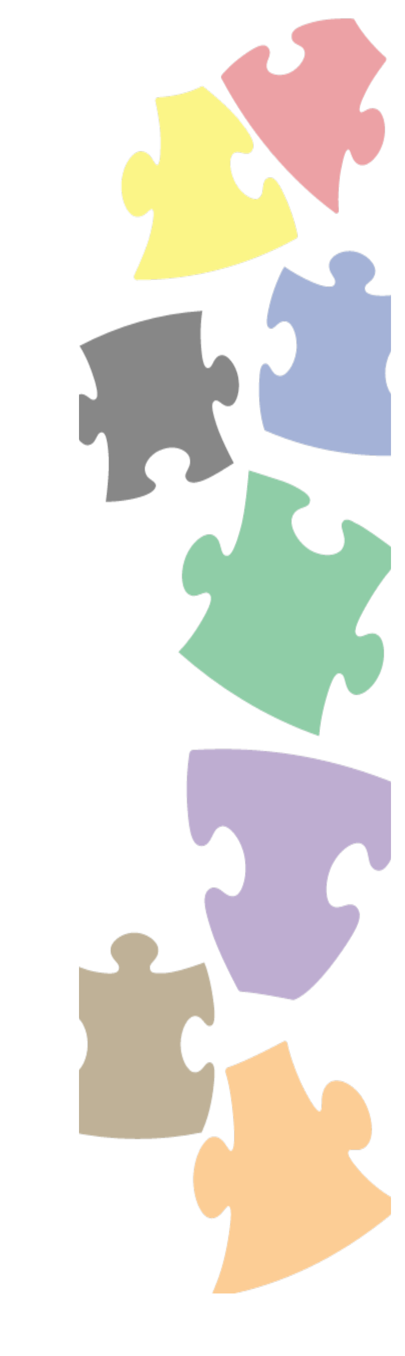
Areas of Improvement

- Emergency Department Utilization
- Increase in FUH appointment attendance (primary focus on African American Members)
- Increasing member Satisfaction Survey return rates
- Connecting members to Primary Care Physicians
- Increasing CCM program enrollment by 20% by proactively engaging members from hospital recidivism, transition of care, inpatient, PHQ list, Foster Care, Foster care chronic condition list

FY2024 Population Assessment



- DWIHN recognizes the importance of analyzing member data to assure that our programs and services meet the diverse needs of the members we serve. This information included gender, age, primary language spoken, ethnic background, disability designation, residency and insurance.
- We use this information to create topic and language appropriate materials, establish partnership with other organizations serving ethnic communities, inform our vendors about specific ethnic and cultural needs; and develop competency training for staff.
- This information is gathered annually

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Primary Care Physician

- During FY24, DWIHN provided services to a total of 75,574* members. This is a slight decrease of 64 (.08%) from FY23

- Only 65.5% of members had an identified Primary Care Physician in FY2024. This is a decrease from 71% of members in FY2023 and from 66% of members in FY2022 who had an identified Primary Care Physician. *(Table 1)*

- ** Data derived from Power BI/Risk Matrix. Numbers are based on claims submitted by providers on members served,*

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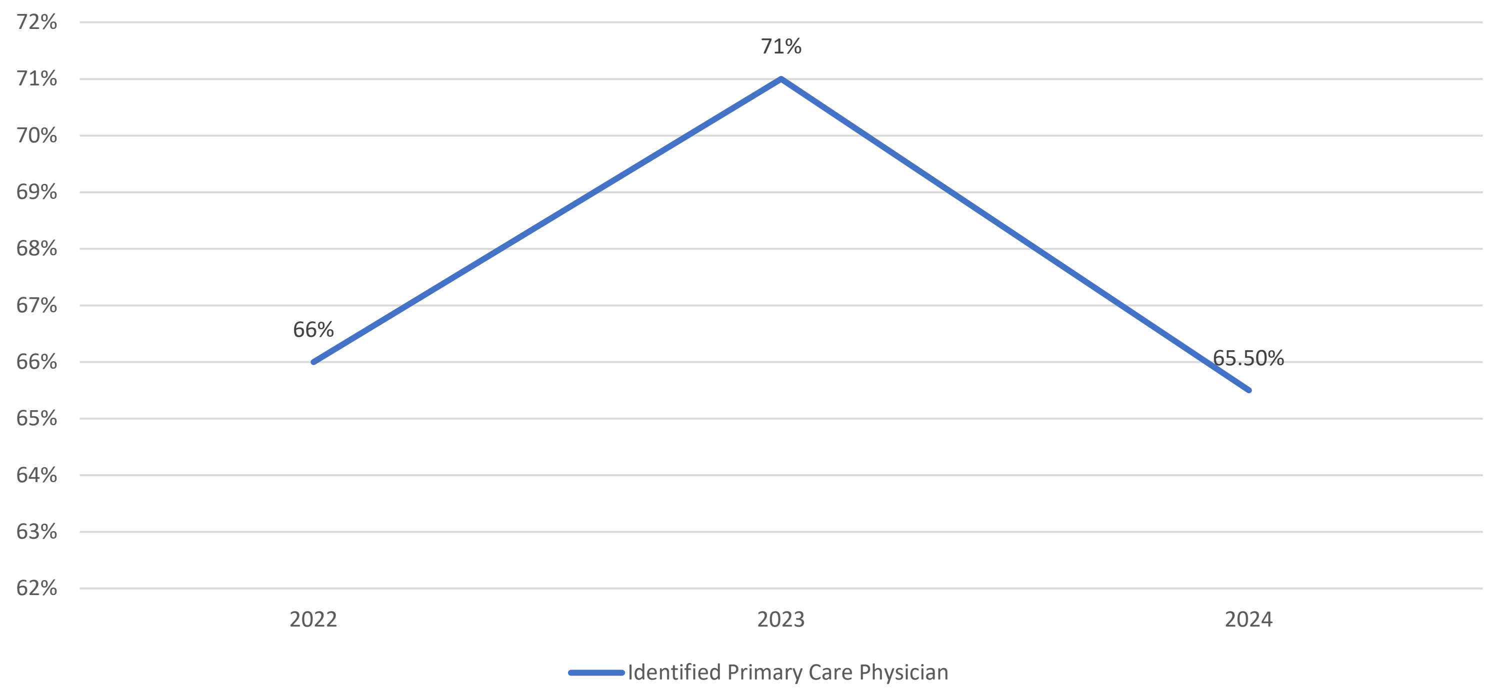


Table 1
*Data derived from PowerBI/Risk Matrix

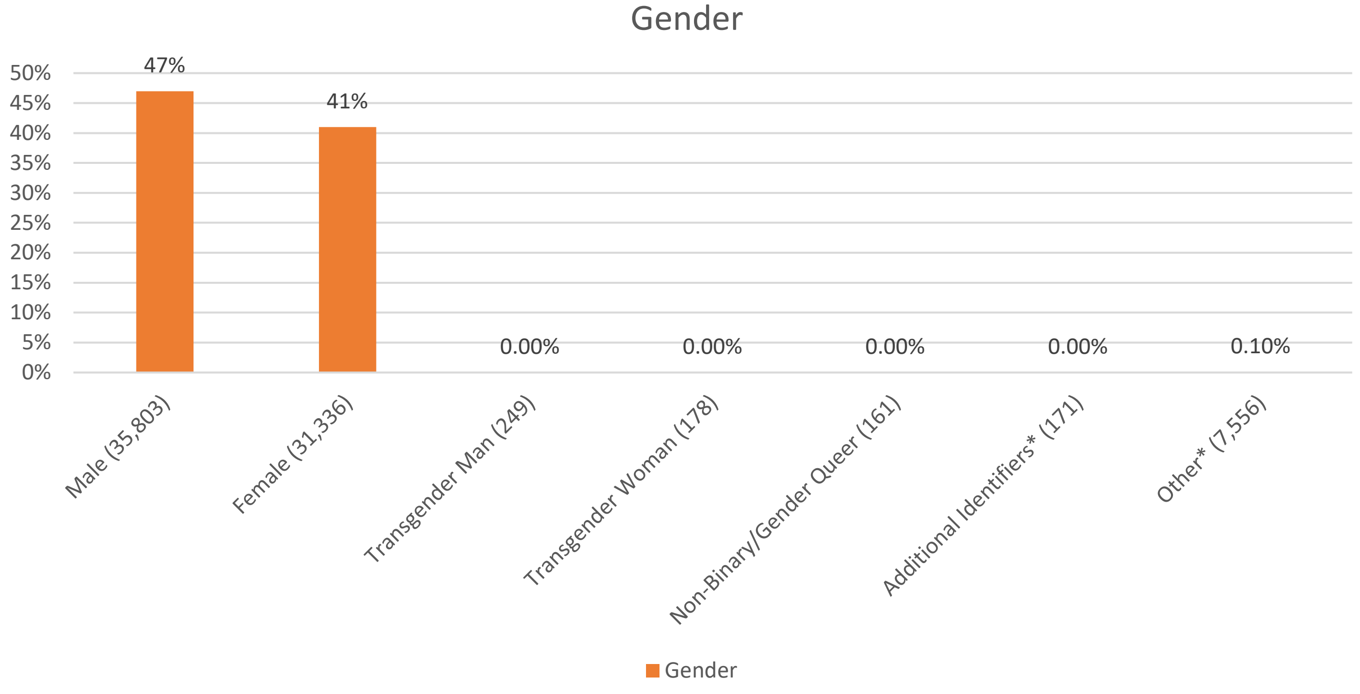
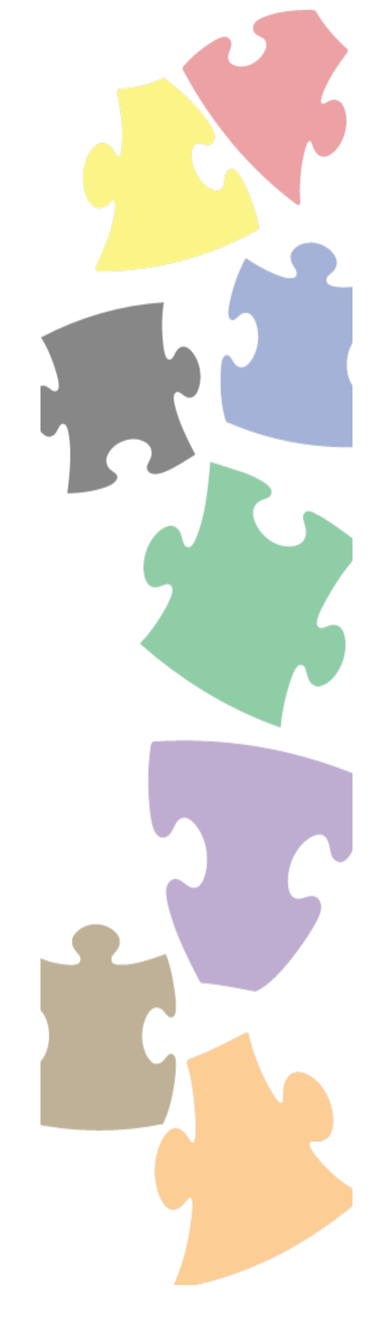


Table 2
*Data derived from PowerBI/Risk Matrix



Age

23%
5%
44%
19%
9%

0-17
18-21
22-50
51-64
65+

Table 3

**Data derived from PowerBI/Risk Matrix*

Age Group	Count
0-17	17,470
18-21	3,616
22-50	33,610
51-64	14,394
65+	6,484

Table 4

**Data derived from PowerBI/Risk Matrix*

Race

- American Indian (non-Alaskan) (250)
- Alaskan Native (11)
- Asian (533)
- Arab American (1,110)
- Unreported (2,145)
- Two or More Races (1,778)
- Other Race (4,601)
- Caucasian (22,100)
- African American (43,009)

0.00% 10.00% 20.00% 30.00% 40.00% 50.00% 60.00%

■ Race

Table 5

**Data derived from PowerBI/Risk Matrix*

Primary Language

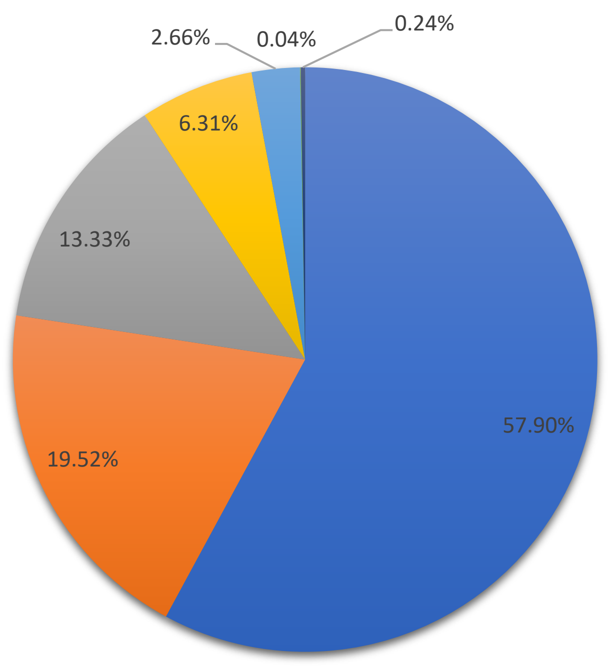
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%

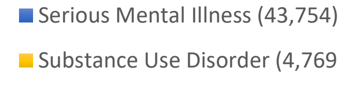
English (69,663)
Unreported (2,482)
Arabic (1,473)
Spanish (804)
Other (1,152)

■ Primary Language

Table 6
**Data derived from PowerBI/Risk Matrix*

Disability Designation





- Serious Mental Illness (43,754)
- Intellectual/Developmental Disability (14,754)
- Serious Emotional Disturbance (10,071)
- Substance Use Disorder (4,769)
- Mental Illness (2,014)
- Emotional Disturbance (34)
- Unreported (178)

Table 7
**Data derived from PowerBI/Risk Matrix*

Residency

52.00%
51.50%
51.00%
50.50%
50.00%
49.50%
49.00%
48.50%
48.00%
47.50%
47.00%

Detroit (38,868)
Outside of Detroit (36,706)

■ Residency

Table 8
**Data derived from PowerBI/Risk Matrix*

Disability Designation

1.45%
1.17
0%
7.16%
7.99%
17.31%
62.17%
25.34%

- Medicaid (46,988)
- Healthy Michigan Plan (19,150)
- DWIHN General Fund (13,080)
- SUD Block Grant (6,042)
- MI Health Link (5,413)
- SUD SDA (1,314)
- HAB Waiver (1,098)
- Child Waiver (1)

Table 9
**Data derived from PowerBI/Risk Matrix*

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Unreported Primary Spoken Language

	FY 2022	FY 2023	FY 2024
Unreported Primary Spoken Language	13.92%	9.30%	3.26%

Table 10

**Data derived from PowerBI/Risk Matrix*

English Primary Spoken Language

	FY 2022	FY 2023	FY 2024
English Primary Spoken Language	82.59%	87.22%	92.20%

Table 11
**Data derived from PowerBI/Risk Matrix*

Two or More Ethnic Backgrounds

2.55%
2.50%
2.45%
2.40%
2.35%
2.30%
2.25%

2.53%
2.38%
2.35%

FY 2022
FY2023
FY2024

Two or More Ethnic Backgrounds

Table 12

**Data derived from PowerBI/Risk Matrix*

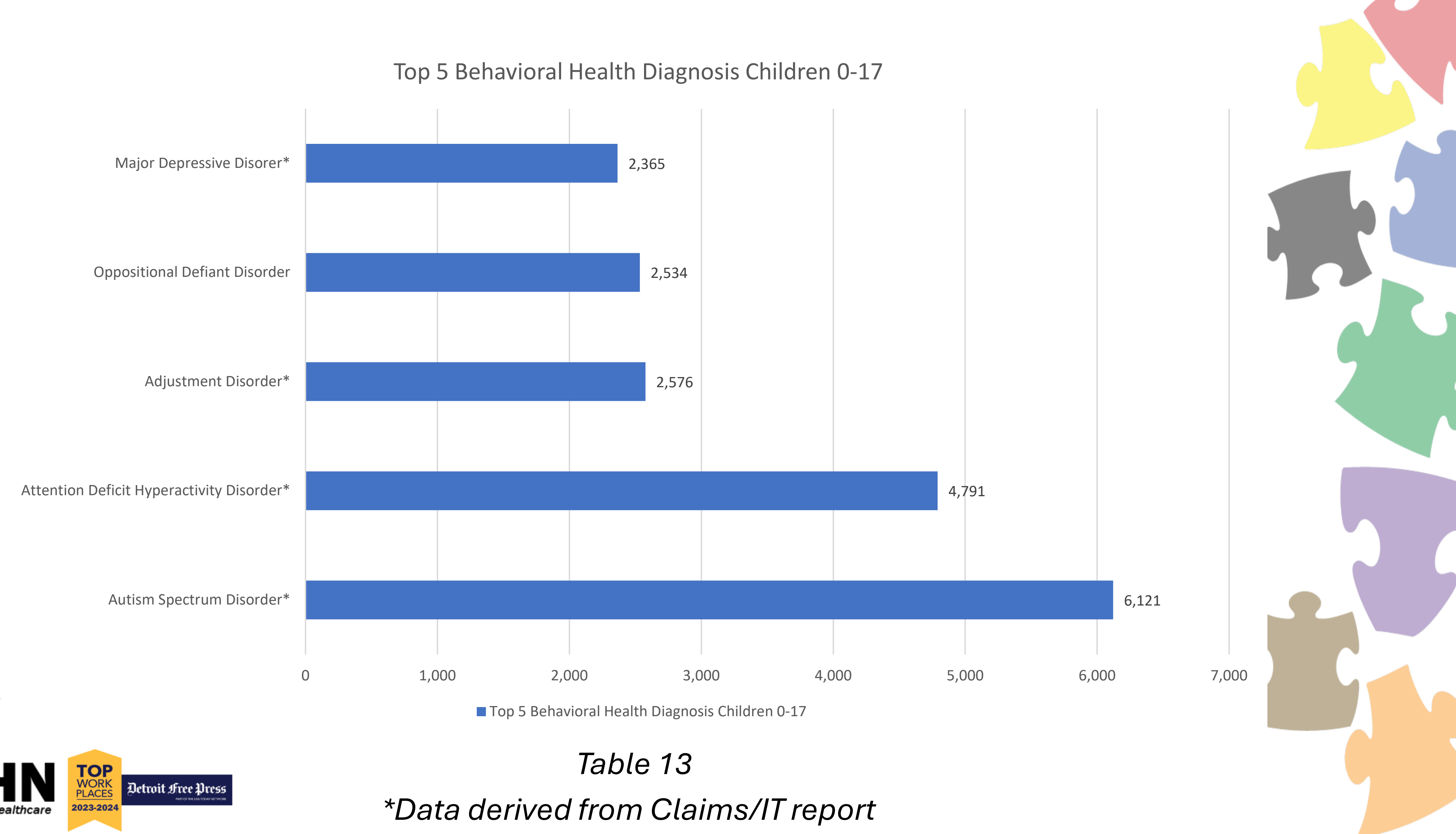

Table 13

**Data derived from Claims/IT report*

Physical Health Diagnosis for Children ages 0-17

Diagnosis	Physical Health Diagnosis for Children ages 0-17
Asthma*	533
Allergic Rhinitis*	177
Obesity*	134
Cerebral palsy*	104
Epilepsy*	88

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Table 14

**Data derived from Claims/IT report*

Behavioral Health Diagnosis Adults 18 and older

Diagnosis	Behavioral Health Diagnosis Adults 18 and older
Major Depressive Disorder*	17,210
Anxiety*	12,962
Alcohol Use Disorder*	10,831
Bipolar Disorder*	9,718
Cannabis Use Disorder*	9,575

Table 15

**Data derived from Claims/IT report*

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SPMI Diagnosis for Adults ages 18 +

Diagnosis	SPMI Diagnosis for Adults ages 18 +
Major Depressive Disorder*	17,210
Anxiety*	12,962
Bipolar Disorder*	9,718
Schizoaffective Disorder*	7,085
Post-Traumatic Stress Disorder*	6,859

Table 16

**Data derived from Claims/IT report*

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SUD Substances Adult 18+

Substance	SUD Dx Adult 18+
Alcohol	470
Other Opiates	569
Marijuana/Hasish	624
Cocaine/Crack	884
Heroin	1,554

0 200 400 600 800 1,000 1,200 1,400 1,600 1,800

■ SUD Dx Adult 18+

Table 17

**Data derived from Claims/IT report*

ASAM Substances

Substance	ASAM Substances
Cocaine	331
Other Opiates	587
Crack	1,162
Heroin	1,757
Alcohol	3,008

Table 18

***Data derived from Claims/IT report**

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Physical Health Diagnosis Adults 18+

Diagnosis	Physical Health Diagnosis Adults 18+
Hypertension*	5,680
Diabetes*	2,600
Asthma*	2,059
Chronic Pain*	1,658
Obesity*	1,521

Table 19

**Data derived from Claims/IT report*

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Diagnosis comparisons FY23 and FY24

Top 5 Behavioral Health Dx Children 2024	Top 5 Behavioral Health Dx Children 2023
1. Autism Spectrum Disorder	1. Attention-Deficit/Hyperactivity Disorder
2. Attention-Deficit/Hyperactivity Disorder	2. Oppositional Defiant Disorder
3. Adjustment Disorder	3. Autistic Disorder
4. Oppositional Defiant Disorder	4. Major Depressive Disorder
5. Major Depressive Disorder	5. Adjustment Disorder

Table 20

**Data derived from Claims/IT report*

Top 5 Physical Health Dx Children 2024	Top 5 Physical Health Dx Children 2023
1.Asthma	1.Asthma
2.Allergic Rhinitis	2.Obesity
3.Obesity	3.Cerebral Palsy
4.Cerebral Palsy	4.Allergy/Epilepsy
5.Epilepsy	5.Diabetes

Table 21

**Data derived from Claims/IT report*

Top 5 Behavioral Health Dx Adults 2024	Top 5 Behavioral Health Dx Adults 2023
1.Major Depressive Disorder	1.Major Depressive Disorder
2.Anxiety	2.Anxiety Disorder
3.Alcohol Use Disorder	3.Schizoaffective
4.Bipolar Disorder	4.Bipolar I
5. Cannabis Use Disorder	5.Opioid Dependence

Table 22

**Data derived from Claims/IT report*

Top 5 Physical Health Dx Adults 2024	Top 5 Physical Health Dx Adults 2023
1.Hypertension	1.Hypertension
2.Diabetes Mellitus	2.Diabetes Mellitus
3.Asthma	3. Asthma
4.Chronic Pain	4.Chronic Pain
5.Obesity	5.Hypercholestrtolemia

Table 23

**Data derived from Claims/IT report*

Top 5 SPMI DX Adults 2024	Top 5 SPMI DX Adults 2023
1.Major Depressive Disorder	1.Major Depressive Disorder
2. Anxiety Disorder	2. Anxiety Disorder
3. Bipolar Disorder	3. Bipolar I Disorder
4.Schizoaffective Disorder	4.Schizoaffective Disorder
5. Post-Traumatic Stress Disorder	5.Post-Traumatic Stress Disorder

Table 24

**Data derived from Claims/IT report*

2024 SUD Diagnosis	2023 SUD Diagnosis
1.Heroin	1.Heroin
2.Cocaine/Crack	2.Cocaine/Crack
3.Marijuana/Hashish	3.Marijuana/Hashish
4.Other Opiates	4.Other Opiates
5.Alcohol	5.Alcohol

Table 25

**Data derived from Claims/IT report*

Asthma

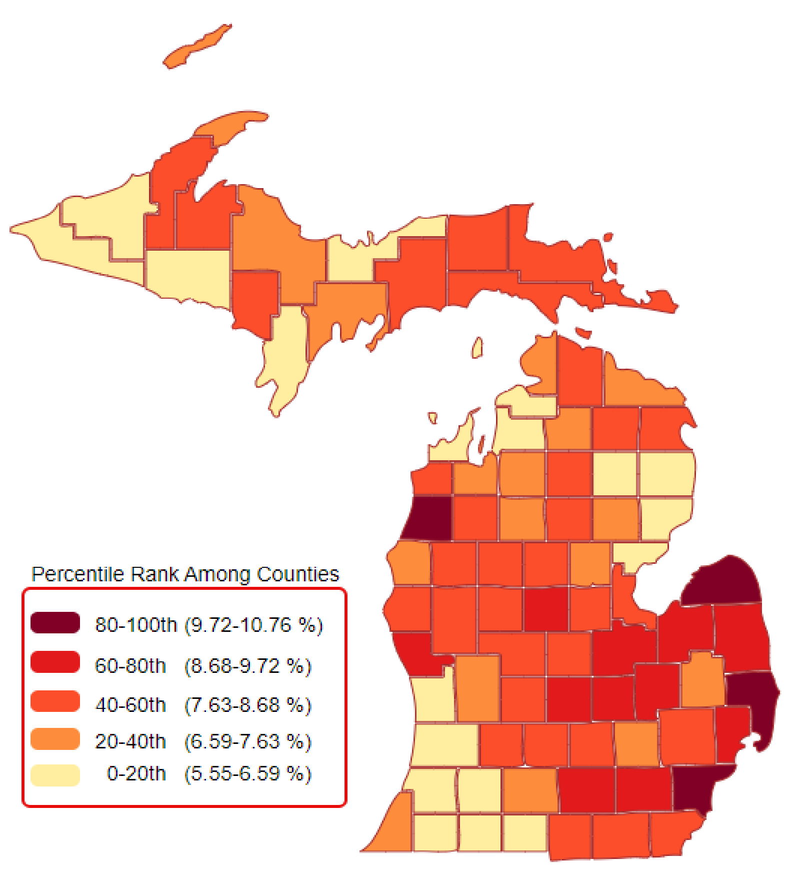
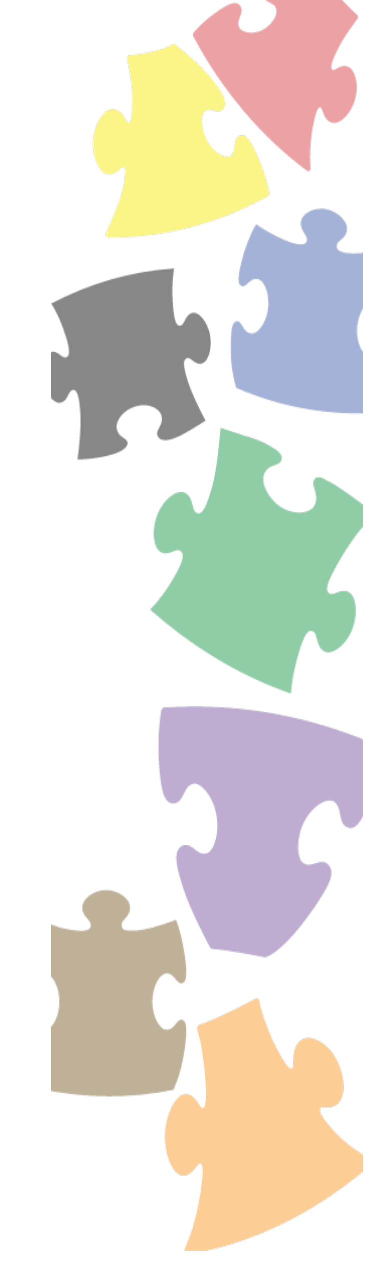


Table 26

**Data derived from CC360/State of Michigan*



Asthma Dx by Zip Children

Zip	Asthma Dx by Zip Children
48224	34
48228	32
48141/48180	24
48205	22
48235	20

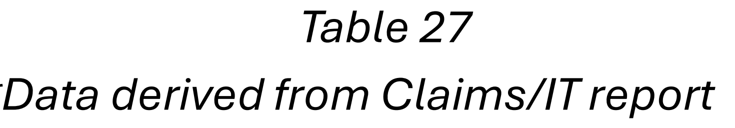


Table 27

**Data derived from Claims/IT report*

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Asthma Dx by Zip Adults

100
90
80
70
60
50
40
30
20
10
0

94
36
82
26
76
28
75
19
64
21

48146
48141
48180
48185
48186

Asthma Dx by Zip Adults
Tobacco users

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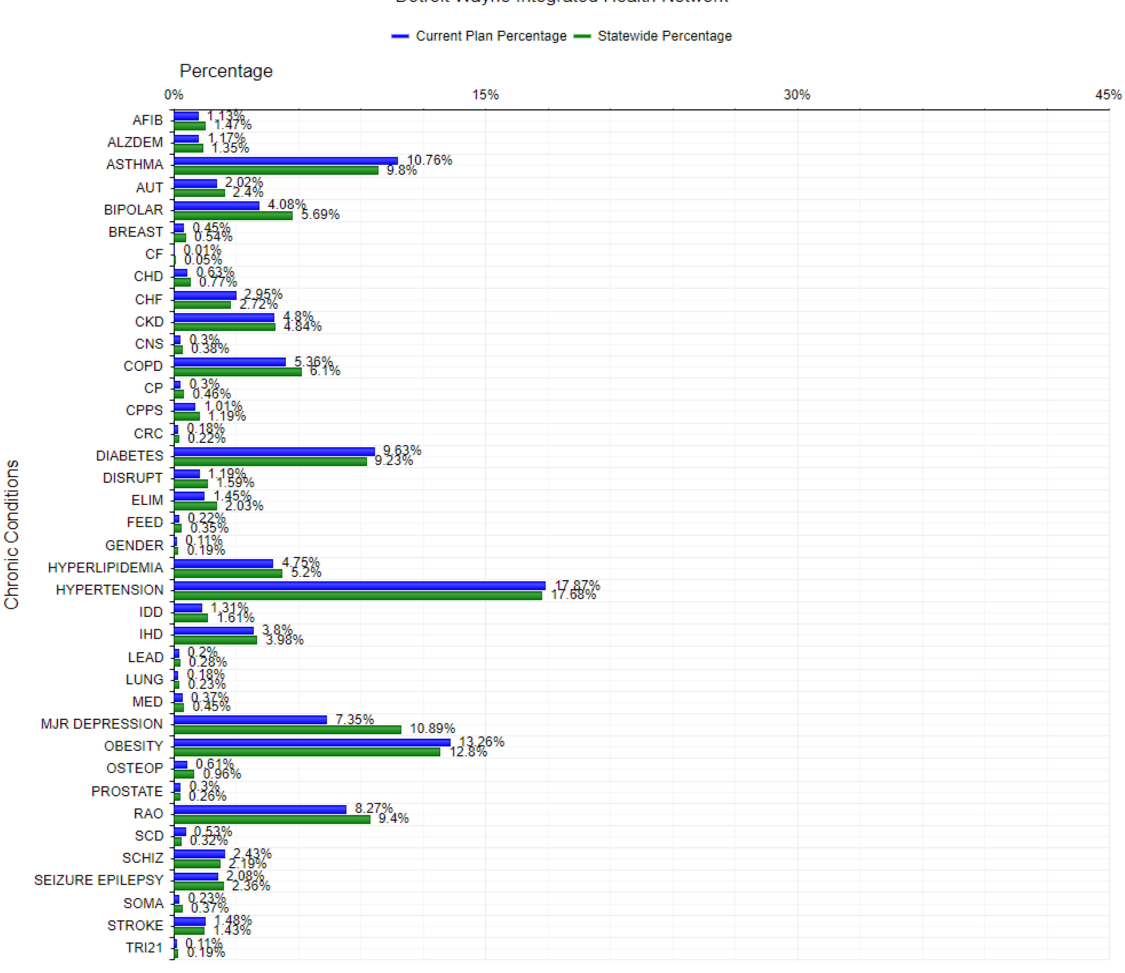
Table 28

**Data derived from Claims/IT report*

Network comparisons with the State



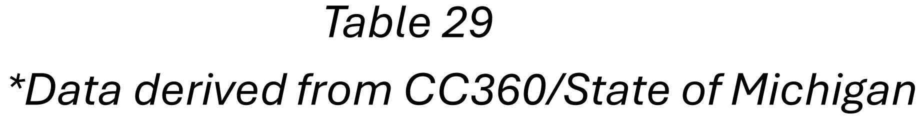


Table 29

**Data derived from CC360/State of Michigan*

Physical Health Diagnoses and Race/Ethnic Group

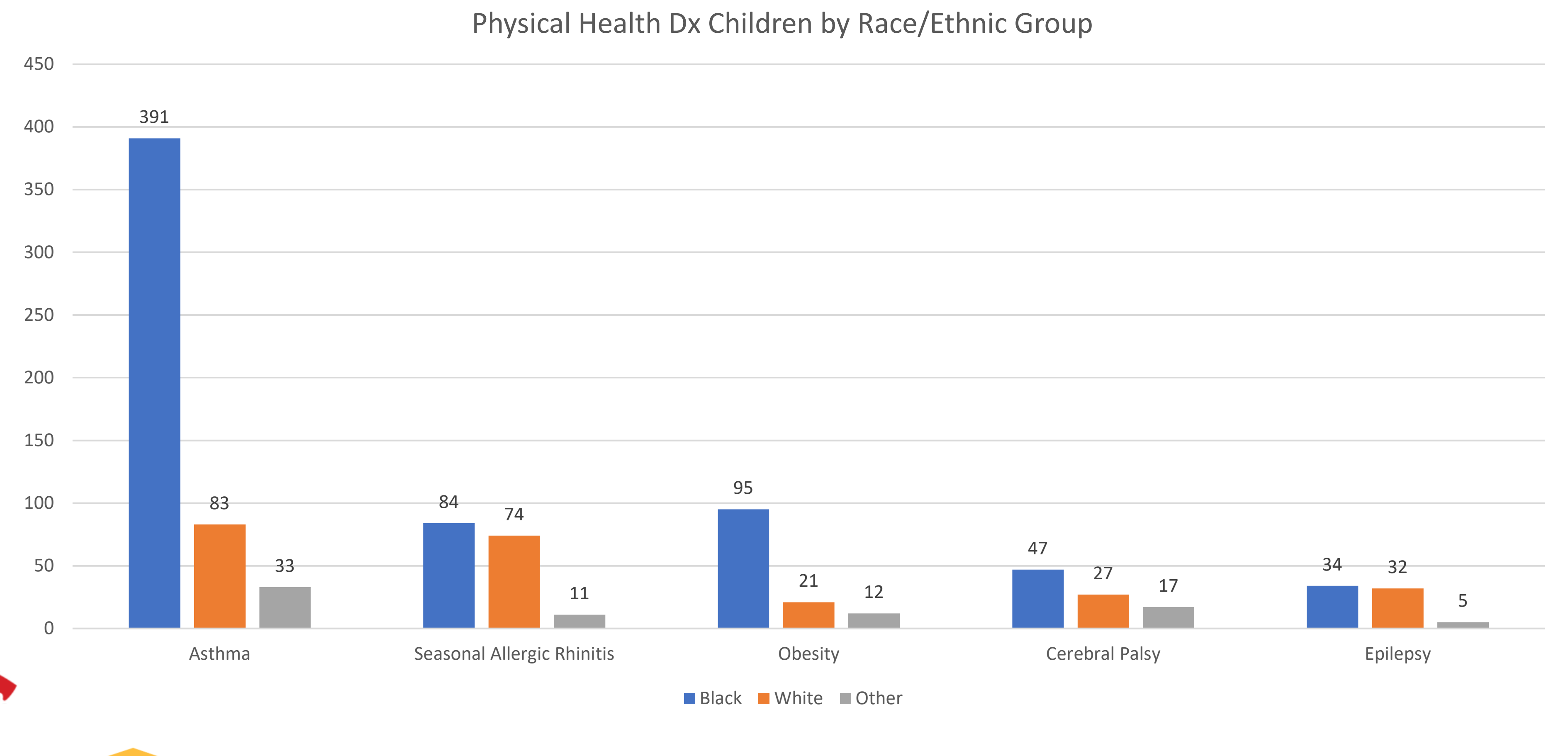


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Table 30

** Data derived from Claims/IT report*

Physical Health Diagnoses and Race/Ethnic Group

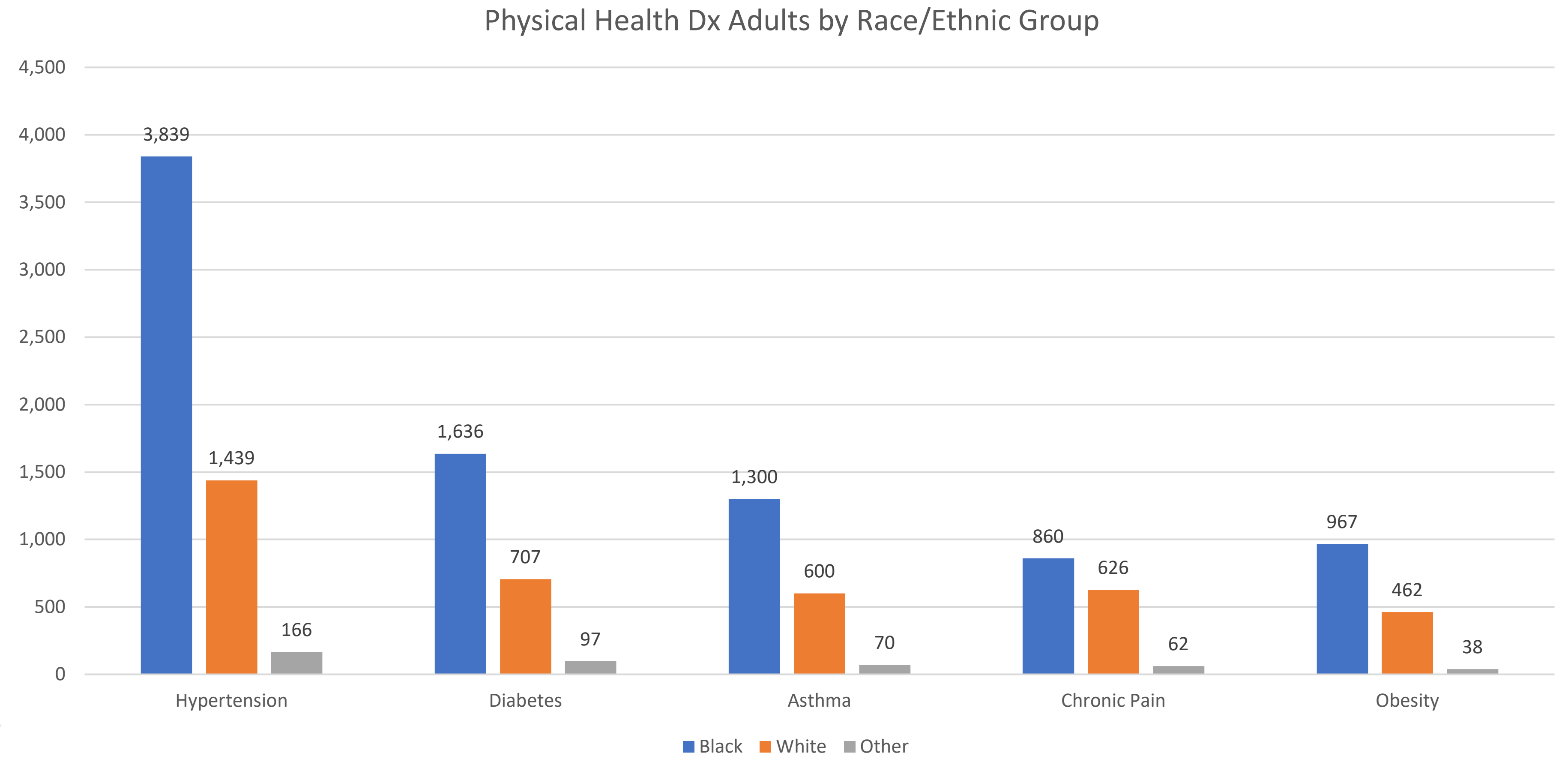

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Table 31

** Data derived from Claims/IT report*

Social Determinants of Health

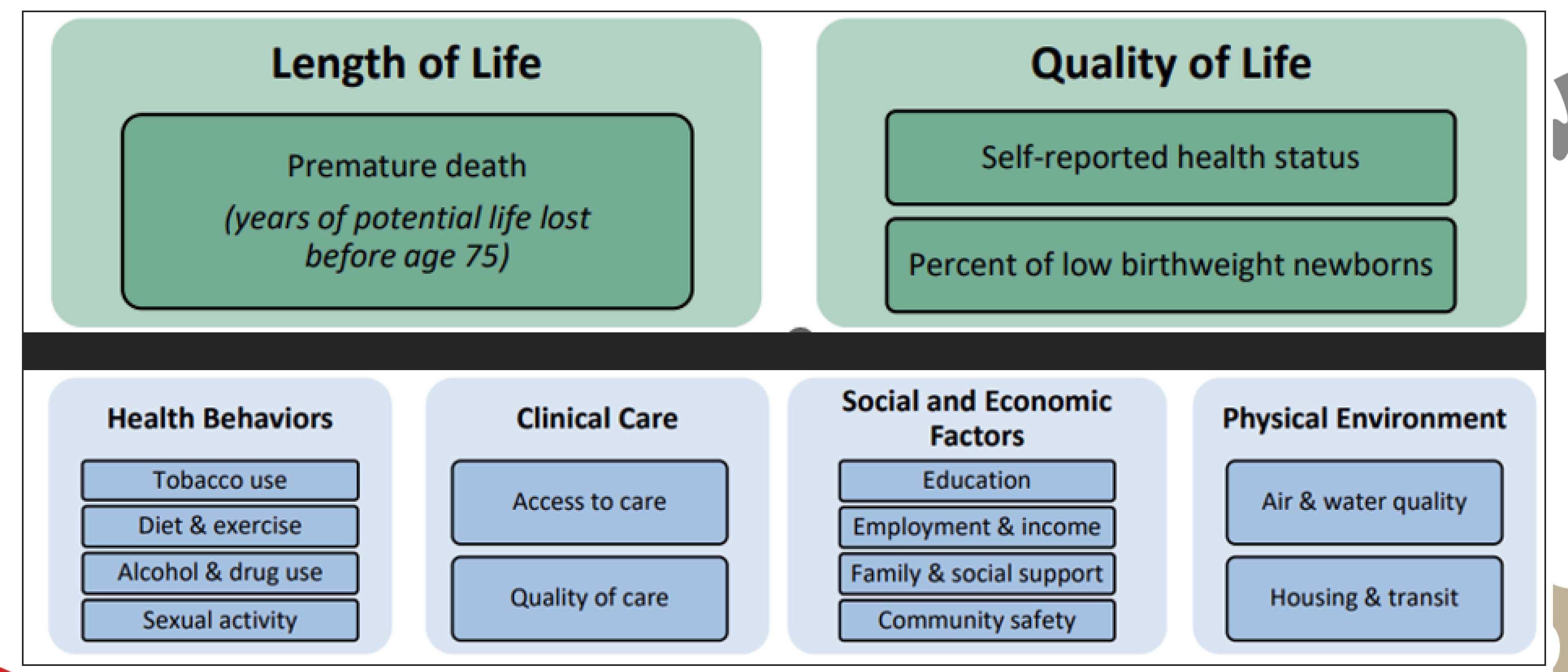

Table 32

** Data derived Wood Johnson Foundation and University of Wisconsin Population Health Institute*

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Social Determinants of Health

	Wayne County	Michigan
Food Insecurity	14%	12%
Insufficient Sleep	39%	36%
Mammography	40%	44%
Children in Poverty	32%	18%
Children eligible for free/reduced lunch	66%	51%
Children in single parent households	38%	25%
Severe Housing Problems	18%	13%
Home Ownership	64%	72%
Severe Housing Costs Burden	17%	12%

Table 33

** Data derived Wood Johnson Foundation and University of Wisconsin Population Health Institute*

Social Determinants of Health Statistics

	Wayne County	Michigan	United States
Residential Segregation (Black/White)	77	73	63
Drug Overdose Deaths	47	27	27
Homicides	18	7	6
Firearm Fatalities	22	13	13
Air Pollution (Particulate Matter)	12.7	6.8	7.4

Table 34

** Data derived Wood Johnson Foundation and University of Wisconsin Population Health Institute*

Analysis of Complex Case Management Activities and Resources

- DWIHN utilizes the information included in the above Population Assessment to review and update complex case management activities and resources to ensure that member needs are addressed.
- Some of the areas of focus for CCM includes ensuring members are connected with PCP's, insurance coverage, and are connected to culturally competent resources and materials.
- CCM utilizes the top diagnoses from this report to update eligibility criteria for CCM program. Based on FY24 report no changes have been made to CCM eligibility criteria for children and adults.

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- During FY24, 40 members were in enrolled in Complex Case Management Services
- The CCM team currently consists of an Integrated Health Care Manager and 2 Complex Case Managers. Our current staffing ratios are adequate to meet the needs of the population
- CCM works closely with the Clinical Specialist OBRA/PASSR nurse to have an increased understanding of member medical conditions as well having a Registered Nurse available to work on member cases as needed

- During FY25 CCM will focus on trainings that includes material on substance abuse, prescription drug abuse and heroin overdose, supporting clients living with chronic pain, motivational interviewing in managing in pain, case management for chronic pain, state of MI health coverage, state of MI picking a Medicaid plan and MIBridges, and trainings with the Detroit Alliance for Asthma Awareness
- CCM continues to utilize resources for members aged 65 and over, and works with the Area of Aging to provide supports for out aging population
- Wayne county residents experience social determinants of health at a higher rate than the rest of the State of Michigan. CCM's are knowledgeable of community resources to address member needs with the most appropriate resources and follow up to ensure members are connected

- Another population that still needs more supports/interventions are African American members and attendance with follow up after hospitalization appointments (FUH)

  - 30% Caucasian Members Hospitalized in which 41% attended FUH appointments
  - 1% of Hispanic Members Hospitalized in which 61% attended FUH appointments
    - 70% of African American Members Hospitalized in which 34% attended FUH

- The Integrated Care Department (under which Care Coordinators function) partners with the Quality Improvement Department on the Reducing Ethnic Disparity with African American Members 7-day FUH project
- Care Coordinators perform transition of care activities and incorporate interventions with given priority to African American members in efforts to reduce this disparity. Interventions include contacting hospital social workers prior to discharge to ensure appropriate discharge planning, contacting members post discharge for FUH appointment reminders, addressing member barriers for appointment attendance, and rescheduling FUH appointment if missed.

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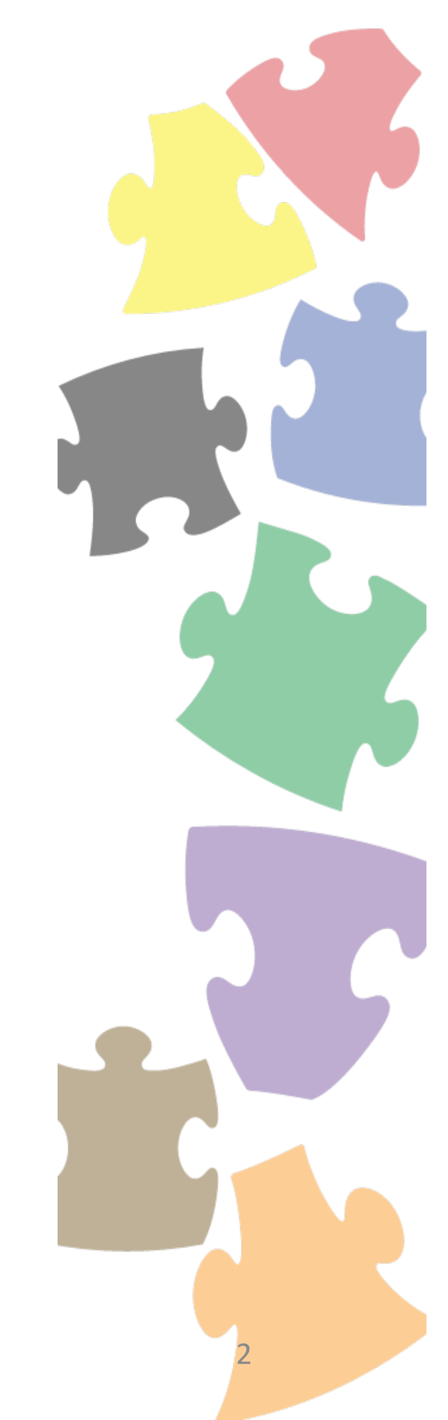
Utilization Management Annual Program Evaluation FY 2024

Marlena J. Hampton, MA, LPC
Director of Utilization Management

Reporting Elements

I. Status of Utilization Management Program Goals

II. Opportunities for Improvement in FY 2025



Six pillars

Pillar 1	Pillar 2	Pillar 3	Pillar 4	Pillar 5	Pillar 6
Customer	Quality	Advocacy	Talent Engagement	Access	Finance

Information Technology

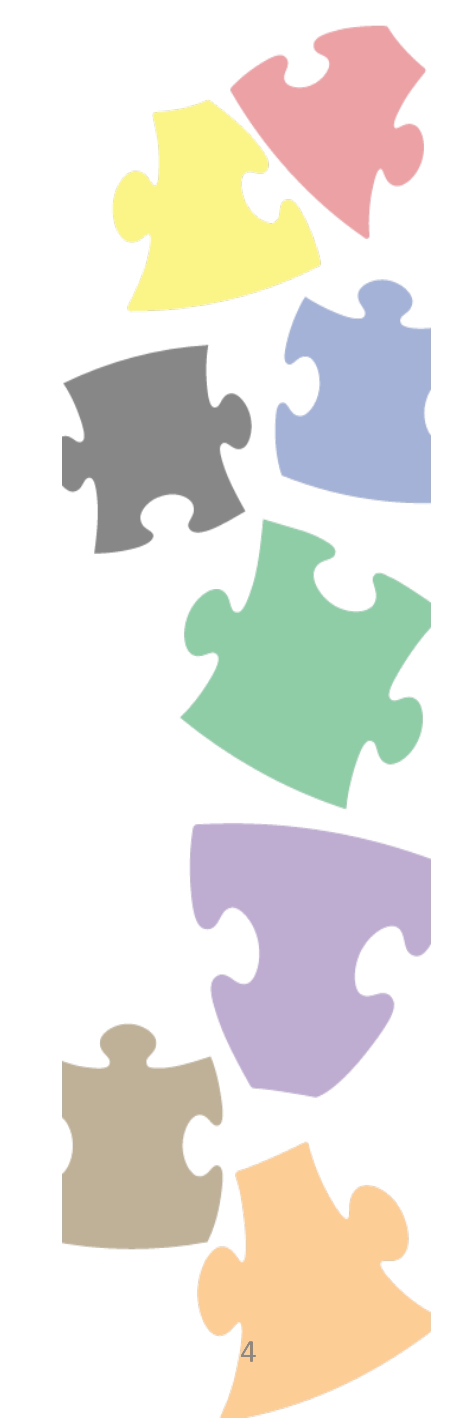
Customer Service Pillar

- ***UM Program Description Goal A:*** Utilize Provider and Practitioner Satisfaction Surveys related to service access and Utilization Management, make recommendations for improvement regarding service provision, treatment experiences and outcomes.

2024 Goal Status: **Partially Met**

- **UM Program Description Goal B:** Enhance provider satisfaction by ensuring a more meaningful experience through use of customer service driven language to improve network relationships.

2024 Goal Status: **Met**



Customer Service – Results & Opportunities

Results

- Department coordination of care efforts identified as "average" in provider satisfaction survey.
- 64% of respondents rated the ability to reach and have access to knowledgeable UM staff from "good" to "excellent." (N=37)

Opportunities

- Provide clearer definition of Utilization Management and its functions.
- Consolidate department communication, including reintroduction of dedicated phone line w/voice mail.
- Create inboxes or other forms of communication unique to each line of business.

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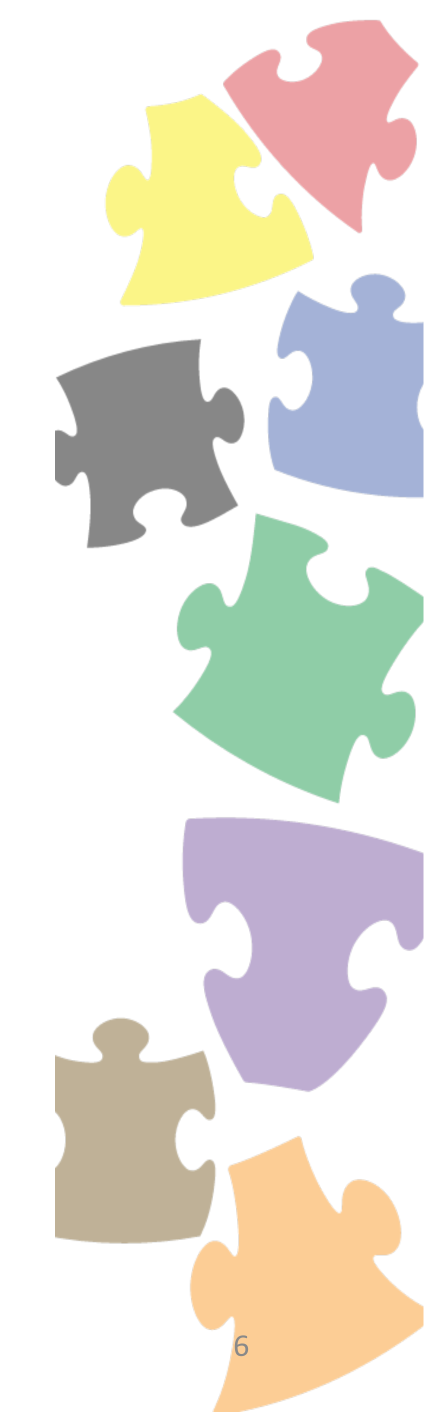
CS Highlight: Self-Directed Services

Self-Directing Services (SD) is a partnership between DWIHN and members using specialty mental health services.

- It is a method of service delivery that shifts budget authority and control of services to the person, as identified in their Individual Plan of Service (IPOS).
- Based on services authorized in the IPOS, the member will select qualified service providers of their choice. The costs of services will be outlined in an individual budget and managed by the person through a Financial Management Service(FMS).
- There are currently about 1,281 members who self-direct their services.
- Team identified goals for FY 25 include data and education on the use of support brokers.



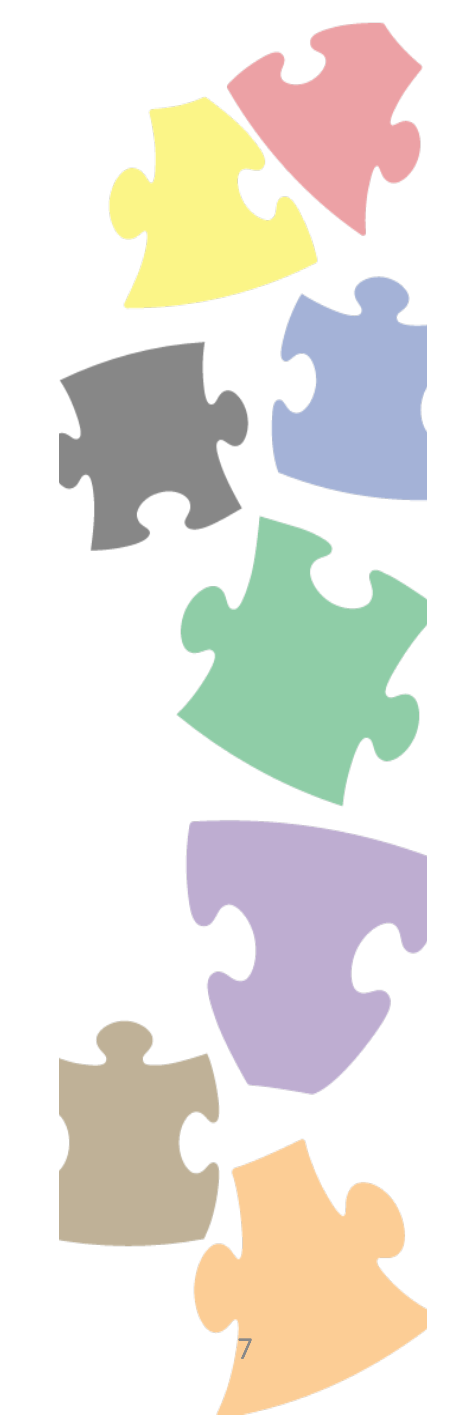
Access Pillar

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

  2024 Goal Status: **Partially Met**

- ***UM Program Description Goal* D**: Monitor the use of specialty behavioral health waiver programs: Autism- Spectrum-Disorder (ASD) benefit, Habilitation and Supports Waiver (HAB), Children's Waiver Program (CWP) and Serious Emotional Disturbances Waiver (SED) through the development and on-going review of DWIHN policies and procedures and monthly monitoring reports.

  2024 Goal Status: **Met**



Access Pillar (cont.)

- **UM Program Description Goal E:** Analyze other populations served, examining services received and services available to identify any gaps.

2024 Goal Status: **Met**

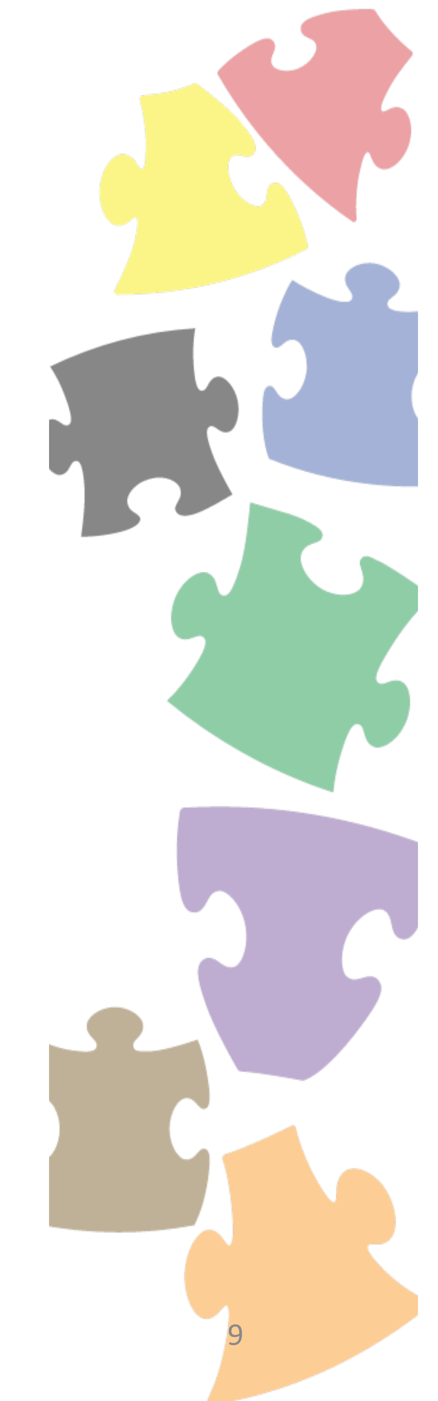
Access - Highlights & Opportunities

Highlights

- Habilitation Supports Waiver (HSW) program consistently exceeds MDHHS requirement of 95% slot utilization, resulting in allotment of 41 additional slots on 10/1/24. We are now able to serve 1,125 members.
- Revision of the General Fund Benefit Grid
- Interdepartmental collaboration to explore targeted interventions for managing recidivism.
- MHWIN updates: provider notifications are now automatically sent, when a request is returned for revisions or additional information.

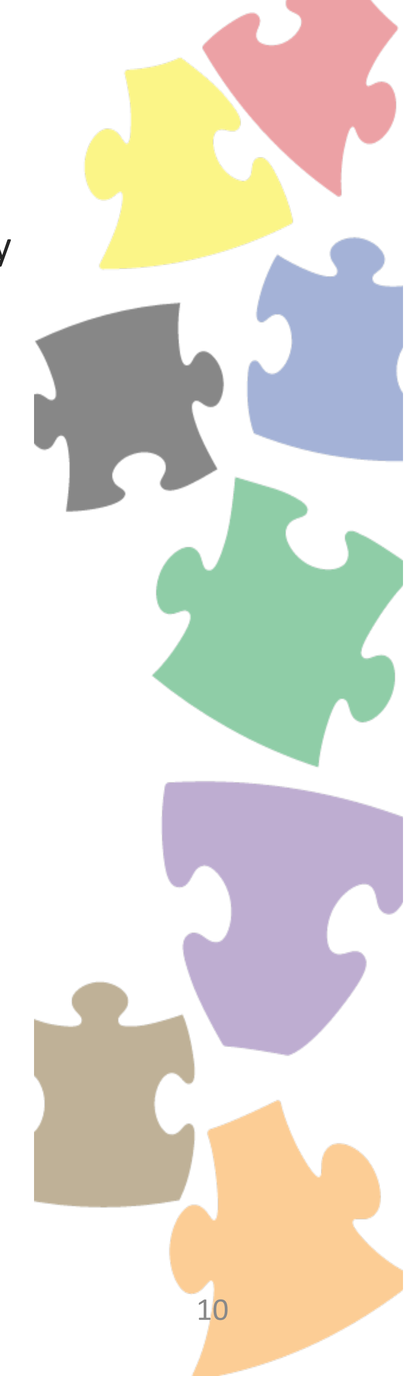
Opportunities

- Health Equity Analysis of UM Policies and Procedures
- Final review and entry of SUD Service Utilization Guidelines
- Monitoring & update of outpatient workflow/procedures in preparation for changes in decision timelines for all standard, non-urgent requests
- Improved depth of reporting for higher levels of care, including greater collaboration with Crisis Services



UM Health Equity Analysis

- The Centers for Medicare and Medicaid (CMS) postulates that prior authorization policies and procedures may have a disproportionate impact on underserved populations and may delay or deny access to certain services.
- In response, a final rule is established to ensure that organizations analyze their utilization management (UM) policies and procedures from a health equity perspective.
- Requirements:
  1. At least one member of the UM committee has expertise in health equity
  2. The UM committee conducts annual health equity analysis of prior authorization policies and procedures used
  3. The results of the analysis be made publicly available on the plan's website.
- Goal: To create additional transparency and identify disproportionate impacts of UM policies and procedures on enrollees.
- Progress/Next Steps: DWIHN's DEI Director has joined the UM Committee, as of 8/1/24. UM Director will initiate a subgroup with DEI Director and relevant departments to focus on how this analysis will be completed



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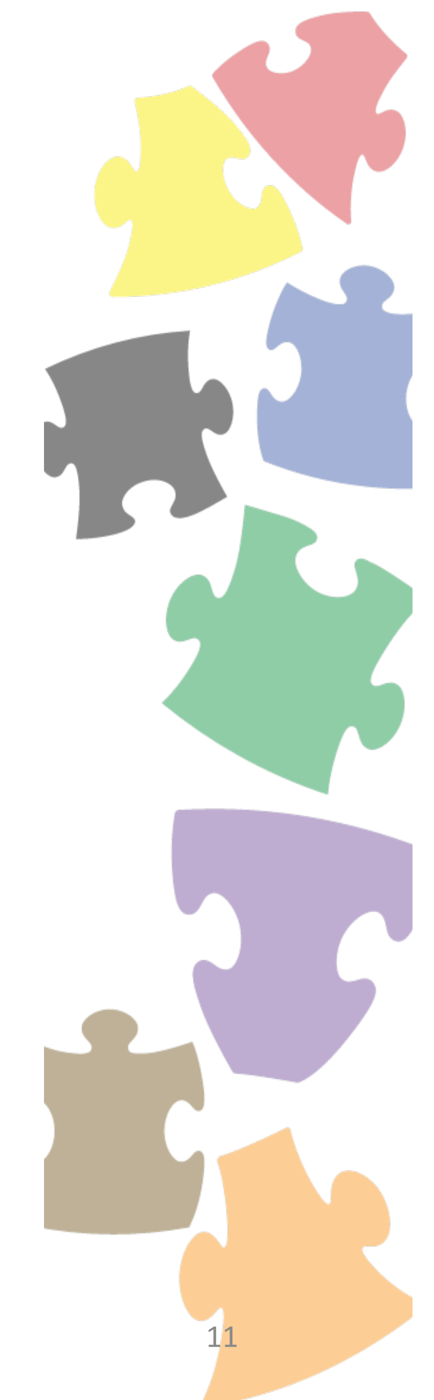
Finance Pillar

- **UM Program Description Goal F:** Promote collaboration and provide guidance to the system by identifying patterns of behavioral health service utilization by funding source and by monitoring over and underutilization of services using dashboards.

  2024 Goal Status: **Partially Met**

- **UM Program Description Goal G:** Develop a system that helps track over- and underutilization

  2024 Goal Status: **Partially Met**



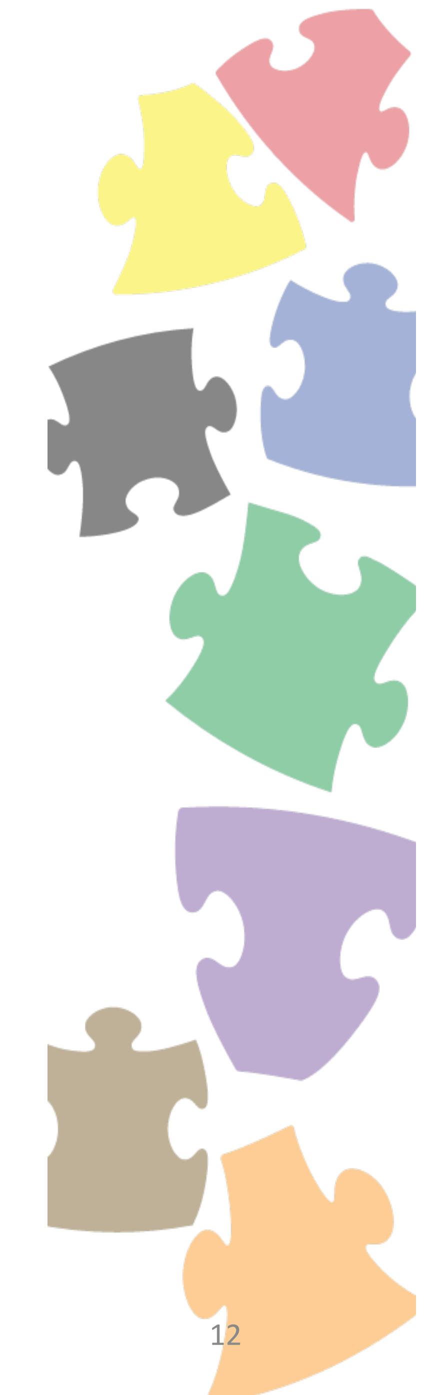
Finance - Highlights & Opportunities

Highlights

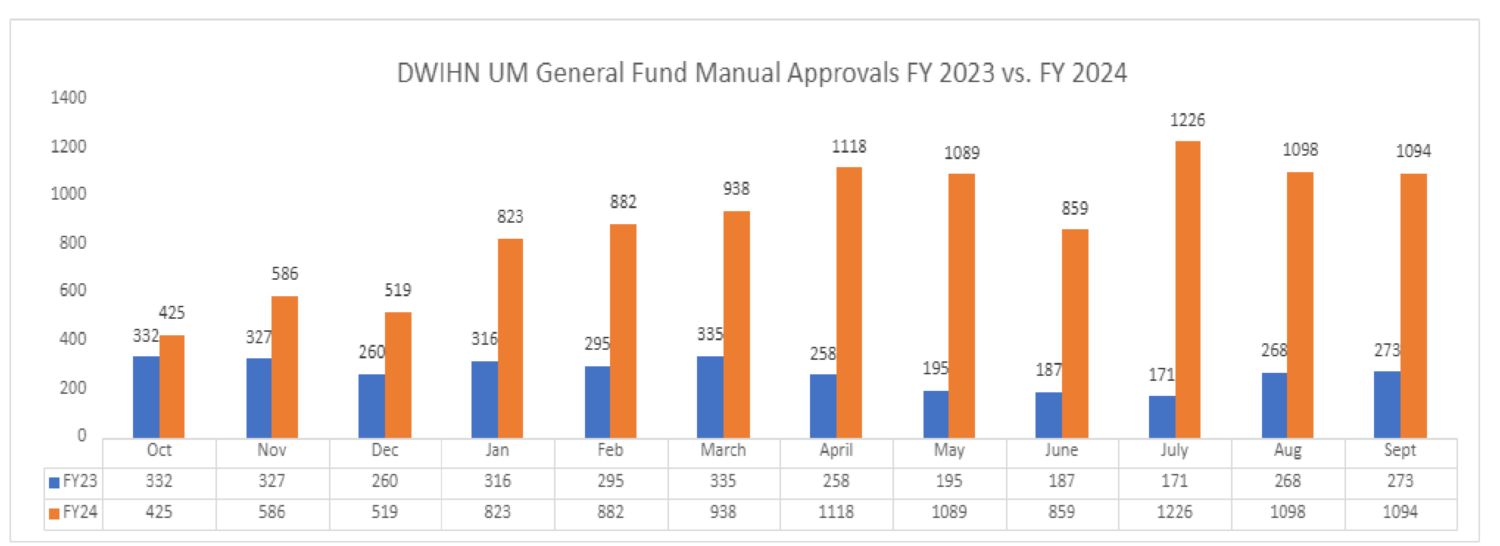
- Revision of the General Fund Benefit Grid
- Addition of ACT Services Utilization to UM Committee Reporting

Opportunities

- Develop a clear procedure & timeline for tracking over and underutilization.
- Intensive review of utilization data and adjust SUGs for FY 25
- Monitoring authorization requests & conferring with CRSPs for members with Medicaid spenddown (deductible).



General Fund Exception



	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

Actions & Next Steps

- Reducing benefit plan to a menu of essential services
- Educating DWIHN departments & provider network on CCBHC and managing Medicaid spenddown (if applicable)
- Develop a progress report for VPs of Clinical Operations & Finance

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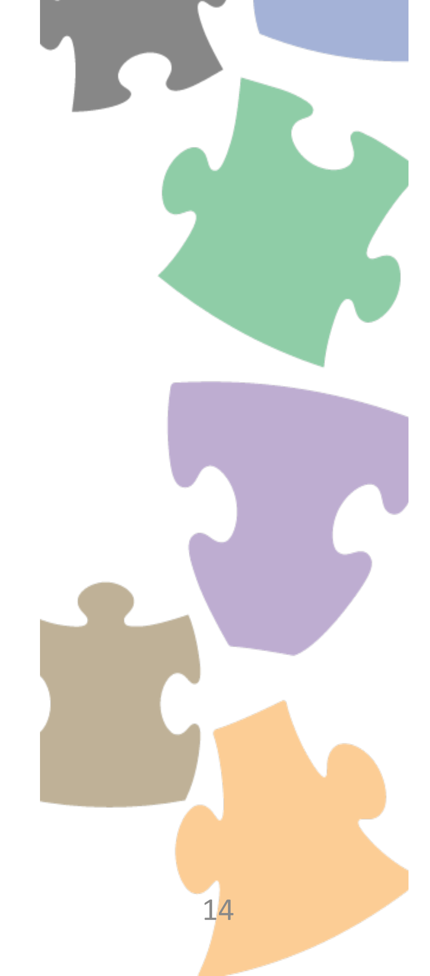
Talent Management (formerly Workforce) Pillar

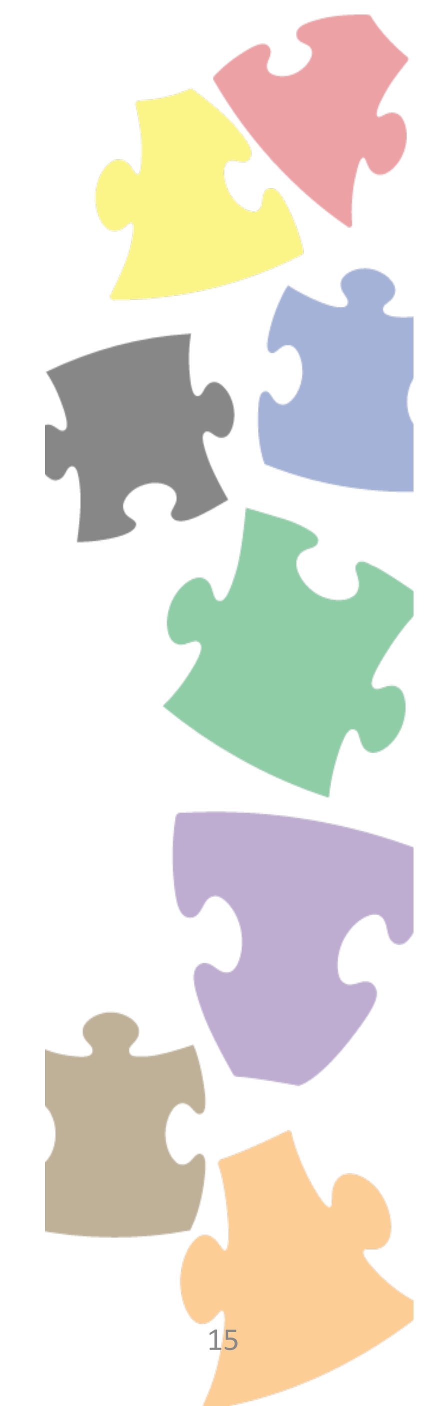
- ***UM Program Description Goal H -*** Assure fair and consistent UM/review decisions based on MCG, Local Coverage Determination (LCD), National Coverage Determination (NCD) and/or American Society of Addition Medicine (ASAM) medical necessity criteria by monitoring the application of the applied criteria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

2024 Goal Status: **Met**



Talent Management - Highlights

- Milliman Care Guidelines (MCG) criteria is used by crisis screening entities, ACT programs, and UM staff to determine the appropriate level of care for our members.
- DWIHN UM and its delegates are tested annually via MCG's interrater reliability (IRR) module to ensure consistent application of the guidelines and medical necessity criteria.



Quality Pillar

- **UM Program Description Goal I:** Monitor the effectiveness of processes that promote clinical review procedures established from accrediting and regulatory agencies by evaluating the efficiency of targeted metrics during UM activities through interdepartmental collaboration.
- **UM Program Description Goal J:** Provide oversight of delegated UM functions through use of policies that reflect current practices, standardized/inter-rater reliability procedures and tools, pre-service, concurrent and post-service (retrospective) reviews, data reporting (i.e. timeliness of UM decisions and notifications), outcome measurements and remedial activities.

2024 Goal Status: **Partially Met**

Quality - Highlights & Opportunities

Highlights

- All delegated entities met the timeliness threshold of 90% for urgent, preservice decisions.
- Monthly audits of Pre-Admission Review (PAR) documents, including feedback on findings and training opportunities for screening entities.

Opportunities

- Consolidate process for annual review and reporting for UM delegates, in conjunction with Crisis Services.
- Increase dialogue with screening entities regarding needs and performance improvement activities.

Timeliness of UM Decision-Making

	Michigan Peer Review Organization
Numerator*	54
Denominator#	55
Rate	98.2%

	COPE	The Guidance Center	New Oakland Family Centers	The Children's Center**
Numerator	10,013	1,551	1,006	104
Denominator	10,294	1,561	1,066	106
Rate	97.3%	99.4%	94.4%	98.1%

Advocacy Pillar

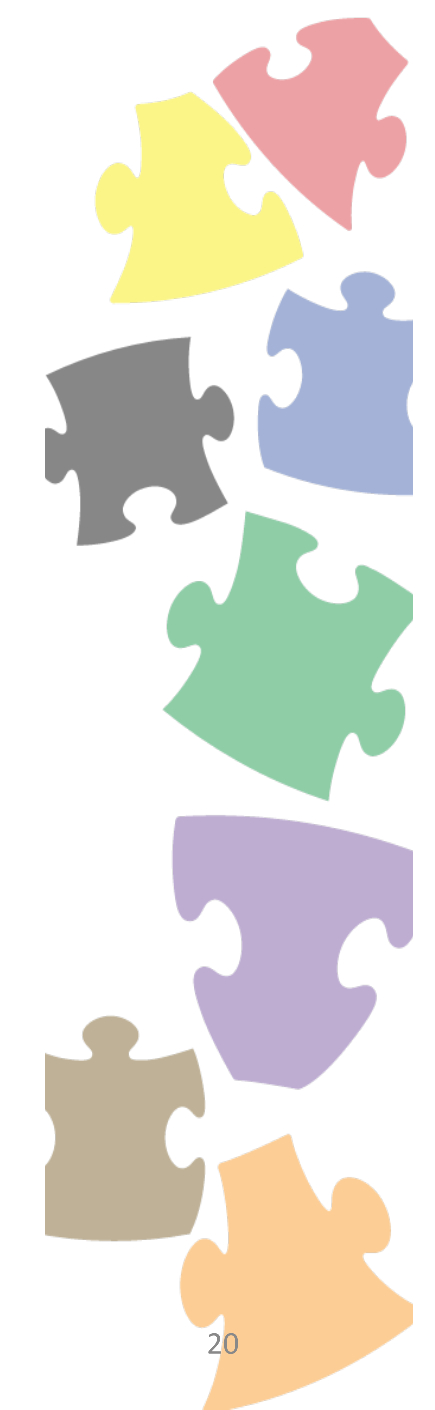
UM Program Description Goal K: Promote need for enhanced use of Social Determinants of Health in making clinical decisions within standardized guidelines as part of the clinical review process.

2024 Goal Status: **Met**

Advocacy - Highlights

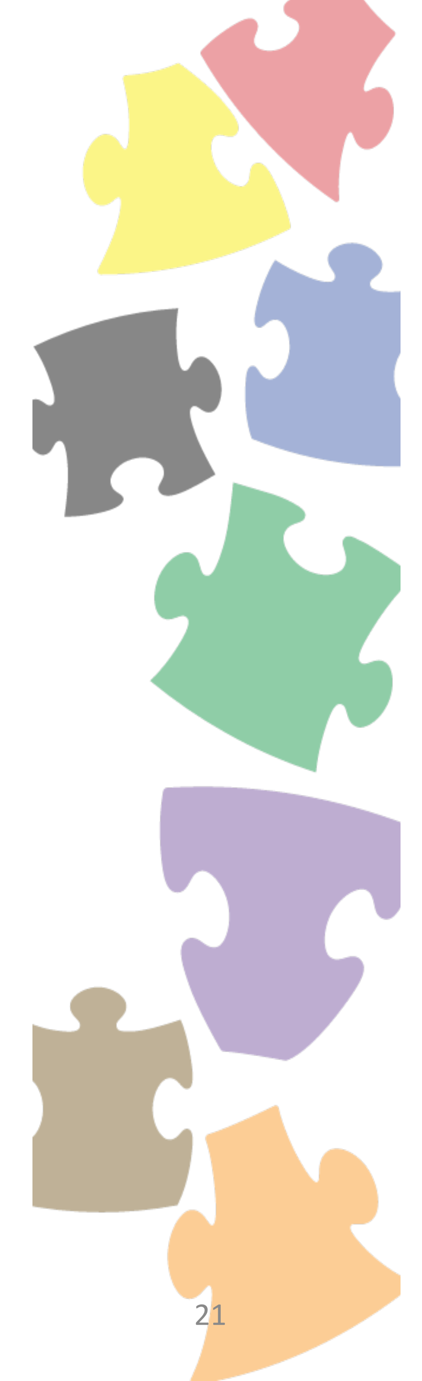
- DWIHN continues its membership in the Michigan Consortium for Healthcare Excellence.

- Milliman Care Guidelines (MCG) criteria, used to determine member medical necessity for higher levels of care, continues to expand their Social Determinants of Health module within their Indicia product.



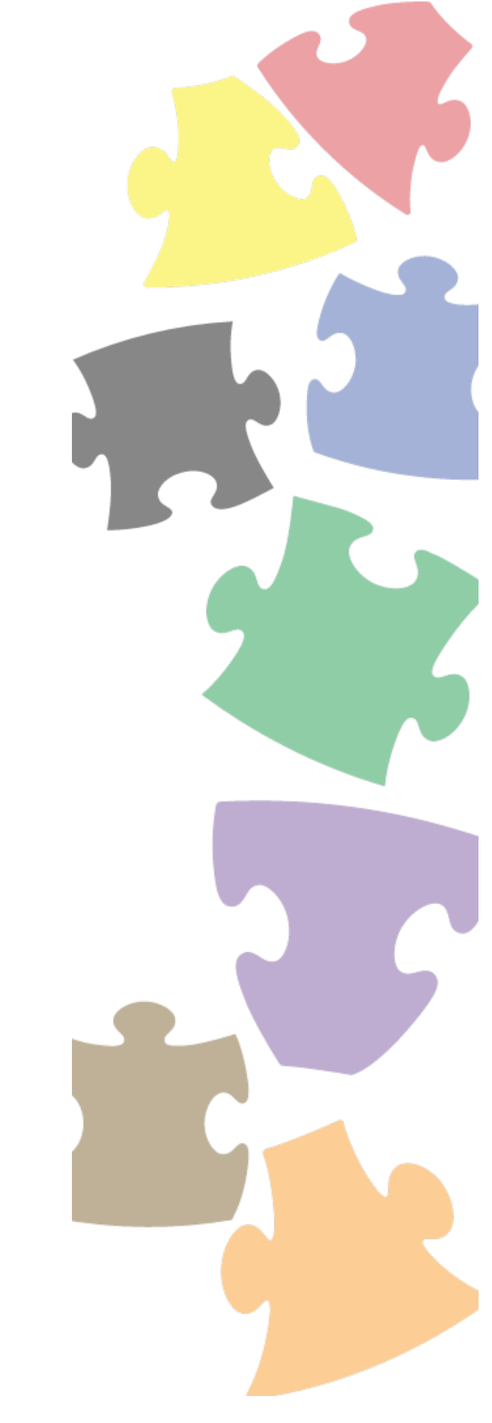
The Foundation: Information Technology

- **MHWIN Continued Stay Review/Discharge Form** - Updates included data points for involuntary admissions, addition of information buttons with instructions for each section, discharge summaries being fully completed by the provider.
- **Updates to UM SSRS Reporting** - During FY24, the UM production queue has been updated to include additional reporting for inpatient length of stay and recidivism.
- **Outpatient Authorization Queue** - MHWIN now sends reminders to providers following returned authorization requests. Additionally, if no response is received, the case will be denied by the system at the end of 14 days.
- **Service Utilization Guidelines** – The Service Utilization Guidelines module has been updated to include SUD ASAM criteria, in anticipation of introducing SUGs for this line of business.



Department Goals & Opportunities for FY 2025

- Incorporating CCBHC requirements into UM program, including SUGs, by end of the 1st Quarter.
- Annual Health Equity Analysis of UM Policies and Procedures
- Review over and underutilization reports, establish schedule of reporting prioritized data for FY25.
- Procedural & IT updates to meet CY 2026 requirement for all standard, non-urgent request decisions within seven (7) calendar days.
- Consolidate process for annual review and reporting for UM delegates.
- Collaborate with other DWIHN departments on common reporting and projects.
- Increased focus on trends & impact, after reestablishing baselines.



Quality Assurance Performance Improvement Plan Description (QAPIP)
QAPIP Evaluation FY2024 and Work Plan FY 2025
January 28, 2025

QAPIP Presentation

- Requesting the QISC Committee's approval for the revised Quality Assurance Performance Improvement Plan (QAPIP) Description for Fiscal Year 2023-2025, QAPIP Annual Evaluation FY 2024, and Work Plan FY2025.

- The QAPIP Plan Description for fiscal years 2023 through 2025 has been updated to enhance the overall quality of the plan. While I won't cover every single update in this presentation, I want to emphasize that significant enhancements have been made in each section. The updated plan now includes more detailed information about our objectives, targeted strategies, expected outcomes, and metrics for measuring success. As you review the updated document, you will see these improvements in clarity and overall quality.

QAPIP Presentation

- The QAPIP Annual Evaluation FY2024 is based on six (6) pillars that are identified in DWIHN's Strategic Plan; Customer, Access, Quality, Advocacy, Finance and Workforce Development.
- The QAPIP Annual Evaluation serves as a yearly report that is completed at the end of each fiscal year. It provides a thorough assessment of the performance outcomes from the previous year, analyzing how effective various initiatives and strategies were.
- The next few slides will provide an overview of the QAPIP Evaluation for Fiscal Year 2024, along with an outline of the Work Plan for 2025. While not all goals will be covered, the focus will be on goals that were met, not met, and partially met.

QAPIP Presentation

- In the Fiscal Year 2024 Work Plan, located on page 97 of the Evaluation document, a total of 40 objectives were identified last year. Out of these, 21 objectives were fully met, 9 were not met, 7 were partially met, and 3 were not evaluated due to a lack of available data.

QAPIP Presentation

- **<u>Goals Met</u>**
  - MMBPI Performance Indictors (pg.101) - DWIHN exceeded the standards for the following: PI#1, which measures (Pre-Admission Screening within 3 hours for both children and adults); PI#3, which assesses the timeliness of the access to services, 4a (Hospital Discharge Follow-Up), 4b related to SUD Detox Discharge Follow-Up); and PI#10, inpatient recidivism rates for children
  - Complex Case Management (pg.105)
  - Performance Monitoring Activities (pg.107, 108, 109)
  - Performance Improvement Projects
    - Reducing the Call Abandonment Rate (pg.114)
  - HSAG (Performance Measurement Validation Review) pg.87

QAPIP Presentation

- **Goals Not Met**
  - Performance Indictors PI#2 - (Completed Biopsychosocial Assessment with 14 days) (pg.102)
  - Recidivism - (Recidivism for Adults) Pg.104
  - Performance Improvement Projects
    - Improving the availability of follow-up with Mental Health Professional with-in 7 days after Hospitalization (pg.110)
    - Adherence to Antipsychotic Medications for Individuals with Schizophrenia (pg.111)
    - Antidepressant Medication Management for People with a New Episode of Major Depression chronic and acute (pg.112)
    - Improving Diabetes Monitoring for People with Schizophrenia and Bipolar Disorder (pg.113)
    - Children's Metabolic Screening for Children on Antipsychotics. (APM) (pg.115)
    - Follow up for Children on ADHD medication (pg.116)

QAPIP Annual Evaluation

Goals Partially Met

- PI#10 (Children)This was met 3 out of 4 quarters. (pg.104)
- Performance Improvement Projects
  - 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 (pg.117)
  - PHQ-A Implementation (pg.118)
  - Decreasing Wait for Autism Services (pg.119)
- Behavior Treatment Review (Clinical Case Record Review) (pg. 109)
- HSAG Compliance (SFY 2024 Year 1 - 88% (CAP implementation). (pg.123)

Goals Not Evaluated (No data)

- ECHO Annual Satisfaction Surveys (Adult and Children)
- Wellness/MySrength
- PHQ-9

QAPIP Presentation

- The goals set forth in the 2023-2024 QAPIP Work Plan have reached a completion rate of 52.8%. This marks a decline compared to the completion rates noted in the previous fiscal year, indicating the need for a reassessment of strategies and efforts to ensure we meet our targets effectively. It is crucial to analyze the factors contributing to this decrease and implement measures that will help us improve progress moving forward.
- The objectives in the work plan that were not met or were partially met will be carried over to the work plan for FY 2024-2025. We will also continue with the goals that we achieved for continuous quality improvement.