Quality Improvement Steering Committee (QISC)
Tuesday, August 25, 2020
1:30 – 3:00 p.m.
Via BLUE JEAN PLATFORM
Agenda

I.	Welcome	T. Greason
II.	Introductions	T. Greason
III.	Approval of August 29, 2020 Agenda	Dr. Hudson-Collins/T. Greason
IV.	Approval of Minutes a. July 30, 2020	Dr. Hudson-Collins/T. Greason
V.	DWIHN Updates	Dr. Hudson-Collins/A. Siebert
VI.	NCQA Updates	Gail Parker
VII.	Managed Care Operations a. Annual Assessment of the Network Availability b. Annul Provider Survey Report	 Sharon Matthews June White
VIII.	IHC Data Sharing Care Coordination	Tina Forman
IX.	Diabetic Screening Guidelines	Alicia Oliver
X.	Performance Improvement Projects	Alicia Oliver

a. HSAG PIP: Improving Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using an Antipsychotic Medication

XI. Quality Improvement
- MMBPI Data Analysis (Quarter 1 & 2 FY 2019-20)
- New Indicator Reporting (Indicator 2a, 2b and 3)

XII. Home & Community Based Services (HCBS) — April Siebert
XIII. Adjournment

Quality Improvement Steering Committee (QISC)
Tuesday, August 25, 2020
1:30 p.m. – 3:00 p.m.
Via BLUE JEAN PLATFORM
Meeting Minutes
Note Taker: Aline Hedwood

Committee Chairs: Dr. Margaret Hudson-Collins, DWIHN Chief Medical Officer, and Tania Greason, Provider Network QI Administrator

Blue Jean Platform Members Present: Alicia Oliver, April Seibert, Chery Fregolle, Crystal Palmer, Darlene Owens, Ebony Reynolds, Fareeha Nadeem, June White, Justin Zeller, Lanetia Norris, Melissa Eldredge, Michele Vasconcellos, Ortheia Ward, Robert Spruce, Rosetsa Baker, Sharon Matthews Tania Greason, and Tina Forman.

Members Absent: Allison Lowery, Allison Smith, Angela Harris, Benjamin Jones, Bernard Hooper, Bill Hart, PHd, Carla Spight-Mackey, Dhannetta Brown, Donna Coulter, Donna Smith, Eric Doeh, Gail Parker, Jennifer Smith, Jesscia Collins, John Pascaretti, Judy Davis, Kau Gofan, Kimberly Floweres, Dr. Margaret Hudson-Collins, Mignon Strong, Nasr Doss, Sandy Ware, Shirley Hirsch, Stacie Bowens, Starlit Smith, Dr. Sue Banks, and Virdell Thomas.

Staff Present: April Seibert, Tania Greason, Fareeha Nadeem and Justin Zeller

1) Item: Welcome:

2) Item: Introduction: Tania asked the group to enter their names & email address in the chat box for attendance of the meeting.

3) Item: Approval of August 2020 Agenda: Approved by group

4) Item: Approval of July 2, 2020 Minutes: The July 2, 2020 minutes was approved by group. Final approval from Dr. Hudson-Collins will occur at the September 2020 scheduled meeting.

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

Decisions Made		
• DWIHN Covid-19 website is continually updated, providers are encouraged to continue and review. • The QISC Minutes for FY 2019/20 and FY 2018/19 are posted on DWIHN website under the QI/Provider Section. • DWIHN will be conducting AFC Homes COVID-19 testing for the residential homes staff and members on September 1 – 16, 2020, notifications have been submitted the CRSP providers.		
Discussion	**Assigned To**	**Deadline**
Action Items	**Assigned To**	**Deadline**

6) Item: SUD Increasing the Screening of Members at Risk for Opioid Abuse QIP – Darlene Owens
Goal: Review of Increasing the Screening of Members at Risk for Opioid Abuse QIP
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems ☐ Quality ☐ Workforce
NCQA Standard(s)/Element #: ☐ QI# ___ ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Decisions Made		
Darlene Owens provided an overview of the SUD Performance Improvement Project (PIP) "*Increasing the Screening of Members at Risk for Opioid Abuse*" Darlene discussed the rationale for the initiation of the project. In 2017 HHS announced 5-Point Strategy to combat the Opioid Crisis: 1. Improving access to treatment and recovery services; 2. Promoting use of overdose-reversing drugs; In response, DWIHN launched a Quality Improvement Project - Increasing in Number of Persons Revived with DWIHN Provided Naloxone Kits in Wayne County MI (Naloxone Project) - which utilized community education and distribution of Naloxone kits to promote the use of overdose-reversing drugs. Approximately 446 persons over a three-year period in Wayne County have been revived with a kit provided by DWIHN. An opportunity was identified to engage those revived in treatment. DWIHN HEDIS measures outcomes have declined or they have been pulled a different way in DWIHN IT system. DWIHN implemented several programs to address the overdose issue each year: DWIHN reviews these programs monthly. For additional information please review PowerPoint presentation **"Increasing the Screening of Members at Risk for Opioid Abuse QIP"** on the following below: Activity Selection and Methodology Rational Opioid Town Hall Meetings and Event Dates Barriers Identified Data/Results Tables 1. Analyze Cycle 2. Intervention Table		
Discussion	**Assigned To**	**Deadline**
Action Items	**Assigned To**	**Deadline**
Recommendations include continued review and reporting of identified barriers to the QISC. Dr. Hudson-Collins will be forwarded the PIP documentation for approval of continuation.	SUD Unit (D. Owens)	On-going

7) Item: NCQA Updates – Gail Parker

Goal: Update QISC of DWIHN's NCQA Reaccreditation Review

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

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

Decisions Made		
Gail Parker provided a NCQA update to the committee to include the following: • All supporting documentation is due to be uploaded to NCQA's IRT system by February 16th,2021. DWIHN will conduct a MOCK review in October of 2020. Documentation submitted to NCQA is based on a 2-3 year look back period and will include information from the QISC meetings demonstrating the evidence that DWIHN understands the Quality Improvement Projects (QIP) processes. • DWIHN appreciates the feedback from the QISC and encourage continued participation from the group to identify barriers and recommendations.		
Discussion	**Assigned To**	**Deadline**
Action Items	**Assigned To**	**Deadline**
None Required		

8a) Item: MCO Annual Assessment of the Network Availability – Sharon Matthews

Goal: Review of the Annual Assessment of the Network Availability

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

NCQA Standard(s)/Element #: X QI# 3 ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Decisions Made		
MCO is responsible for NCQA standard #QI 3 the focus of this standard is for DWIHN to maintain sufficient numbers and types of behavioral health practitioners within our provider network and monitor how effectively our network meets the needs and preference of our member served**.** Availability Assessment Findings for 2019 Performance Goal Not Met (30 minutes/30 miles) include the following: ○ Adult Psychiatrists – 81%/88% ○ Child Psychiatrists – 82%/71% ○ Clinical Psychologists – 81%/88% ○ Physician Assistants - 72%/65%		

For additional information please review PowerPoint "NCQA Standard QI 3 Availability of Practitioners and Providers on the following item below: 1) QI 3 Availability of Practitioners and Providers • Standard • Intent 2) QI 3 Required Measurements • Element A • Element B 3) Why MCO for QI 3 4) DWIHN's Network Adequacy Assessment Tools 5) Element B: DWIHN 's Availability Assessment Tools and Performance Standards 6) 2019 Geographic Distribution of Behavioral Health Practitioners Assessed by Practitioner Type 7) Availability Assessment Finding of 2019 Performance Goal Met 8) Next Steps		
Discussion	Assigned To	Deadline
Action Items	**Assigned To**	**Deadline**
Recommendations include continuation of review and analysis for recruitment efforts for the Adult/Child Psychiatrists, Clinical Psychologists and Physician Assistants. Dr. Hudson-Collins will be forwarded the QI #3 Annual Assessment of the Network Availability documentation for approval.	QISC	December 30, 2020

8b) Item: MCO Annual Provider Survey Report -June White
Goal: Review of Annual Provider Survey Report
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems **X Quality** ☐ Workforce
NCQA Standard(s)/Element #: X QI# 3 ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Decisions Made		
June White shared with the committee the FY 2019-20 MCO Provider/Practitioner Survey results. This survey was designed to measure how DWIHN is doing with our provider organizations and is administered annually. There is a fivefold purpose of the survey which include the following: 1. Measure DWIHN's effectiveness in meeting its contractual obligations to providers 2. Measure DWIHN's support of providers in meeting the needs of DWIHN members 3. Measure DWIHNs responsiveness to providers 4. Uncover gaps and/or deficiencies in DWIHN's operation 5. Identify opportunities for improvement and /or for corrective action The survey finding results scores that receive less than 85% will be reviewed by the QISC for recommendations. Some of the barriers and takeaways identified from the FY 19 survey are as follows: a. Low response rate b. No pre-notification or promotion of survey to providers c. No follow up on surveys not returned d. Length of survey (76 questions) e. Invalid email addresses (bounced back) For additional information please review PowerPoint **"FY 2019-20 Provider/Practitioner Survey Summary"** on the following items below: 1. Provider Survey Overview 2. Survey Composition & Distribution 3. Survey Response Rate 4. Survey Findings 5. Opportunities for Improvement		
Discussion	**Assigned To**	**Deadline**

Action Items	**Assigned To**	**Deadline**
Recommendations include that analysis and comparison for areas that score < 85% be reviewed for recommendations by the QISC. Final Report to be approved by committee and Dr. Hudson-Collins for recommendations.	MCO Unit (J. White)	December 30, 2020

9) Item: Diabetic Screening Guidelines – Alicia Oliver
Goal: Review of the Diabetic Screening Guidelines
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems ☐ Information Systems ☐ Workforce
NCQA Standard(s)/Element #: ☐ QI# ___ ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Decisions Made		
Alicia Oliver discussed with the committee the *Diabetic Screening Guidelines*. The guidelines were shared/emailed to each of the CRSP's organization's Quality Directors. The guidelines detail the eligibility criteria, screening for diabetes, treatment and follow-up and monitoring. These guidelines can be located on DWIHN's website. For additional information please review "DWIHN Clinical Practice Guidelines" located on DWIHN website under UM.		
Discussion	**Assigned To**	**Deadline**
Action Items	**Assigned To**	**Deadline**
None Required		

10) Item: HSAG PIP – Alicia Oliver

a. Improving Diabetes Screening for people with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medication

Goal: Review for recommendations of the Improving Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medication

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

NCQA Standard(s)/Element #: X QI# 10 ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Decisions Made		
Alicia Oliver reviewed with the committee the *Diabetes Screening for People with Schizophrenia or Bipolar Disorder* PIP. This PIP is selected by MDHHS/HSAG and has been submitted to HSAG for our 2nd remeasurement period. To date, HSAG has not submitted the final analysis/report. This PIP measures the percentage of members 18-64 years of age with schizophrenia or bipolar disorder who were dispensed an atypical antipsychotic medication and had a diabetes screening during the measurement year. DWIHN's IHC unit continues to work with our provider network for improving diabetes monitoring with people with schizophrenia and/or bipolar disorder. Through this committee and ranking priorities, it has been noted that potential needs and planned actions are required for improving the overall health and safety for our members. Interventions that received a # 1 priority ranking is due to the importance of educating our members and providers while improving the health, outcomes and coordination of members served. DWIHN saw a decrease in its HEDIS measure of Diabetes Screening for Schizophrenia and Bipolar Disorder members from 81.4% in 2018 to 76.9% in 2019. This is a 4.5 percentage point decrease. Interventions have been updated and will be brought to the QISC for continued review. For additional information please review handout **"QIP Improving *Diabetes Monitoring for people with Schizophrenia and/or Bipolar Disorder"*** *on the following items below:* 1. Measure 2. Screening Method 3. Goal 4. Interventions 5. Impact to Improvement 6. New Interventions to help achieve DWIHN goal		
Discussion	**Assigned To**	**Deadline**
Action Items	**Assigned To**	**Deadline**
Committee approval to continue PIP with updated interventions (Intervention progress and follow-up to be brought back to committee). Information submitted to Dr. Hudson-Collins for continuation.	IHC Unit (A. Oliver)	On-going

11) Item: Quality Improvement - Tania Greason & Justin Zeller (tabled)

a. MMBPI Data Analysis (Quarter 1 & 2 FY 2019-20)
b. New Indicator Reporting (Indicator 2a, 2b, and 3)

Goal:

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

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

Decisions Made		
Discussion	**Assigned To**	**Deadline**
Action Items	**Assigned To**	**Deadline**
Table to September 29th Meeting		

12) Item: Home and Community Based Services (HCBS) – April Siebert (tabled)

Goal:

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

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

Decisions Made		
Discussion	**Assigned To**	**Deadline**
Action Items	**Assigned To**	**Deadline**
Table to September 29th, 2020 Meeting		

Next QISC Meeting: Thursday September 29, 2020 Via **Blue Jean Platform**

Adjournment: 3:30 pm

ah10/05/2020