Detroit Wayne Integrated Health Network (DWIHN)
QAPIP FY2025 Annual Evaluation & FY2026 Work Plan

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Approved:

Approved by Quality Improvement Steering Committee (QISC)	**1/27/2026**
Approved by Program Compliance Committee (PCC)	**2/11/2026**
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Executive Summary

The Detroit Wayne Integrated Health Network (DWIHN) plays a vital 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 dedicated to offering a wide range of behavioral health care and support services to individuals and families in need.

A key aspect of DWIHN's operations is the Quality Assessment Performance Improvement Plan (QAPIP) Evaluation. This comprehensive annual document evaluates the effectiveness of DWIHN's services, measures progress over the year and assesses overall outcomes against the goals outlined in the Annual Work Plan for Fiscal Year 2025. The QAPIP Evaluation not only highlights successes but also identifies areas for improvement, ensuring that DWIHN continues to enhance the quality of care it provides to the community.

Through systematic assessment and ongoing improvement efforts, DWIHN aims to meet the evolving mental health needs of its population while adhering to best practices in service delivery.

Description of Service Area

Wayne County, Michigan's most populous county, is an important region encompassing 34 cities and 9 townships. It covers 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, is 645,705 residents, according to data from the U.S. Census Bureau released in May 2025. This figure represents a notable increase from previous years, ranking Detroit as the 26th largest city in the United States. This population growth highlights ongoing trends in urban demographics, which can affect various services and resources. Throughout this evaluation, the populations of individuals receiving services through DWIHN will be referred to by a specific abbreviation to ensure 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 FY2025, DWIHN provided essential services to 78,835 unique members, demonstrating the organization's commitment to meeting the diverse needs of the community. A significant portion of those served, specifically 48,725 individuals, accounted for 61.80% of the total and received support through Medicaid funding. Additionally, 19,472 members, or 24.70%, accessed services funded by the Healthy Michigan Plan, highlighting the importance of these funding sources in promoting health and wellness among vulnerable populations.

In FY2025, 13,460 members, approximately 17.07%, received support from the General Fund. Additionally, 7,415 individuals (9.41%) benefited from the Substance Use Disorder (SUD) Block Grant, while 4,605 individuals (5.84%) received care through MI Health Link. Furthermore, 1,385 individuals (1.76%) received assistance through State Disability Assistance (SDA), and 1,123 members (1.42%) used the Habilitation Supports Waiver.

The report indicated that 44,261 adults (56.14%) were living with a Serious Mental Illness (SMI) in FY2025, showing a slight decrease of 0.75% from the previous year. Alongside this, 10,783 individuals (13.68%) reported experiencing Serious Emotional Disturbance (SED), and 15,970 individuals (20.26%) identified as having Intellectual and Developmental Disabilities (IDD). An estimated 1,498 members (1.90%) dealt with substance use disorder (SUD), while 2,344 individuals (2.96%) reported mental health issues without further specification.

Notably, the category of individuals with co-occurring disorders totaled 3,655, and there were 281 cases (0.36%) that were classified as unreported. This signifies a slight increase of 0.09% in unreported disability designations compared to the prior year. Demographically, among those served, 45,162 individuals (57.29%) identified as African American, showing strong representation from this community. The Caucasian population comprised 22,478 individuals (28.51%), while the remaining 14.20% consisted of individuals from various racial and ethnic backgrounds, including those identified as having two or more races, unreported, Asian, American Indian, Native Hawaiian, and Alaskan.

Among age demographics, the largest group served was individuals aged 22 to 50 years, totaling 34,770 (44.10%). Of this group, 19,399 individuals (24.61%) were in the 0-17 age bracket, highlighting the continued need for services for younger populations. Additionally, 14,089 individuals (17.87%) fell within the 51-64 age range. Notably, the population aged 65 and over experienced a slight increase, with a total of 6,725 individuals (8.53%) served in FY2025, indicating demographic shifts and the ongoing necessity for targeted support for older adults.

Overall, these statistics reflect the wide range of services provided by DWIHN and underscore the ongoing need for tailored interventions to address the complex and varied challenges faced by these underserved populations.

Data for this report was gathered on December 29, 2025.

Customer Pillar
Member Experience with Services
ECHO Annual Satisfaction Surveys (Adult and Children)
At DWIHN, we recognize that Member Experience is shaped by every interaction a member has within our care system. We strive to ensure that each engagement—whether it's a beneficiary's first phone call to our access center or a visit to their long-term care provider—is positive, supportive, and welcoming. We are committed to actively listening to our members, documenting their feedback, and analyzing their experiences.

We believe that proactively fostering a positive experience is crucial for building trust and achieving better clinical outcomes for our members. It is our responsibility to make their health journey as smooth as possible. When members feel heard, they become active participants in their own health care, which enhances their recovery and overall quality of life.

DWIHN places great value on the data and feedback we receive from our members. We aim to gain a deeper understanding of their experiences as they navigate our care system. In our analysis, we consider how one individual's experience may negatively or unproductively affect others. While we are ready to address the personal issues our members face, we also focus on developing systemic solutions.

At every level of care, DWIHN prioritizes resolving issues quickly, combining compassion with data-driven strategies in our problem-solving approach. Key insights from our staff analysis are shared with a multi-disciplinary team, which then formulates recommendations for the Quality Improvement Steering Committee (QISC). This committee comprises both internal and external members, including a clinical panel of providers, peers, and family members. The discussions surrounding the collected data help us identify immediate interventions and develop Quality Improvement Plans (QIPs), which are then approved by the Improvement Planning Leadership Team (IPLT).

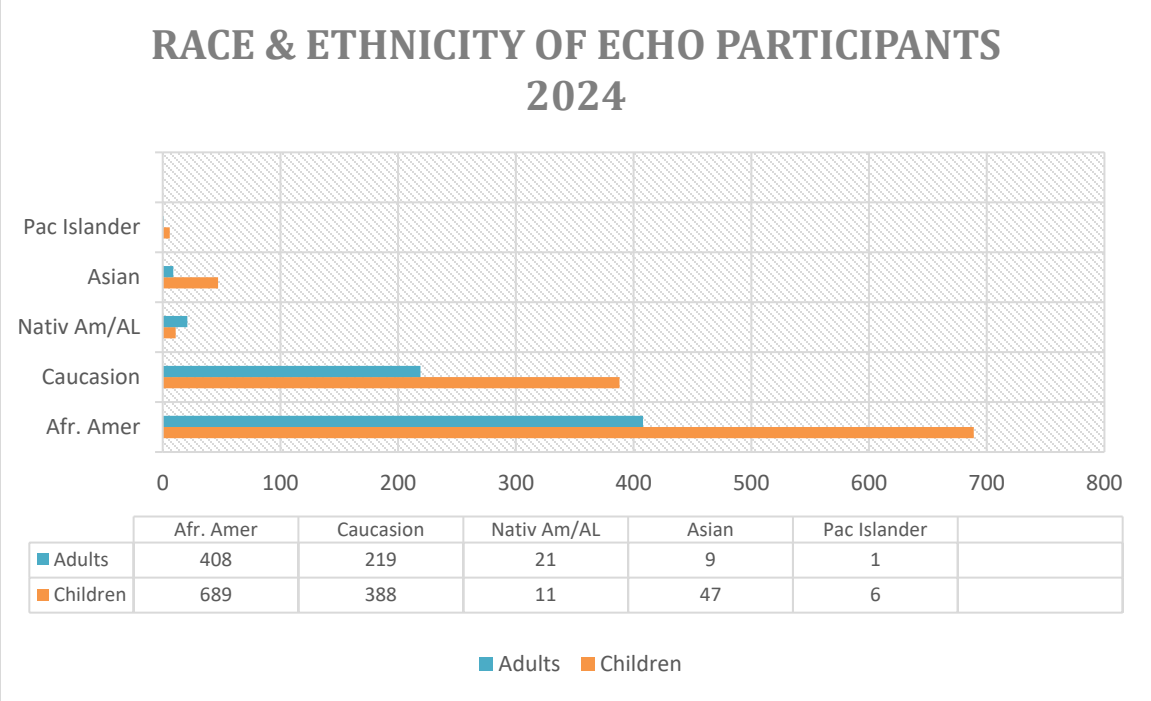
This ongoing process fosters a culture of proactive quality care that emphasizes Continuous Quality Improvement (CQI) as standard practice. By using surveys and various data-collection methods to define issues, DWIHN demonstrates adaptability and resilience, continually assessing our strengths and learning from our solutions.

Quantitative Analysis and Trending of Measures
Surveying members annually is one of the measures DWIHN uses to ensure our system of care meets established goals and standards. Since 2017, DWIHN has used the ECHO® Survey (Experience of Care & Health Outcomes) for adults. Additionally, we began using the ECHO® Children/Families version to measure satisfaction separately in 2020. The ECHO® survey is approved by the National Committee for Quality Assurance (NCQA) and was developed by the Agency for Healthcare Research and Quality (AHRQ). It is one of the leading national surveys specifically designed for Behavioral Managed Care Organizations.

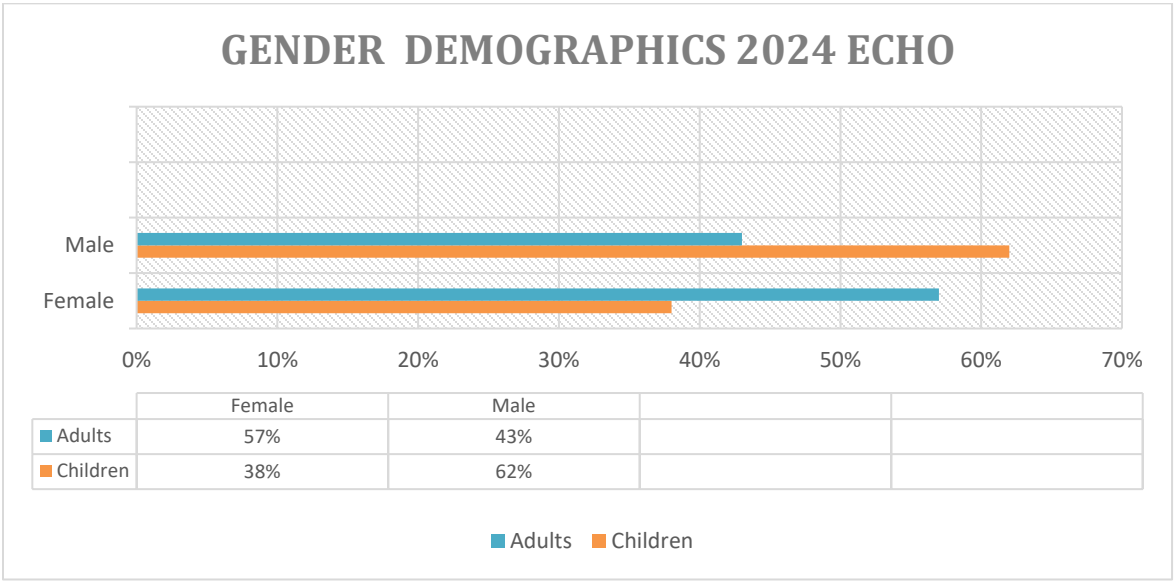
By administering the ECHO survey annually, DWIHN gains valuable insights into how we are advancing the system and identifying areas that need improvement to enhance the overall care experience for participants. This survey is a mission-critical and mandatory function of our operations and accreditation. The charts below provide a snapshot of the data collected over the past three years, contributing to a comprehensive review of our members' experiences. This review provides DWIHN staff with insights into beneficiaries' satisfaction with key performance indicators. We will continue to administer the ECHO® survey annually; however, results from the 2025 survey have not yet been completed.

Evaluation of Effectiveness

In 2024, a random sample of potential respondents was provided to our confidential partners at Wayne State University's (WSU) School of Urban Planning. A third-party team from WSU administered two ECHO® surveys to our member community. Important demographic information about respondents from both the Children and Adult Surveys is detailed in the graphs below, which depict the represented races and ethnicities and gender.

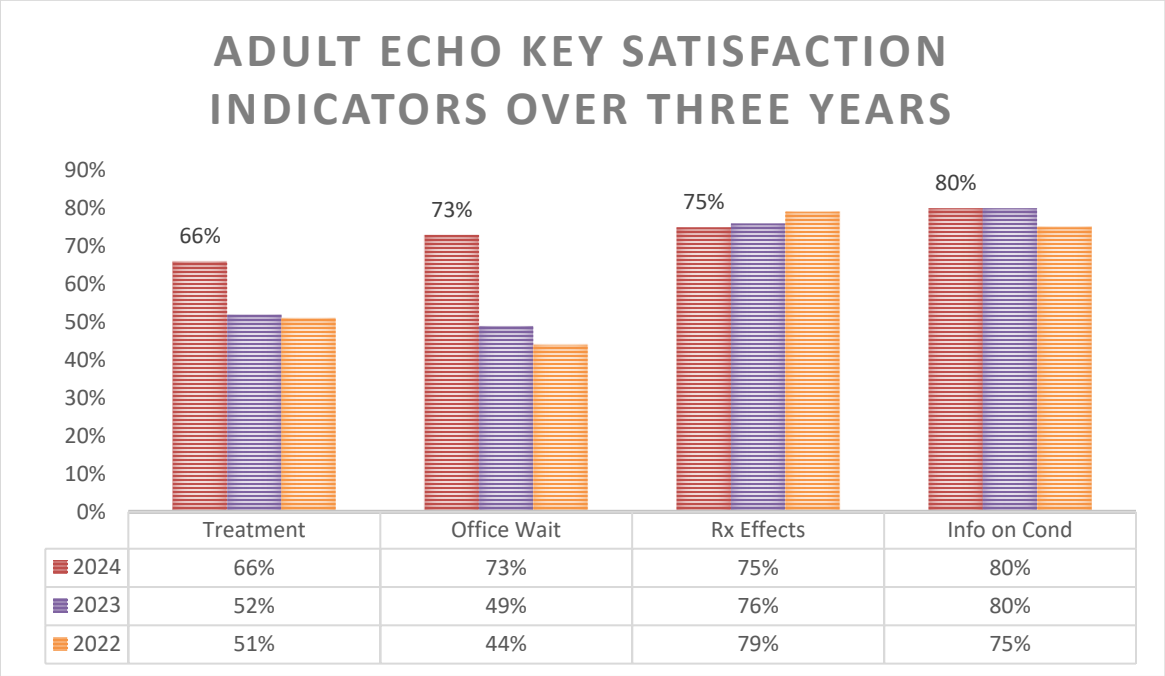


	Afr. Amer	Caucasion	Nativ Am/AL	Asian	Pac Islander
Adults	408	219	21	9	1
Children	689	388	11	47	6



	Female	Male		
Adults	57%	43%		
Children	38%	62%		

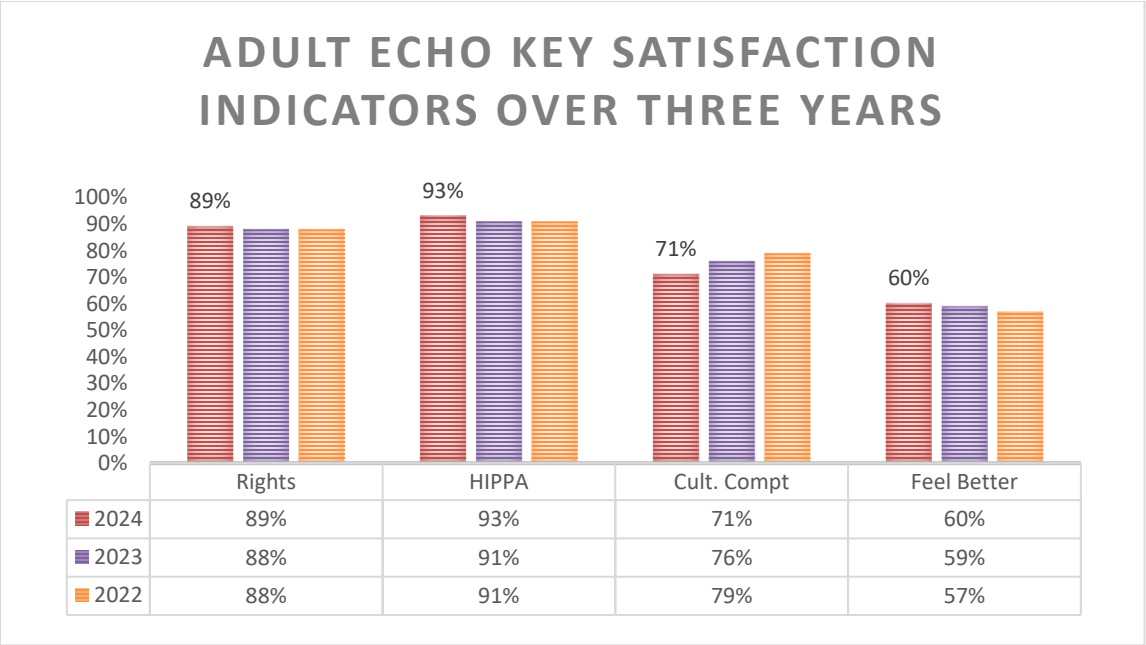
The charts below provide a summary of key indicators measured over the past three years among adult respondents. These measures reflect positive progress in improving the system, thanks to the collaborative efforts of DWIHN and practitioners and providers who deliver care within it.



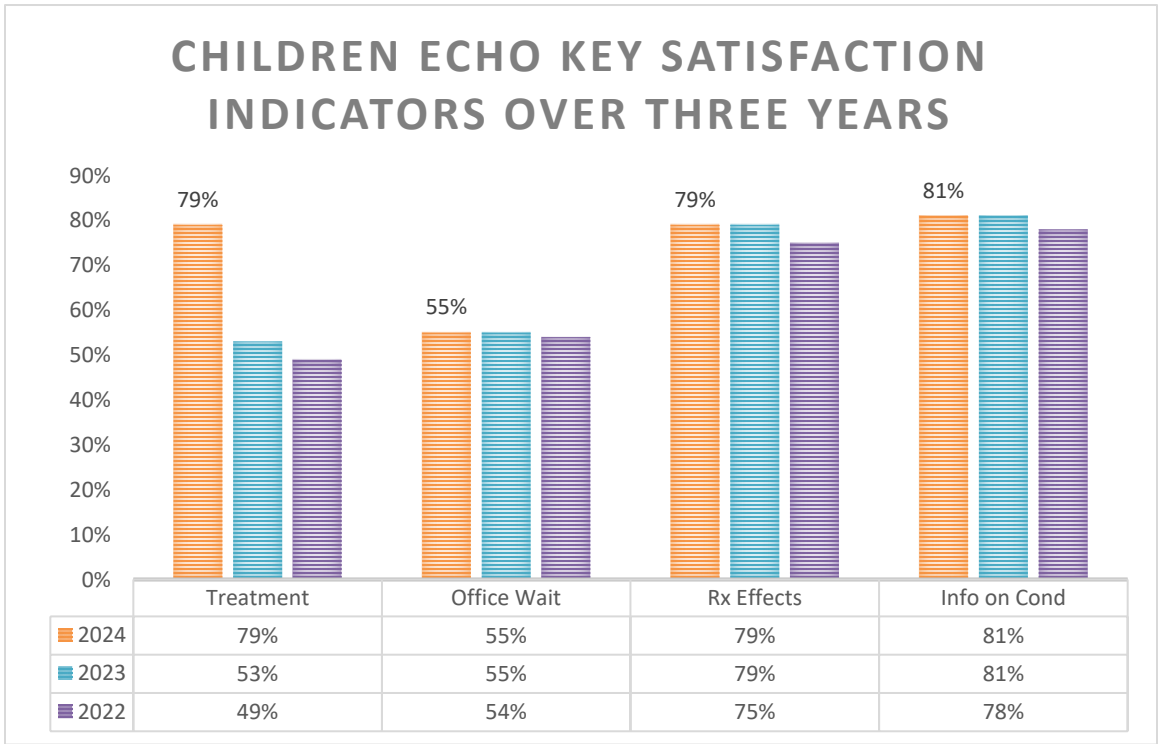
	Treatment	Office Wait	Rx Effects	Info on Cond
2024	66%	73%	75%	80%
2023	52%	49%	76%	80%
2022	51%	44%	79%	75%

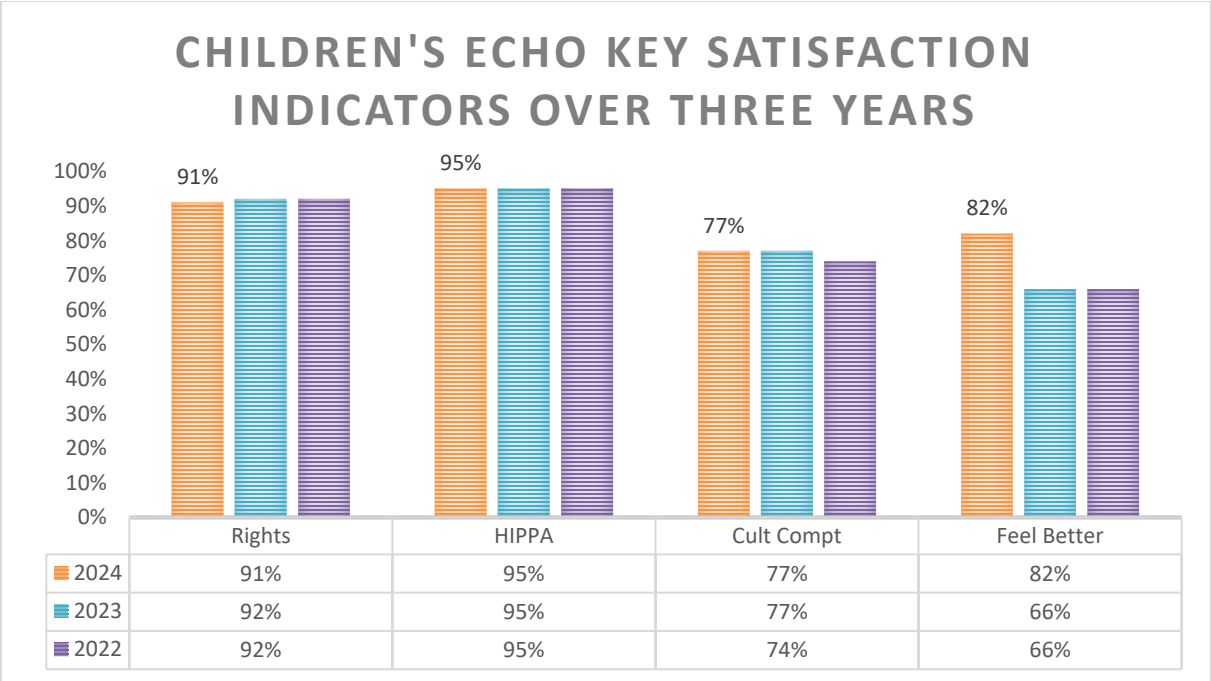
The chart also shows the percentage of global ratings from 2022 and 2023. In 2024, the ratings will specifically focus on the following areas: Treatment Options, Wait Times with Providers, Explanation of Prescription Effects (including a thorough explanation of the effects of prescribed medications), and Information on how members can manage or obtain details regarding their condition. Overall, satisfaction across these key indicators increased by 37%.

A total of 728 adult members responded to the 2024 survey, with satisfaction percentages ranging from 60% to 93%. DWIHN aims to improve every measure to achieve a satisfaction rate of at least 85%. The key indicators below represent satisfaction rates from adult respondents in four specific categories: understanding their rights (column 1, left to right), satisfaction with privacy (HIPAA), satisfaction with cultural competency, and perceptions of improvement, indicating how many respondents feel better now than they did 12 months prior to the survey. The percentages from 2023 and 2022 reflect overall ratings from previous ECHO results. Over the past three years, satisfaction has increased slightly, averaging 78%.



The Children's ECHO® respondents are primarily parents or guardians responsible for the healthcare recovery journey of participants under 18. In 2024, 1,394 respondents contributed to this dataset. DWIHN has prepared an additional analysis of the outcomes, showing a slight improvement in the experiences of children and families over the past three years.





The two Children's Satisfaction Charts above provide a quick overview of satisfaction results regarding Overall Treatment (Chart C), wait times with providers, the effects of medication, and whether parents feel informed about their children's conditions or diagnoses. Chart D is similarly structured to Adult Chart B, reflecting data percentages related to Understanding Rights, confidence in Privacy (HIPAA), Cultural Competency, and parents' perceived improvement in their children compared to the previous 12 months.

DWIHN's Member Experience staff, along with the quality team and other clinical personnel, analyze incoming data to identify trends. This analysis enables us to recommend and implement systemic interventions and Quality Improvement Plans (QIPs) that aim to correct and enhance the system. During the period represented in 2024, the following issues were highlighted as opportunities for improvement.

OPPORTUNITIES FOR IMPROVING THE ADULT MEMBER EXPERIENCE DERIVING FROM THE 2024 ECHO® SURVEY

- Explore treatment options with members through service providers to ensure that all applicable programs are identified and appropriate for their care.
- Provide increased opportunities for independent facilitation to assist with treatment planning.
- Collaborate with providers to better identify barriers that members may face in obtaining quicker treatment.
- Recommend Clubhouse services to all members and take advantage of Medicaid Spenddown grant opportunities.
- Continue researching subgroups to gain insights into the disparities related to gender, age, and race, to identify additional factors contributing to discrepancies among males.
- Launch a population health study to examine other factors related to the social determinants of health.

OPPORTUNITIES FOR IMPROVING CHILDREN & FAMILY EXPERIENCE DERIVING FROM THE 2024 ECHO® SURVEY

- Ensure that parents are informed before treatment and receive updates afterward regarding each next step in their child's care.
- Involve parents more in clinical assessments through person-centered plans, allowing them to see the actual improvements made alongside the clinical assessment.
- Conduct further surveys to assess the cultural needs of each family member, identifying areas related to religion, language, or other services that could be offered.
- Enhance the information provided to parents about the effects of prescription medications and their impact. Consider scheduling follow-up calls at 7, 21, and 60 days to address any concerns about the prescribed treatments.

Provider and Practitioner Satisfaction Survey
Evaluation of Effectiveness

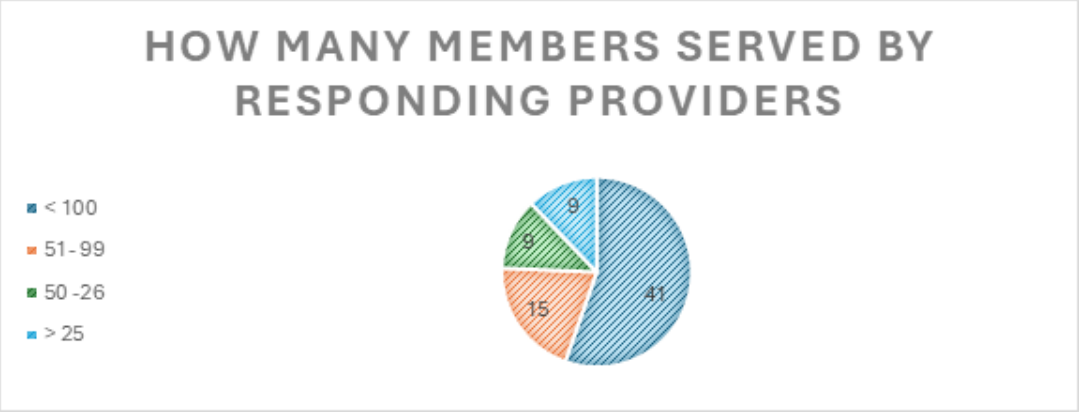
Effective provider network management is a key objective of the Detroit Wayne Integrated Health Network (DWIHN). We are placing strong emphasis on high-performing Value-Based Care to promote efficiency rather than on service volume alone. It is essential that we reward providers based on outcomes and ensure that our providers and practitioners feel supported, as this is fundamental to our sustainability and continued growth.

In 2025, DWIHN began discussions on how to enhance engagement with our network providers through active collaboration, a more assertive approach to workforce training, recruitment, and retention, and improved communication. We are prioritizing the quality of treatment and services while improving overall network efficiency. Additionally, we are focusing on interoperability, standardizing technologies, ensuring cybersecurity, and enhancing system adequacy to reduce risks. The fiscal year 2025 emphasized leadership, stewardship, and professionalism, with a commitment to proactively engage providers with purpose and intent to improve network management.

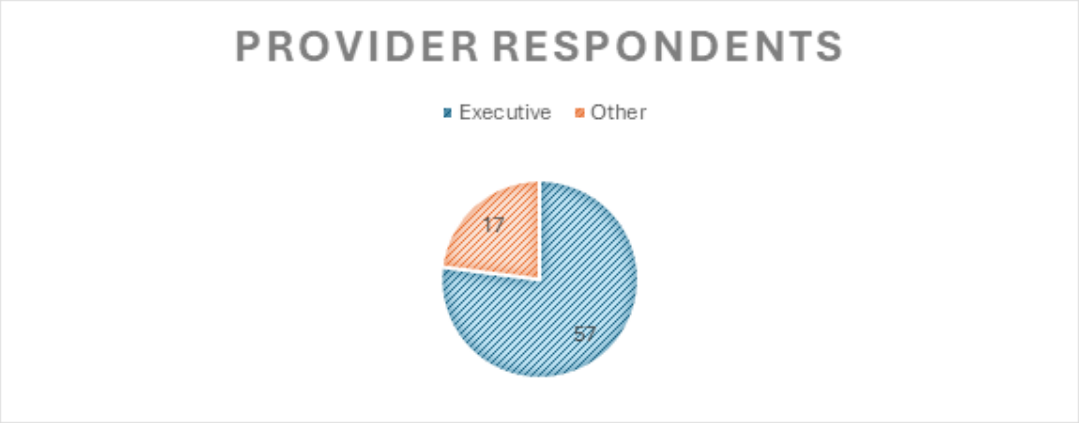
At the end of the 2024 fiscal year, we distributed 237 surveys to DWIHN contracted providers, achieving a response rate of 31% (74 responses). We decided to use this data as a foundation for improving our relationship with providers. We carefully reviewed and analyzed overall operational performance and efficiency items to identify trends and opportunities. To enhance our network management, we concentrated on three critical areas that needed attention. These three key measures are:

- Accessibility of DWIHN Staff
- Knowledge of DWIHN Staff
- Communications from DWIHN Staff

Most respondents to the 2024 survey were from larger providers serving more than 100 members, accounting for 55% of the total. Most respondents identified themselves as executive-level staff, specifically as CEOs, COOs, or Directors. Additionally, 17 respondents identified as managers, clinicians, or held other roles. Overall, the respondents were considered knowledgeable about the Detroit Wayne Integrated Health Network (DWIHN) and its internal workings.



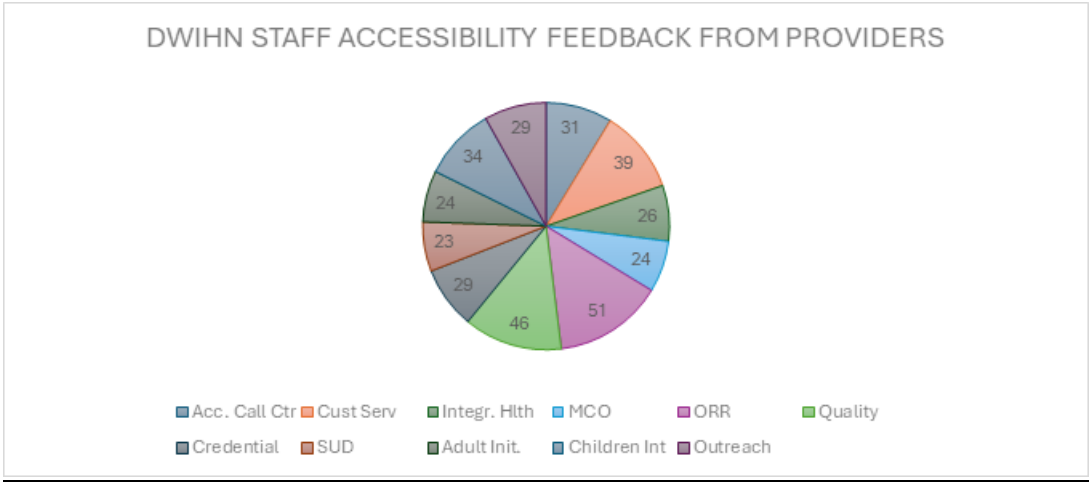
The providers highlighted in the darker shade of blue have over 100 members. Next, the respondents represented in orange, who serve between 51 and 99 members, account for 15-20%. The remaining two categories, each representing 9% and 12%, serve between 26 and 50 members or fewer than 25 members, respectively.



57% of service provider respondents reported their roles as executive level, as indicated in the pie chart above.

Accessibility: Improving DWIHN staff's accessibility as a resource for providers is critically important. Being available to answer questions or resolve issues helps bridge the gap between administrative needs and clinical outcomes. This accessibility allows our system to focus on supporting members, thereby reducing frustration, burnout, and administrative burdens. The availability of DWIHN staff fosters a well-informed, efficient, secure, and high-quality system of care.

The pie chart below shows feedback from 74 respondents on the accessibility of DWIHN staff by department, rated as good, very good, or excellent. Notably, the Office of Recipient Rights (ORR) staff received the highest rating, with 51 out of 69% (plum color), followed by the Quality Department at 46 out of 62% (bright green). Additionally, the 2024 survey has provided baseline data for setting goals and standards in three focus areas.

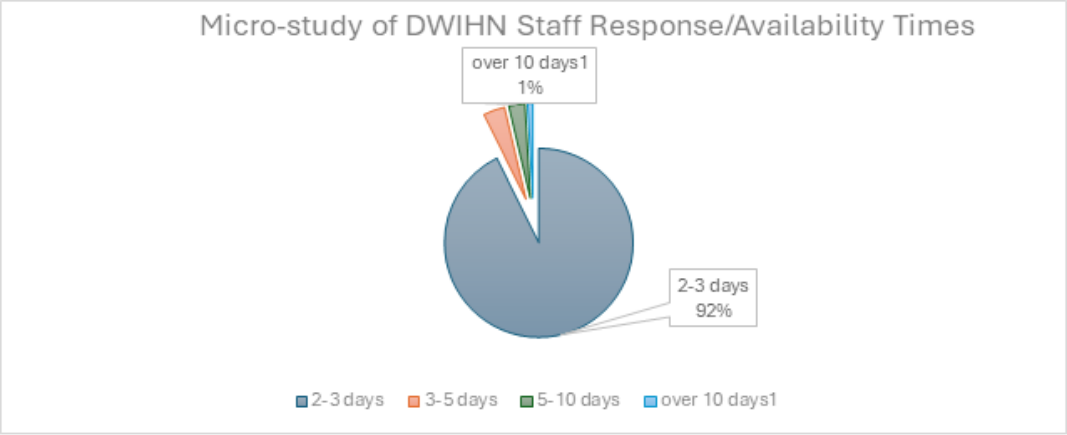


Opportunities: Corrective Interventions were pursued in every aspect of the organization to emphasize the availability and responsiveness of staff and departments, including the following:

- Improvements to our telephone Genesys system will include identifying phone numbers/extensions for all staff. If a call is not answered, the system will use bounce-back features, directing calls to Customer Service for follow-up or allowing CS staff to send an email to notify the staff members.
- We will implement standardized signature closures that provide all network participants with information about a person's title, working hours, email, phone number, and cell number when applicable.
- We will issue 24 cell phones to [insert number] employees to enhance accessibility.

- A Rapid Response System will be established, featuring a messaging center that, when answered, will forward inquiries via email to the appropriate department for timely responses and follow-ups.
- We will launch a trial study on embedded email surveys to assess response times.
- There will be an increase in staff in-office time and adjustments to office hour policies in a hybrid model following the COVID-19 pandemic.

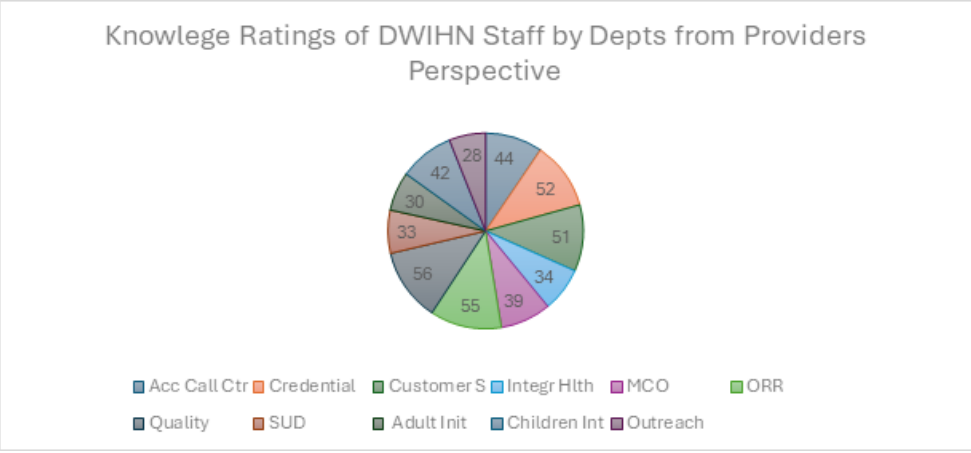
While some improvements are still being assessed, data indicate that the response time and staff accessibility in one department have improved. According to the pie chart below, providers reported greater availability of DWIHN staff.



Improvements in network management were achieved through a survey process that allowed DWIHN providers to rate the services of the Managed Care Operations (MCO) team. This micro-study involved training and staff recognition, which helped identify opportunities for improvement. Through this study, DWIHN leadership enabled staff to enhance their response times and availability. Of the 109 participating providers, 101 (92%) reported that the availability and accessibility of DWIHN staff were optimized. Monitoring these aspects, along with managing workloads, identifying bottlenecks, and encouraging senior staff to address complex issues, contributed to improved productivity and staff availability. DWIHN is considering expanding the use of this responsiveness measurement tool to monitor and evaluate the satisfaction and responsiveness of other departments in FY 2026. Ongoing efforts to build provider relationships and satisfaction through accountability processes are continuously being assessed.

A knowledgeable workforce is crucial to the operations of DWIHN. Service providers depend on our staff for information and expertise, which helps enhance their performance, mitigate risks, and safeguard the needs of the members they serve. Knowledge plays a vital role in quality assurance, ensuring smooth workflows, secure data management, informed clinical monitoring, and effective decision-making. It is a strategic priority to keep our staff well-informed and prepared regarding training, regulatory, and accreditation standards and requirements. When staff are knowledgeable, collaboration improves, innovation is fostered, and the system becomes more member-centric. A staple of this effort is ensuring workforce training and development, alongside finding better ways to share relevant operational information among all staff.

The 2024 Provider Survey established a baseline for assessing how well providers felt that our DWIHN team possessed the necessary knowledge in their respective areas of expertise across departments.



The pie chart above illustrates the feedback from 74 respondents on the knowledge of DWIHN staff by department. A total of 28 respondents rated the staff as "very good" or "excellent." Among the departments, the Quality Improvement department received the highest ratings, with 56 respondents (75%) indicating that the team's expertise was "very good" or better. This was followed by the ORR Department, where 74% of providers shared a similar sentiment. The Credentialing department received a rating of 70%, and Customer Service was viewed positively by 68% of respondents, with a total of 51 individuals rating their expertise as "very good" or better.

Opportunities: The DWIHN team aimed to create potential adjustments to enhance knowledge-based feedback. This approach is designed to equip staff with the tools needed to address issues or concerns that may arise within the provider network.

- In 2025, DWIHN reviewed all online training modules, updating and revising them to ensure the information remains current and incorporating capacity for new content.
- DWIHN combined online training with in-person sessions and increased independent self-study programs through Mastery program apps.
- Resources for technology integration training were provided, focusing on best practices and the development of AI tools and other applications to improve work productivity and risk stratification.
- A workforce leadership training program was introduced for mid-management candidates, aimed at succession planning and helping to identify and support individual staff strengths and weaknesses to prepare future leaders.
- Key competencies were emphasized, leading to the introduction of merit-based performance raises for staff who excel in their areas of expertise.
- Support for advanced degree preparation was offered, including tuition reimbursement increases for formal degrees among peers.
- Mentorship opportunities were established between clinicians and Certified Peer Support Specialists (CPSS), along with training for managers overseeing CPSS team members.
- A focus on data analytics was implemented to help staff become familiar with interdisciplinary collaboration and to utilize data for evidence-based decision-making and policies, thereby enhancing the system's organization and efficiency.
- Staff training included awareness of health equity and recognition of social determinants contributing to health disparities and the root causes of recidivism.
- Technical assistance was offered to providers without penalty if training was needed.
- Staff were trained to recognize risk probabilities or trends with struggling providers, aiming to prevent crises or service disruptions through improved communication and the use of risk matrices.

While some metrics and measures for these opportunities have not yet been fully implemented, DWIHN has established a workforce development strategy that outlines the necessary next steps to improve the professional care team employed by DWIHN. Building a knowledge consortium within and across departments is a key aspect of these fundamental and incremental steps toward achieving world-class efficiency.

DWIHN prioritizes ensuring that qualifications, credentialing, ethical codes, and regulatory standards are met, as well as compliance with NCQA accreditation standards and the Joint Commission's provisions. This commitment aims to enhance organizational management and care.

In FY 2026, we will reveal improvements in these benchmark achievements, which will better serve our provider network with valuable knowledge and professional acumen that is often overlooked in the public sector.

The final core baseline for developing a more robust network management system and, consequently, achieving higher satisfaction rankings from our service providers will focus on how DWIHN staff communicate with these providers.

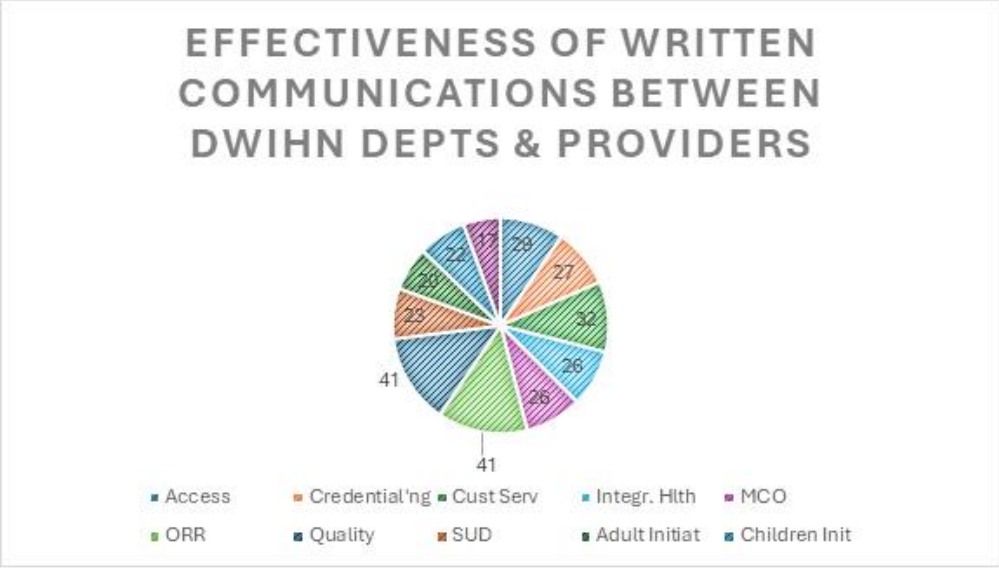
Communication: A strong and relevant communications strategy is essential for any business or organization. A well-crafted plan should be accessible to both internal staff and stakeholders. It is crucial to ensure clear, concise, and timely responses, especially for network providers who need to stay informed and engaged in key decisions and information that may impact the delivery of services or care.

In addition to keeping providers informed, effective communication helps us deliver seamless care and improve transitions, preventing errors and misunderstandings. DWIHN recognizes that no tool is more powerful than a clear, shared allocation of information for crisis management, public notices, or emergencies. This addresses the complexities of regulations, policies, problems, and barriers that could otherwise lead to confusion or systemic failures.

Effective communication streamlines operations, saves time, and conserves energy. DWIHN understands that successful written communication, supported by a framework that emphasizes clarity, timeliness, and accuracy, will yield tangible business benefits between network providers and the organization. The new CEO of DWIHN, who joined us in 2025, has strongly emphasized the need to enhance communication with our providers at all levels.

To begin this process, DWIHN reviewed the status of how communications are perceived between our providers and different operating departments within the organization.

The effectiveness of written communication among departments in DWIHN, as indicated by the 2024 Provider survey, is illustrated in the pie chart below.



The question posed to network providers was about how they would rate the overall timeliness of written communications regarding policies, processes, changes, updates, requests, concerns, and other notices. While the number of respondents (N) for this question was 60 rather than 74, it is evident that the ORR and Quality Improvement departments significantly outperformed most other departments. In fact, 68% of respondents felt that their respective departments provided good or better communication.

Customer Service achieved a rating of 53% for good or better communications, followed by the Access Call Center at 48%, Credentialing at 45%, MCO and Integrated Health at 44%, SUD at 38%, Children's Initiatives at 36%, and Adult Initiatives just below 35%. Additionally, 14 participants in the overall survey did not respond to this question.

Understanding the metrics for improving communication is critical for building stronger alignment and trust between the DWIHN team and the network of practitioners and administrators. Effective connection and communication are essential for providing high-quality care, whether it involves ensuring that an individual member's health journey is complete or impacting the entire network. Concise and effective communication help avoid misinterpretations and promotes a strong business strategy.

Opportunities*:* Our CEO is leading in impactful interventions to enhance communication between DWIHN departments. We will leverage every available tool to create a plain language framework that fosters collaboration and cultivates work environments that support a culture of excellence. The following steps are planned for the 2026 and 2027 fiscal years:

- Increased Staff Development: Focus on promoting soft skills such as active listening, empathy training, plain language reinforcement, and teach-back programs (e.g., the LEAD program).
- Supplementing Verbal Communication: Provide clearly written materials and visual aids to support verbal information (MCO continues to enhance its Quarterly Newsletter for providers).
- Leveraging Digital Tools: Utilize the provider portal and other secure digital messaging tools for fast and monitored communication by DWIHN.
- Addressing Individual Provider Needs: Offer personalized in-person technical assistance, gather data, and provide ongoing training.
- Improved Coordination: Enhance cross-department monitoring and auditing processes.
- Reissuing the Communications Plan: Update DWIHN's overall communications strategy to promote effective communication behaviors throughout the organization.
- Organizational-Wide Provider Meetings: Increase the frequency of meetings to engage all DWIHN staff.
- Utilizing the Communications Unit: Help departments overcome communication barriers with support from the Communications team.
- Fostering Collaboration: Work with MCO as the lead to establish clear channels for urgent information or changes.
- Employing a Mass Notification System: Ensure widespread distribution of important information to providers.
- Tailoring Messaging Systems: Customize communication methods to easily identify specific provider groups for targeted messaging.
- Updating Communication Methods: Develop systematic approaches for maintaining and updating email and communication systems.
- Embedding Cultural Literacy: Integrate opportunities for cultural literacy into all communication strategies.
- Allocating Time for Changes: Allow sufficient time for the adoption of new policies and provide appropriate training for adjustments.
- Encouraging Feedback Loops: Create channels for open communication between providers and DWIHN.
- Using Surveys for Improvement: Continue utilizing the Provider Survey and other methods to better understand and enhance communication efforts.

Ensuring that DWIHN staff are accessible, knowledgeable, and able to communicate with succinct, timely professionalism is a key focus in building a strong provider network. At DWIHN, we continue to support the issuance of routine Provider Satisfaction Surveys. However, in 2025, our team aims to develop a more effective method to uncover the underlying issues that may act as barriers or create challenges for providers working within our network.

We are committed to identifying these issues and exploring further questions to dig deeper and find sustainable solutions that enhance network performance. Our goal is to eliminate unnecessary bureaucracy and burdens that may impact providers. We will use survey data and commit to employing additional tools and processes to strengthen our network's infrastructure, ultimately enabling us to better serve our intended beneficiaries.

Member Grievance and Appeals

DWIHN's Due Process unit plays a crucial role in analyzing trends and occurrences related to member experiences by conducting a thorough review of Grievance and Appeals data. This review is not done in isolation; instead, it is integrated with other agency-wide data to create a comprehensive understanding of member interactions and experiences. Customer Service ensures that members have access to their rights to due process. This due process includes Complaints, Grievances, Appeals, Access to Mediation, and State Fair Hearings.

Quantitative Analysis and Trending of Measures

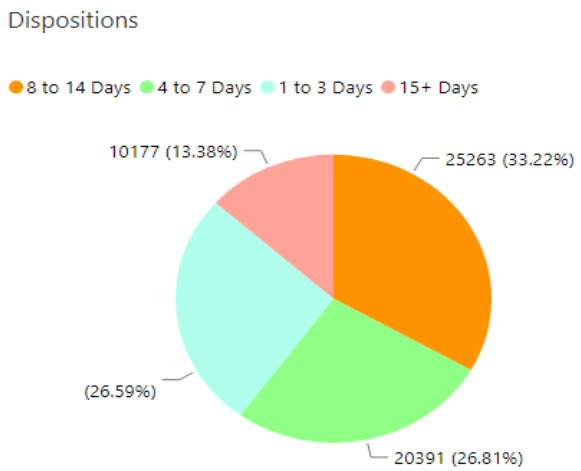
In FY25, the Complaint and Grievance Unit recorded 3,729 complaints, reflecting ongoing engagement by members and providers in addressing service concerns. Additionally, 79 formal grievances were received during the fiscal year, of which 50 were successfully resolved within established timelines. This resolution rate demonstrates a strong commitment to timely and effective grievance management, though opportunities remain to further reduce resolution time and enhance member satisfaction. Trending analysis indicates that while the overall volume of complaints remains consistent with prior years, the proportion of grievances escalated to formal review has remained relatively low, suggesting that early intervention and informal resolution strategies are effective. A qualitative review of grievance themes highlights recurring issues in service accessibility and communication gaps, underscoring the need for targeted provider education and improved member outreach.

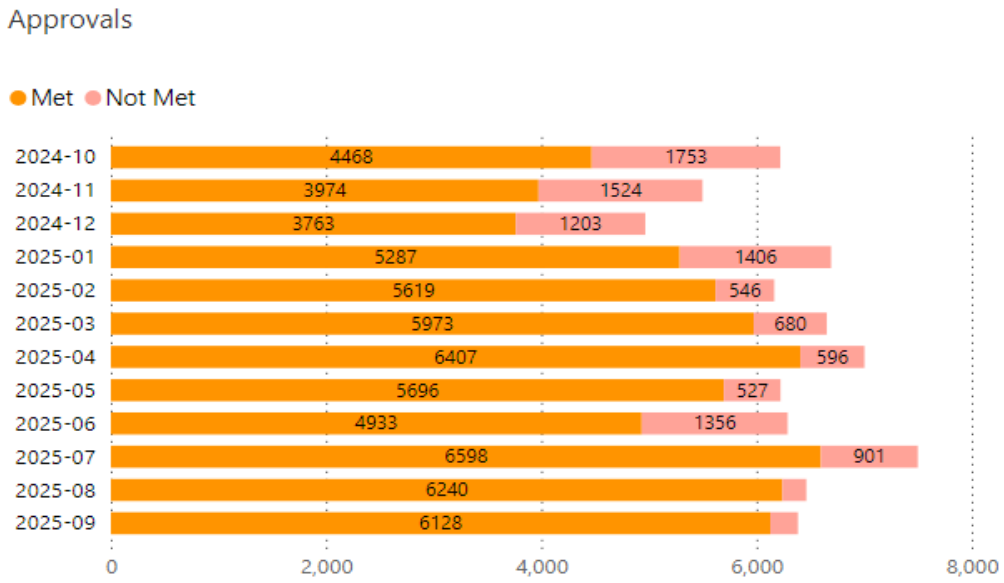
Opportunities for Improvement

- As we move forward, our recommended actions include implementing a root cause analysis process for frequently occurring complaint categories, improving the tracking of resolution timelines, and using member feedback to guide quality improvement initiatives aimed at reducing the recurrence of complaints and enhancing the overall experience.
- DWIHN is committed to significantly expanding our collaborations with community partners to better support our most vulnerable populations. Our goal is to improve the health and safety of our members through innovative services and strategic partnerships that cater to their unique needs.
- To ensure that both our members and providers are well-informed about the grievance process, we will continue enhancing our training program. This program will emphasize the importance of effective communication and customer service within our provider network. It will systematically address interpersonal challenges and provide resources to help resolve these issues.
- We will assess the need for specialized training programs to address the specific interpersonal and customer service challenges faced by the populations we serve. In partnership with the Member Engagement division, we will launch a series of initiatives to increase outreach and education. These initiatives will include advocacy programs, the development of peer support networks, and surveys to gather and analyze member experiences.

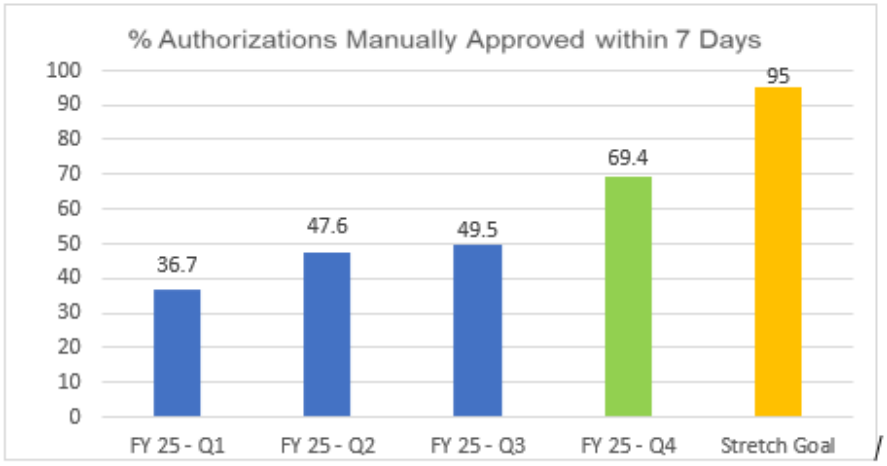
Timeliness of Utilization Decisions within 14 calendar days
Quantitative Analysis and Trending of Measures

The timeliness of utilization decisions is critical to reducing delays in care and minimizing administrative burdens for both providers and members. The charts below provide an overview of monthly trends in the manual approval of standard, non-urgent authorization requests, measured against compliance with the 14-day standard. Throughout FY25, the Utilization Management (UM) Department implemented several key initiatives to enhance consistency and quality in the approval process. These included updating standard operating procedures, revising departmental policies to align with best practices, and leveraging technology solutions to streamline communication with providers. These improvements have contributed to greater efficiency, reduced turnaround times, and improved provider satisfaction, ensuring that members receive timely access to necessary services.





The department also tracked the percentage of authorizations that were manually approved within seven days.



***Data does not include Residential Services authorizations*

Opportunities for Improvement

Moving forward, sustaining these gains will require continued investment in automation tools, ongoing staff training, and proactive monitoring of compliance metrics. Additionally, effective January 1, 2026, the state has shortened the timeframe for prior authorization decisions from 14 calendar days to 7 days for standard requests and from 72 hours to 48 hours for expedited requests. To meet these new requirements, the UM Department will prioritize workflow optimization, implement real-time tracking systems, and strengthen provider engagement strategies to ensure timely and accurate decision-making under the revised standards.

Practice Guidelines

DWIHN adopts clinical practice guidelines based on extensive evidence and adheres to nationally recognized standards of care. These guidelines are specifically designed to meet the diverse needs of the individuals and communities we serve. Each year, our guidelines undergo a comprehensive review process, during which they are meticulously evaluated and approved by the Chief Medical Officer and the Associate Vice President of Clinical Services. This ensures that they remain current and effective.

To support this ongoing improvement process, the Improving Practices Leadership Team (IPLT) holds regular meetings where members discuss potential updates, approve revisions, and strategize on how to effectively disseminate these important guidelines throughout 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 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 intended to provide comprehensive guidance to healthcare practitioners for managing common behavioral health disorders. The primary objective is to present promising practices alongside evidence-based recommendations to support clinicians in delivering high-quality care. This includes accurate screening and assessment processes, tailored treatment options, and continuous care tailored to the unique needs of individuals facing psychiatric and behavioral health challenges. The guidelines emphasize the importance of correct diagnosis and align treatment recommendations with the specific requirements of each member. While these guidelines serve as a valuable framework, they are meant to complement, not replace, healthcare providers' clinical judgment.

To ensure effective implementation of these guidelines, the Detroit Wayne Integrated Health Network (DWIHN) will monitor its provider network through a robust oversight approach. This includes thorough clinical evaluations, quality assurance measures, compliance audits, and utilization management to confirm that the guidelines are properly followed. The primary goal of this oversight is to ensure the safety and well-being of individuals receiving care, thereby preventing any harm that may result from the application of these clinical practice guidelines. Furthermore, DWIHN is committed to ensuring that these guidelines are applied in accordance with 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, to align care practices with the best interests of those served.
This holistic approach aims to create an environment that fosters effective treatment, respects individual rights, and promotes optimal health outcomes.

During Fiscal Year 2024, DWIHN collaborated with Vital Data to enhance the HEDIS Scorecard, a vital tool that provides comprehensive performance metrics for all Clinically Responsible Service Providers (CRSPs), Medicaid Health Plans, and Integrated Care Organizations within the network. This scorecard enables stakeholders to assess their performance both collectively and individually, utilizing a framework based on established alignment measures. In this latest update, DWIHN has incorporated new performance measures specifically for Certified Community Behavioral Health Clinics (CCBHC), Substance Use Disorder Health Homes (SUDHH), and Behavioral Health Homes (BHH). These additions not only broaden the scope of the Scorecard but also enable a more targeted assessment of how well these specialized services deliver care. The Scorecard features an extensive data set dating back to 2019, allowing stakeholders to identify long-term trends and areas for improvement.

This historical perspective is essential for informing strategic planning and resource allocation. The database supporting the Scorecard contains detailed information that underpins the claims data displayed. It includes critical elements such as member diagnoses, prescribed medications (Rx), physician details for each claim, and identified care gaps requiring attention. 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 platform's capabilities.

Identified Barriers and Interventions
The implementation of clinical practice guidelines is often complicated by the significant time needed to thoroughly review their content. Many practitioners struggle to find enough time for this critical evaluation due to staffing shortages, extensive documentation requirements, and various training obligations imposed by their organizations.

To address these challenges and enhance implementation, organizations could benefit from adopting one or two selected guidelines that closely align with their specific service delivery goals. By narrowing their focus, practitioners can allocate time and resources more effectively.

Furthermore, conducting research on the latest publications from credible sources, such as peer-reviewed journals or recognized health organizations, will help practitioners stay informed about the most current evidence-based practices. This approach not only meets the PIHP's requirements for demonstrating that clinical guidelines are developed with valuable provider feedback but also empowers practitioners to engage in continuous learning. Ultimately, by prioritizing evidence-based practices, organizations can enhance the quality of care they provide, resulting in improved outcomes for their clients.

Access Pillar

Mission Michigan-Based Performance Indicators (MMBPI)

Beginning in January 2026, the Michigan Mission-Based Performance Indicators (MMBPI) system will start a phased discontinuation. However, Indicator #2a, which measures Access and First Request Timeliness, will continue to be used. The Michigan Department of Health and Human Services (MDHHS) has developed a comprehensive three-year quality improvement plan to systematically evaluate all Prepaid Inpatient Health Plans (PIHPs). This evaluation will utilize 11 distinct Healthcare Effectiveness Data and Information Set (HEDIS) measures to assess various aspects of healthcare delivery and member outcomes. The goal of this initiative is to enhance the quality of services provided to individuals by accessing mental health and substance use disorder treatments within Michigan's healthcare system. Below are the MMBPI reporting data for Fiscal Year 2025.

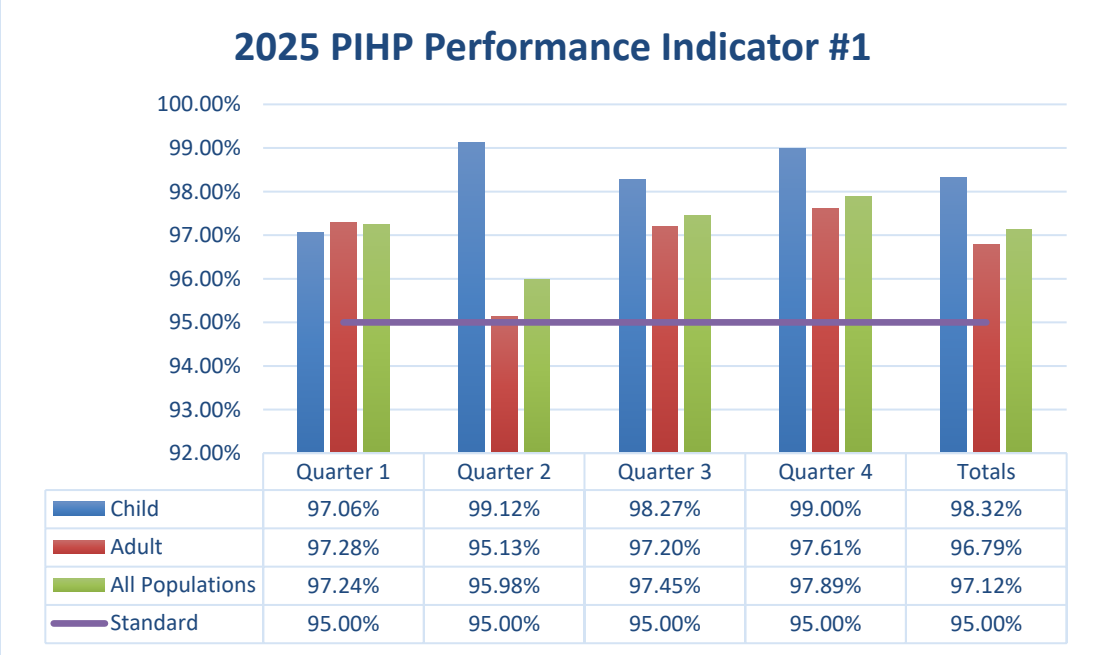
Qualitative Analysis and Trending of Measures Indicator

#1- Pre-Admission Screening within 3 hours

The percentage of persons during FY2025 receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.

Goal: Attain and maintain performance standards as set by the MDHHS contract. Standard 95% or above.

Results: All populations have met the FY2025 standards, achieving a total population rate of 97.32%, which is 0.2 percentage points higher than last year.



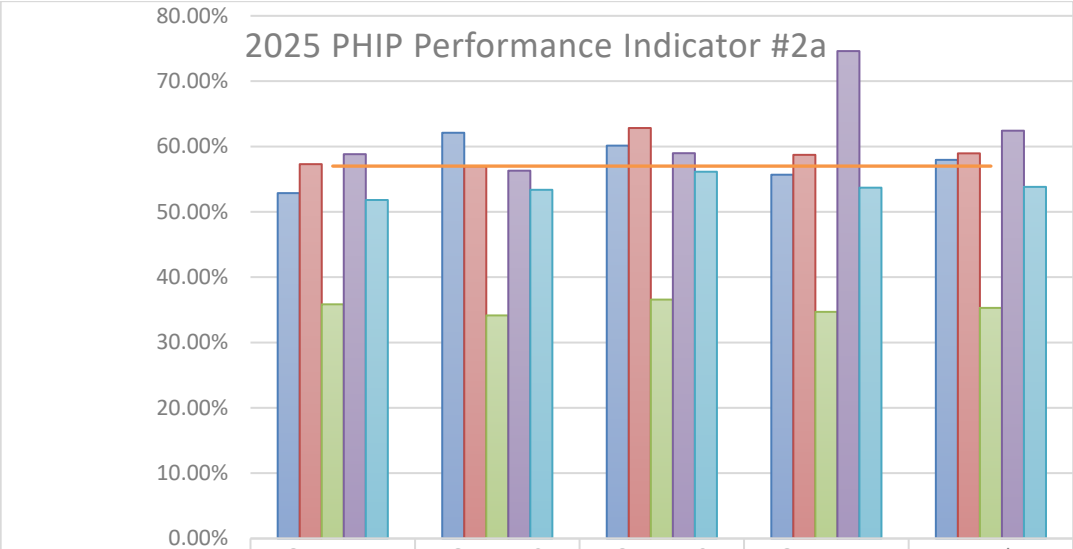
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Totals
Child	97.06%	99.12%	98.27%	99.00%	98.32%
Adult	97.28%	95.13%	97.20%	97.61%	96.79%
All Populations	97.24%	95.98%	97.45%	97.89%	97.12%
Standard	95.00%	95.00%	95.00%	95.00%	95.00%

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: Attain and maintain performance standards as set by the MDHHS contract. The goal for FY2024 is 57.0%.

Results: In Q1, the rate was 51.81%. Q2 increased to 53.37%, Q3 rose to 56.14%, and Q4 dropped to 53.70%. The total population rate increased slightly to 53.82% in FY2025, up from 53.23% the previous year.



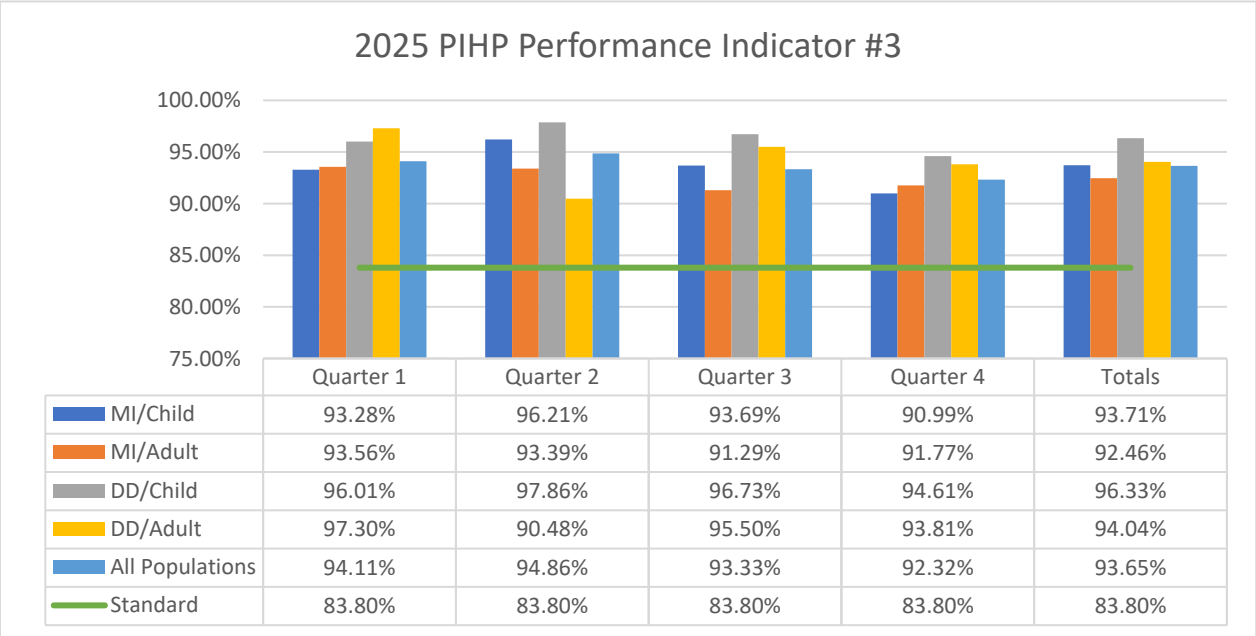
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Totals
MI/Child	52.86%	62.10%	60.13%	55.68%	57.95%
MI/Adult	57.30%	56.97%	62.82%	58.72%	58.95%
DD/Child	35.84%	34.14%	36.57%	34.69%	35.30%
DD/Adult	58.82%	56.30%	58.97%	74.60%	62.42%
All Populations	51.81%	53.37%	56.14%	53.70%	53.82%
Standard	57%	57%	57%	57%	57%

Indicator #3- Access/1st Service Timeliness

The percentage of persons during FY2024 who needed ongoing service within 14 days of a complete non-emergent biopsychosocial assessment.

Goal: Attain and maintain performance standards as set by the MDHHS contract. FY2024 standard is 83.8%.

Results: Q1 (94.11%), Q2 (94.86%), Q3 (93.33%), and Q4 (92.32%) indicate an overall population rate of 93.65%, which is 3.48 percentage points higher than last year's rate of 90.17%.



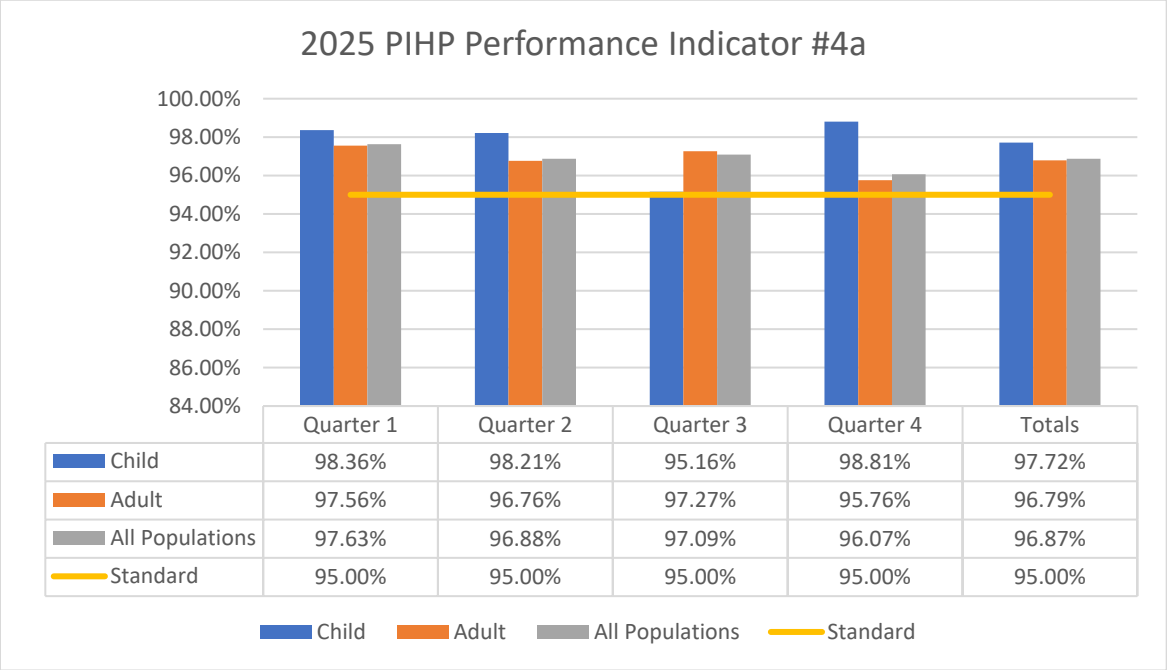
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Totals
MI/Child	93.28%	96.21%	93.69%	90.99%	93.71%
MI/Adult	93.56%	93.39%	91.29%	91.77%	92.46%
DD/Child	96.01%	97.86%	96.73%	94.61%	96.33%
DD/Adult	97.30%	90.48%	95.50%	93.81%	94.04%
All Populations	94.11%	94.86%	93.33%	92.32%	93.65%
Standard	83.80%	83.80%	83.80%	83.80%	83.80%

Indicator #4a- Hospital Discharge Follow-Up

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

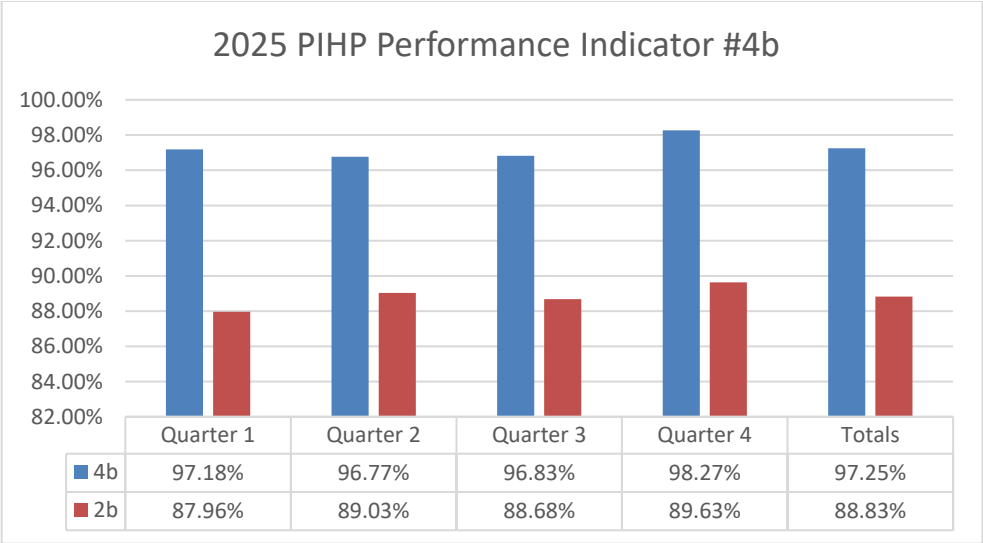
Goal: Attain and maintain performance standards as set by the MDHHS contract. Standard 95% or above.

Results: All population groups successfully met the performance standard for the fiscal year 2025, achieving a rate of 96.87%. This result is consistent with the previous fiscal year, 2024, when the performance was slightly higher at 98.25%. This stability reflects a consistent level of achievement among the evaluated populations.



	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Totals
Child	98.36%	98.21%	95.16%	98.81%	97.72%
Adult	97.56%	96.76%	97.27%	95.76%	96.79%
All Populations	97.63%	96.88%	97.09%	96.07%	96.87%
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 received follow-up care within 7 days.
Goal: Attain and maintain performance standards as set by the MDHHS contract. Standard 95% or above.
Results: All populations met the FY2025 standards, resulting in a total population rate of 97.25% for that fiscal year.



	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Totals
4b	97.18%	96.77%	96.83%	98.27%	97.25%
2b	87.96%	89.03%	88.68%	89.63%	88.83%

Identified Barriers to Achieving Performance Indicator Goals:
Substance Use Disorder (SUD) - % of Persons Requesting a Service Who Received Treatment or Support Within 14 Days
To address the barriers to achieving the performance indicator goal related to substance use disorder (SUD), specifically the percentage of individuals requesting a service who received treatment or support within 14 days, it is important to consider several key factors:

Public Awareness: 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 help bridge this gap.

Interventions to Improve Rates: To enhance the performance indicator for SUD and effectively utilize the Mental Health and Wellness Information Network (MHWIN) system, several interventions have been implemented. Technical assistance sessions and collaboration with the Detroit Wayne Integrated Health Network (DWIHN) have been provided to ensure that service providers are informed about the performance indicator goals, understand how to achieve them, and are equipped with best practices. Moreover, SUD has been sending weekly reports to remind providers of the importance of performance indicators and keep them engaged in the process. Regular feedback and coaching are also provided to help providers understand their performance, identify areas for improvement, and develop action plans to address any deficiencies.

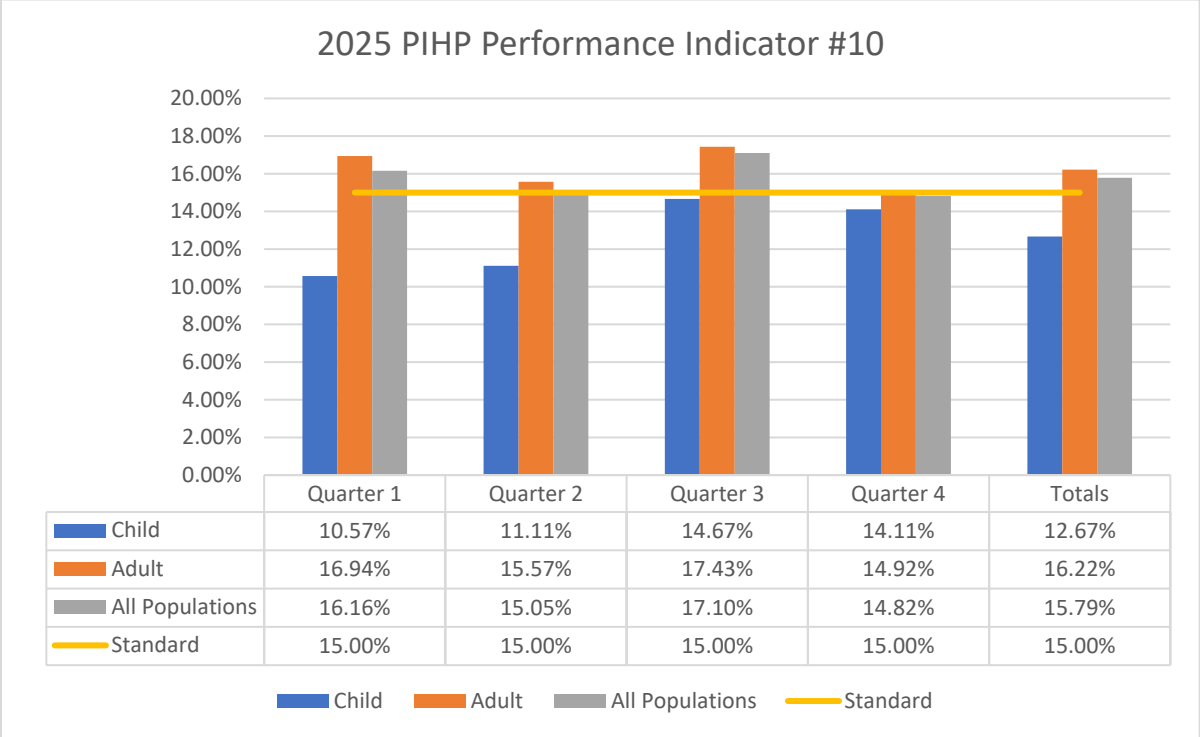
Measuring Interventions: To assess the impact of these interventions, SUD has conducted a series of before-and-after comparisons of the reports generated and sent to providers. Specifically, SUD compared the performance indicators before and after implementing the interventions, utilizing both monthly and quarterly reports. By analyzing the changes in performance indicators over time, we gained valuable insights into the effectiveness of these interventions.

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: Attain and maintain performance standards as set by the MDHHS contract. Standard 15% or below.

Results: The child population remained below the 15% threshold each quarter in FY25. However, the adult population was above the standard, except for Q4, which was 14.82%. The total population rate for the year was 15.79%.



	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Totals
Child	10.57%	11.11%	14.67%	14.11%	12.67%
Adult	16.94%	15.57%	17.43%	14.92%	16.22%
All Populations	16.16%	15.05%	17.10%	14.82%	15.79%
Standard	15.00%	15.00%	15.00%	15.00%	15.00%

Evaluation of Effectiveness

DWIHN consistently met the performance criteria for each quarter in FY2025 across several key indicators: PI#1 (Children and Adults), PI#3 (Mental Illness in Children and Adults, Intellectual and Developmental Disabilities in Children and Adults), and PI#4a (Children and Adults). For PI#1, DWIHN achieved an impressive overall rate of 97.12% for conducting pre-admission psychiatric inpatient care screenings within three hours of a service request. This high level of efficiency is largely attributed to the dedication of DWIHN's Crisis and Access team, which collaborates closely with various crisis service providers to ensure the timely completion of these screenings.

As the demand for crisis services continues to grow, DWIHN's progress in FY2025 positions the organization to expand its integrated approaches, leverage technology, and strengthen provider alignment in FY2026. These efforts aim to reduce risks, improve recovery outcomes, and ensure that no member in crisis falls through the cracks.

Performance Indicator 2a

In 2025, the DWIHN reported a population rate of 53.82% for Performance Indicator #2a (PI #2a). Although this figure did not meet the organization's targets, it is important to note that PI #2's overall performance showed consistent improvement throughout FY2025. Analyzing the rates for populations under PI #2 yielded the following results:

- The rate for children with mental illness (MI/children) was reported at 55.68% for Q4, reflecting an increase of 2.82 percentage points compared to Q1's rate of 52.86%. This indicates a positive trend in service delivery for children experiencing mental illness.
- The rate for adults with mental illness (MI/adults) was 58.72% for Q4, representing a slight increase of 1.42 percentage points from Q1's rate of 57.30%. This modest rise suggests progress in enhancing service delivery for adults affected by mental illness.
- The rate for children with intellectual and developmental disabilities (IDD/children) in Q4 was 34.69%, showing a slight decrease of 1.15 percentage points from Q1's rate of 35.84%. Although this downward trend indicates a need for ongoing monitoring, it also suggests potential improvements in outcomes for children with IDD.
- In contrast, the IDD/adult rate was reported at 74.60% for Q4, demonstrating a significant increase of 15.78 percentage points from Q1's rate of 58.82%. This indicates strong progress in enhancing services for adults with intellectual and developmental disabilities.
- Lastly, the total population rate for PI #2 reached 53.70% in Q4, up 1.89 percentage points from Q1's 51.81%. This overall improvement reflects DWIHN's commitment to monitoring and elevating the quality of services provided to its diverse population.

Performance Indicator 10

In FY25, the recidivism performance indicator for children consistently met the MDHHS benchmark of 15% across all four quarters. This achievement demonstrates strong adherence to state standards and effective interventions to reduce repeat service episodes among youth. The sustained performance reflects the success of targeted strategies, including early engagement, family-centered care planning, and coordination with community resources.

In contrast, adult recidivism did not meet the 15% criterion in three of the four quarters, suggesting a need to improve continuity of adult care and follow-up practices. Trending analysis shows that while children's recidivism rates have remained stable and compliant, adult rates exhibit variability, which may be linked to gaps in post-discharge support and engagement.

Recommended actions include implementing enhanced transition planning for adults, expanding peer support programs, and utilizing predictive analytics to identify individuals at higher risk of readmission. Continued monitoring and quarterly reviews will be essential to ensure progress toward meeting MDHHS standards for both populations.

Indicator 10: Percentage who had a Re-Admission to Psychiatric Unit within 30 Days	Population	2024				2025			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Children	8.62%	8.82%	15.69%	12.14%	10.57%	11.11%	14.67%	14.11%
	Adults	17.58%	16.65%	17.62%	16.52%	16.94%	15.57%	17.43%	14.92%
	Total	16.79%	15.97%	17.36%	16.04%	15.05%	17.10%	14.82%	15.79%

Evaluation of Effectiveness

DWIHN's Recidivism Workgroup, in conjunction with the 45-day provider meetings, has played a critical role in improving strategies to reduce recidivism across the network. These collaborative forums have facilitated data-driven discussions, identified high-risk patterns, and implemented targeted interventions to strengthen continuity of care. By engaging providers in regular reviews of member progress and discharge planning, the workgroup has promoted accountability and early intervention practices that help prevent unnecessary readmissions. Additionally, these meetings have supported the alignment of provider workflows with MDHHS standards, ensuring that both adult and child populations receive timely follow-up and community-based support. Moving forward, the workgroup will continue to leverage performance data and provide feedback to refine strategies, enhance care coordination, and sustain reductions in recidivism rates.

The DWIHN Crisis Services Department has played a vital role in identifying and supporting individuals who undergo crisis assessments and demonstrate patterns of readmission. By leveraging real-time data and close coordination with providers, the department ensures that high-risk individuals receive timely follow-up care, linkage to community-based resources, and individualized support plans to reduce repeat crises. This proactive approach not only addresses immediate behavioral health needs but also contributes to long-term stability and improved member outcomes. Qualitative analysis indicates that early intervention and consistent engagement are key drivers of readmission prevention. To strengthen these efforts, recommended actions include: (1) expanding predictive analytics to flag members at elevated risk for crisis recurrence, (2) enhancing collaboration with outpatient providers to ensure seamless transitions post-crisis, (3) increasing access to peer support and wraparound services, and (4) implementing a standardized post-crisis follow-up protocol to monitor progress and reinforce engagement.

Identified Barriers

Despite these advancements, DWIHN continues to face ongoing network challenges related to workforce shortages, which have particularly impacted services for the child population. Limited availability of qualified providers has constrained access to timely care and placed additional strain on existing resources, leading to longer wait times and reduced capacity for specialized interventions. To address these challenges, DWIHN has implemented a financial incentive program designed to improve staff recruitment and retention. This initiative aims to attract qualified professionals into critical service areas and encourage long-term commitment by offering competitive compensation and retention bonuses. These efforts, combined with targeted recruitment strategies, expanded training programs, and telehealth solutions, are expected to strengthen workforce capacity and ensure sustainable improvements in service delivery for children. Financial Incentives by Quarter for FY2025:

- 1st Quarter: 25 payments totaling $854,372
    - $452,156 awarded to AMI providers
    - $219,401 awarded to SED providers
    - $182,815 awarded to IDD providers
- 2nd Quarter: 23 payments totaling $999,992
    - $588,036 awarded to AMI providers
    - $273,276 awarded to SED providers
    - $138,680 awarded to IDD providers
- 3rd Quarter:25 payments totaling $1,004,950
    - $570,959 awarded to AMI providers
    - $262,340 awarded to SED providers
    - $171,651 awarded to IDD providers

The Children's Initiatives Department at DWIHN has implemented several strategic measures to enhance care coordination with local hospitals and Clinically Responsible Service Providers (CRSP). A significant development occurred in 2024 when the Children's Director announced the addition of two new providers to the CRSP network. This initiative was introduced to address ongoing staffing issues affecting service delivery across the system.

In response to growing concerns about transportation barriers faced by members seeking services, DWIHN launched a new intervention in 2024. To improve access to care, DWIHN partnered with two transportation providers to offer non-emergency transportation services across the network. This program enables members to attend essential appointments, including medical visits, outpatient behavioral health meetings, and follow-up care after hospital discharge. Members must submit their transportation requests at least 48 hours before the service is needed. The program officially began in the fourth quarter of FY2023 and was announced in a memo released in October 2024 to inform stakeholders about this new initiative.

Opportunities for Improvement

The Quality Team will continue to monitor all performance indicators to ensure ongoing compliance and improvement, even though reporting to the state will no longer be required, except for Indicator 2a: Access Timeliness/First Request. This continued oversight reflects our commitment to maintaining high standards of care and operational excellence. Moving forward, the focus will shift toward the 12 HEDIS measures, which will be tracked and analyzed over a three-year period. This strategic emphasis on HEDIS will allow for deeper insights into clinical quality, member experience, and health outcomes, positioning the organization to drive measurable improvements and align with national benchmarks.

Complex Case Management (CCM)

DWIHN utilizes various tools to evaluate the effectiveness of the Care Coordination and Management (CCM) program, ensuring improved outcomes for the members served. The organization utilizes evidence-based assessment tools, including the PHQ-9, PHQ-A, and WHO-DAS. These assessments are conducted at the beginning of CCM services and continue every 30 days during the members' participation in the program. Additionally, DWIHN provides a Satisfaction Survey to all members who have been enrolled for at least 60 days upon the completion of their CCM services.

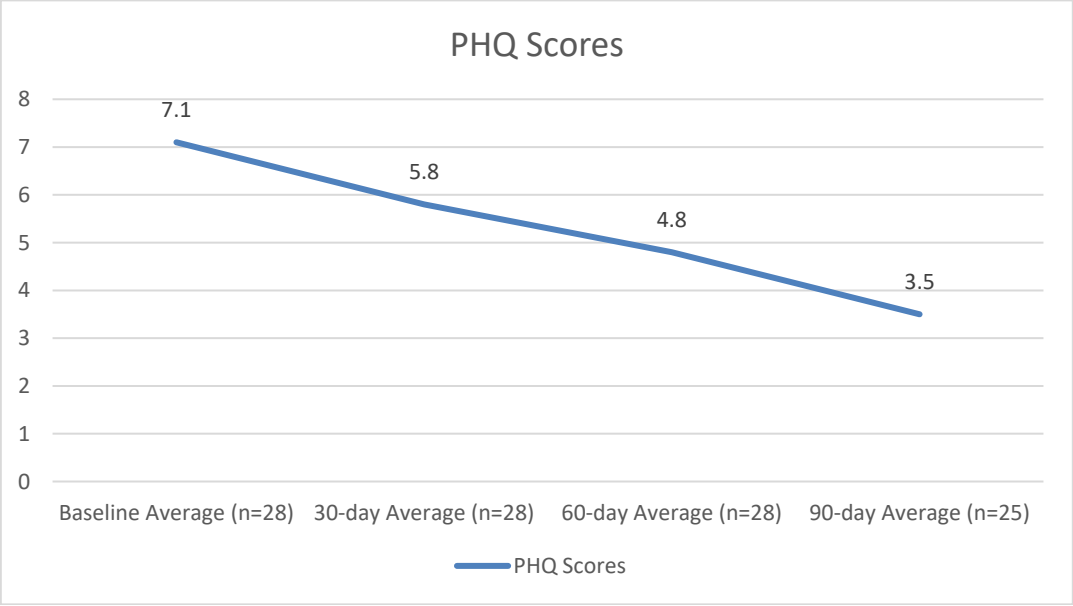
Qualitative Analysis and Trending of Measures

During FY25, a total of 64 members enrolled in CCM services. Of these, 30 members remained enrolled for more than 90 days, and 7 remained enrolled for more than 60 days.

PHQ Scores

During FY2025, information was collected to determine the prevalence of depressive symptoms among members. Depression symptoms were measured using the Patient Health Questionnaire (PHQ-9) for adults (ages 18 and older) and the Patient Health Questionnaire (PHQ-A) for children (ages 11-17). These PHQ assessments are integrated into the Complex Case Management (CCM) evaluations for both adults and children, and they are completed at the start of CCM services and every 30 days thereafter until the services conclude. A higher score on the PHQ-9 or PHQ-A indicates more severe depression symptoms, while a reduction in the score signifies an improvement in symptoms.

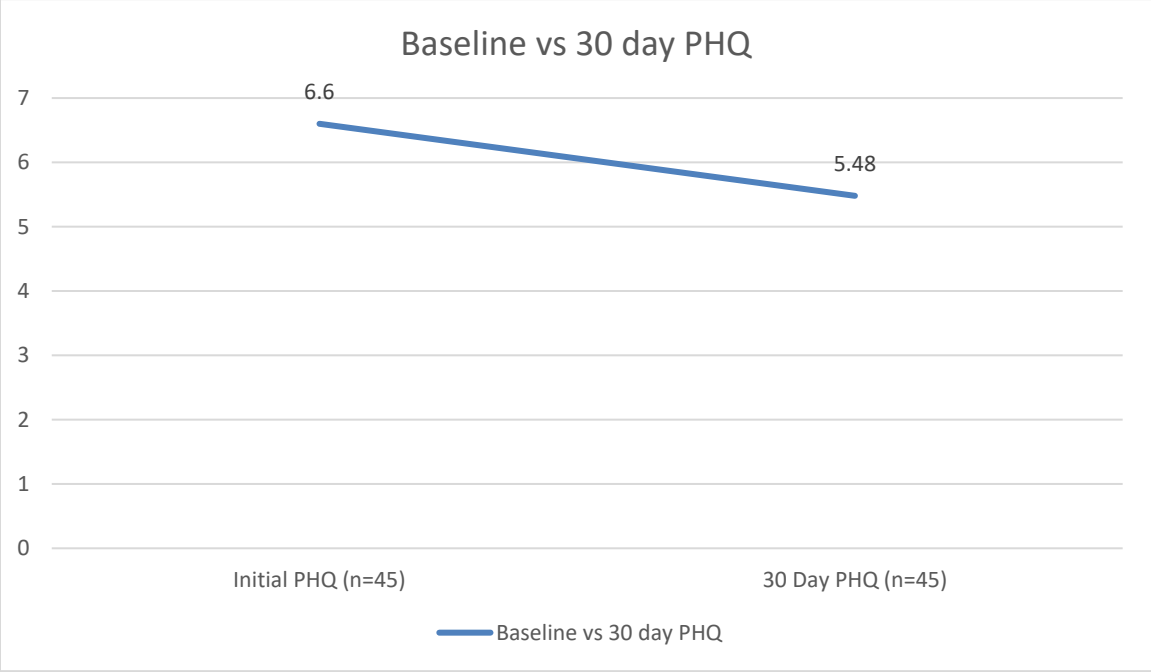
PHQ scores were collected from assessments conducted at the beginning of CCM services and at 30, 60, and 90 days after initiation. These scores were evaluated for members who had been in the CCM program for at least 90 days during FY2025. Baseline PHQ scores among members ranged from 2 to 21, with an average score of 7.15. Members participating in Complex Case Management services generally showed improvement in their PHQ scores, with greater improvement over time. Average PHQ scores improved by 18% from baseline at 30 days, 17% at 60 days, and 27% at 90 days of receiving CCM services.



Evaluation of Effectiveness

Of 64 members, 28 were included in the denominator for baseline PHQ scores. We excluded 24 members because their cases had not been open for at least 90 days. Additionally, 12 members were excluded because they were active at or after the end of fiscal year 2025 (after October 31, 2025). Of the 28 members included, 23 (82%) achieved a 20% improvement in their PHQ scores from the beginning to the end of CCM services.

We also compared the average initial PHQ scores of members with their scores at 30 days to assess improvements within the first month of starting CCM services. For this analysis, 45 out of 64 members were included. Seventeen members were excluded because they had not been open for at least 60 days, and two were excluded due to an incomplete 30-day PHQ. The average PHQ score decreased from baseline to the 30-day mark, indicating improvement during the first month of CCM services. See the chart below.



Although we initially achieved our goal of a 20% improvement in PHQ scores during the first year of the goal increase, we aim to have at least 85% of our members experience this improvement. We will continue to monitor whether this improvement remains consistent over time to determine if we should significantly raise or retire this goal. Overall, members who participated in the Care Management Model (CCM) for just 30 days demonstrated a notable improvement in their scores. There was a 6% increase in the 90-day PHQ scores from FY2025 compared to FY2024.

We continually evaluate interventions that can enhance member outcomes and help us achieve this goal. Out of 28 members, 23 showed improvement, with their PHQ scores increasing from baseline to the end of CCM services. The scores of three members remained unchanged.

Barriers to improvement in PHQ scores may include feelings of hopelessness, low motivation, fear of medication side effects, and difficulty in recognizing symptoms. Additionally, social determinants of health—such as unstable housing, food insecurity, limited social support, and lack of transportation can hinder progress.

Provider-related barriers may include inconsistent follow-up, insufficient time during visits, reluctance to adjust medications, limited training in evidence-based depression care, and fragmented care. We believe our ongoing efforts to connect members with behavioral health providers, address preferences for providers and clinics, arrange transportation, and assist with appointment scheduling will help overcome some of these barriers.

Furthermore, facilitating communication about medication concerns, reducing isolation by connecting members with support networks, providing appointment reminders, and addressing social determinants of health will also reduce barriers. The CCM will continue to focus on developing crisis plans, coordinating with members' care teams, educating members on symptom management, and connecting them with peers for additional support.

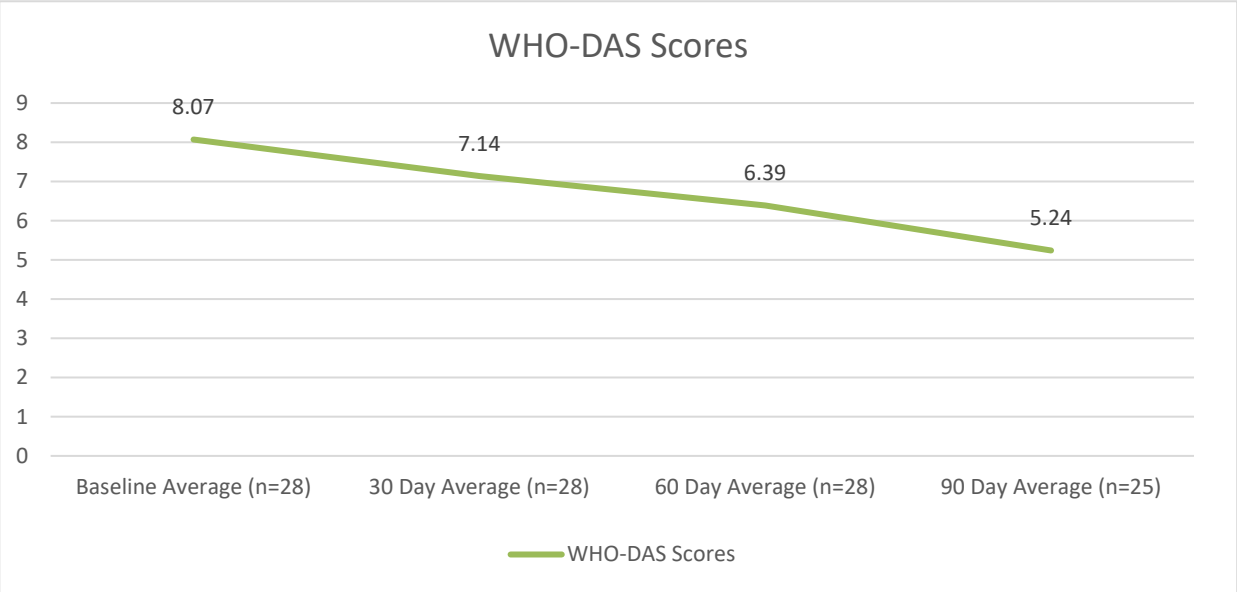
WHO DAS Scores

During Fiscal Year 2025, data was collected to evaluate members' quality of life using the World Health Organization's Disability Assessment Schedule (WHO-DAS). This assessment is integrated into the Complex Case Management (CCM) evaluation and is conducted at the beginning of CCM services, with follow-up assessments every 30 days until the conclusion of those services. The WHO-DAS measures six key areas: cognition, mobility, self-care, relationships with others, daily activities, and social participation.

For children and youth, the WHO-DAS child version assesses how health conditions impact daily functioning and participation in various activities. It focuses on six areas: understanding and communication; mobility; self-care; social interactions; life activities (such as school and household chores); and social engagement. Practitioners administering this assessment require appropriate training.

A higher WHO-DAS score indicates greater disability, while a lower score indicates improvement in that level. Scores were collected from CCM assessments at the start of services and at 30, 60, and 90 days after initiation. For members who participated in the CCM program for at least 90 days, scores at the time of closure were also evaluated.

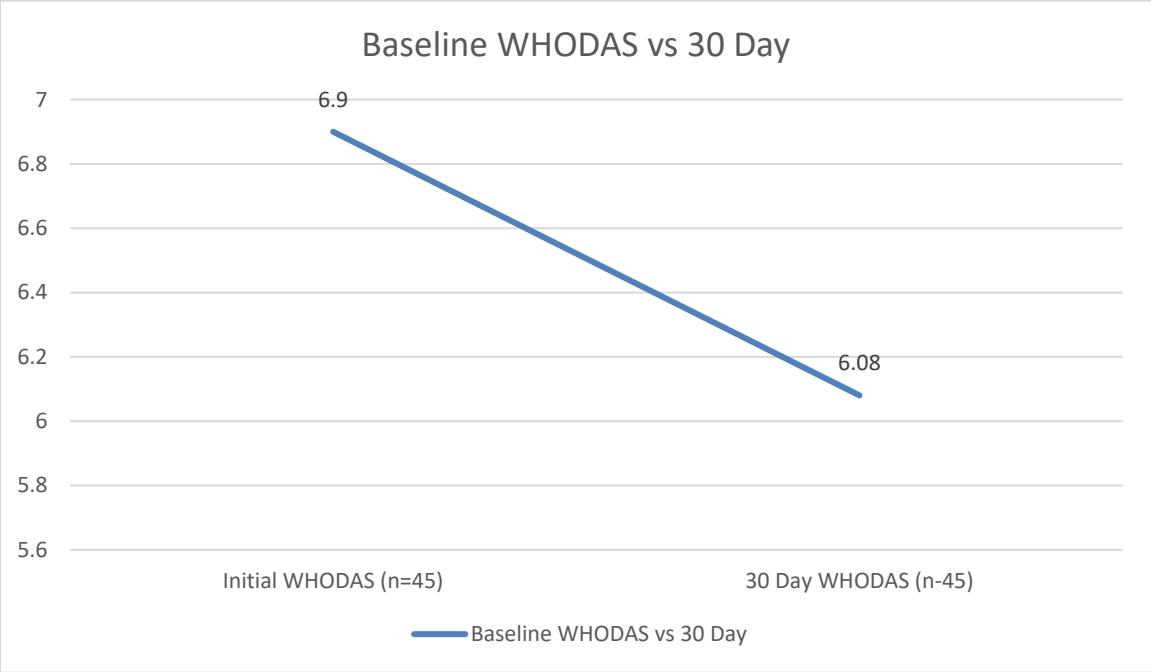
Baseline WHO-DAS scores ranged from 2 to 32, with an average score of 8.07. Members enrolled in Complex Case Management services demonstrated overall improvements in their WHO-DAS scores, with these improvements becoming more pronounced as they continued to participate in CCM. On average, WHO-DAS scores improved by 10% from baseline at 30 days, by 11% at 60 days, and by 18% at 90 days of participation in CCM services.



Qualitative Analysis and Trending of Measures

A total of 28 out of 64 members were included in the denominator for the baseline WHO-DAS scores. Twenty-four members were excluded because their cases had not been opened for at least 90 days. Additionally, 12 members' cases remained active at the end of FY2025 (after October 31, 2025). Out of the 28 members included, 21 (75%) achieved a 20% improvement in WHO-DAS scores from the start to the end of the CCM services.

To assess improvements within the first 30 days of starting CCM services, we compared members' initial WHO-DAS scores with their scores at 30 days. A total of 45 out of 64 members were included in this comparison. Seventeen members were excluded because their cases had not been open for at least 60 days, and two were excluded due to the absence of a completed 30-day WHO-DAS evaluation. The average score decreased from baseline to 30 days, indicating an improvement in WHO-DAS scores during the first month of CCM services. (See the chart below.)



Evaluation of Effectiveness

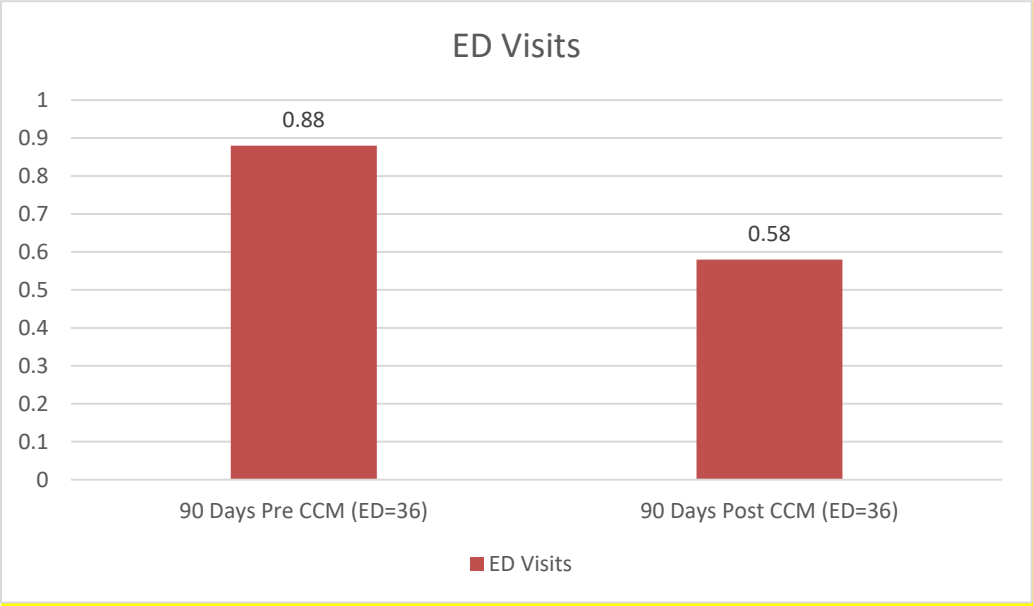
We have successfully met our goal of achieving a 20% improvement in WHO-DAS scores and aim to see this improvement in at least 85% of our members. We will continue to monitor this objective. Members who participated in the CCM program for at least 90 days showed positive changes in their WHO-DAS scores. Among 28 members, 21 demonstrated progress from their baseline to the end of CCM services, while six members' scores remained unchanged.

Several barriers may hinder improvement in WHO-DAS scores, including chronic pain, low self-efficacy, fluctuating symptoms, coexisting medical conditions, misperceptions about limitations, and progressive or poorly managed health issues. Social determinants of health, such as housing instability, caregiver burden, limited social support, and lack of transportation, can also impede progress.

Additionally, barriers related to providers and treatment may include limited access to treatment services, insufficient duration of therapy, under-recognition of functional impairments, long waitlists, and fragmented care. The CCM program continuously evaluates all members for physical limitations and ensures they receive the necessary support—such as durable medical equipment, therapeutic services, and community living support—to help maintain their independence. Furthermore, CCM assists members in transitioning to higher levels of care as needed.

Emergency Department Utilization and Hospital Admissions

DWIHN analyzed member Admission, Discharge, and Transfer (ADT) alerts alongside claims data to evaluate the utilization of the Emergency Department and hospital admissions in the 90 days preceding and following the initiation of CCM services, concluding in fiscal year 2025. Members who participated in CCM services experienced an average reduction of 34% in Emergency Department visits from the 90 days preceding the initiation of CCM services to the 90 days following its initiation. Specifically, members averaged 0.88 Emergency Department visits in the 90 days preceding CCM initiation, compared with 0.58 visits in the 90 days following CCM initiation. (See the chart below.)



Qualitative Analysis and Trending of Measures

Among the 64 active cases, 16 members were excluded because they had not been enrolled in CCM services for at least 60 days at the time of the report. Additionally, 12 members were excluded from the total because their CCM cases remained open after October 2025. Seventeen members were excluded because they had no Emergency Department visits within 90 days of starting CCM services. Out of the 16 members included, 9 (56%) achieved a goal of at least a 10% reduction in Emergency Department visits from 90 days prior to the initiation of CCM services to 90 days after. Two members showed no change, while three members experienced an increase in Emergency Department visits.

DWIHN also monitors inpatient admissions for members participating in CCM services. Of the 64 active cases, 12 members were excluded from the total because their CCM cases were still active and scheduled to close after October 2025 at the time of the review. Furthermore, 16 members were excluded from this measure because they had not been enrolled in CCM services for 60 days at the time the report was generated. No inpatient hospitalizations were recorded for 29 members. Among those analyzed, 4 out of 7 (57%) members achieved the goal of experiencing at least a 10% decrease in inpatient hospitalizations from 90 days prior to starting CCM services to 90 days after.

Evaluation of Effectiveness

Out of 16 eligible members, only 56% achieved the goal of reducing Emergency Department visits by 10%. We aim to see this improvement in at least 85% of our members. Complex Case Management (CCM) members demonstrated a greater reduction in emergency department use in FY2025 compared to FY2024, with a 25% decrease in utilization.

Four members experienced an increase in Emergency Department visits from 90 days before to 90 days after starting CCM services, and three members saw no change during this period. Twenty-nine CCM members had no inpatient admissions in the 90 days before starting CCM services and continued to have no inpatient admissions within 90 days after beginning these services. Two members experienced an increase in Emergency Department visits during this time, while one member saw no change.

If members are hospitalized in FY2026, we can compare both data sets. Several barriers to reducing Emergency Department utilization and inpatient admissions may include medication non-adherence, lack of early intervention supports, missed follow-up appointments, difficulties in following care and crisis plans, and low insight into their illness. Additionally, social determinants of health—such as housing instability, lack of support, food insecurity, unsafe living environments, lack of transportation, and gaps in community resources—can also hinder reductions in Emergency Department visits.

Provider and treatment-related barriers may include fragmented discharge planning, inadequate member education, a lack of integrated care models, limited after-hours services, and law enforcement policies that often default to bringing members to the Emergency Department. The limited availability of Partial Hospitalization Programs (PHP), Intensive Outpatient Programs (IOP), crisis stabilization units (CSU), and insufficient same-day or urgent behavioral health services could lead to an increase in inpatient admissions.

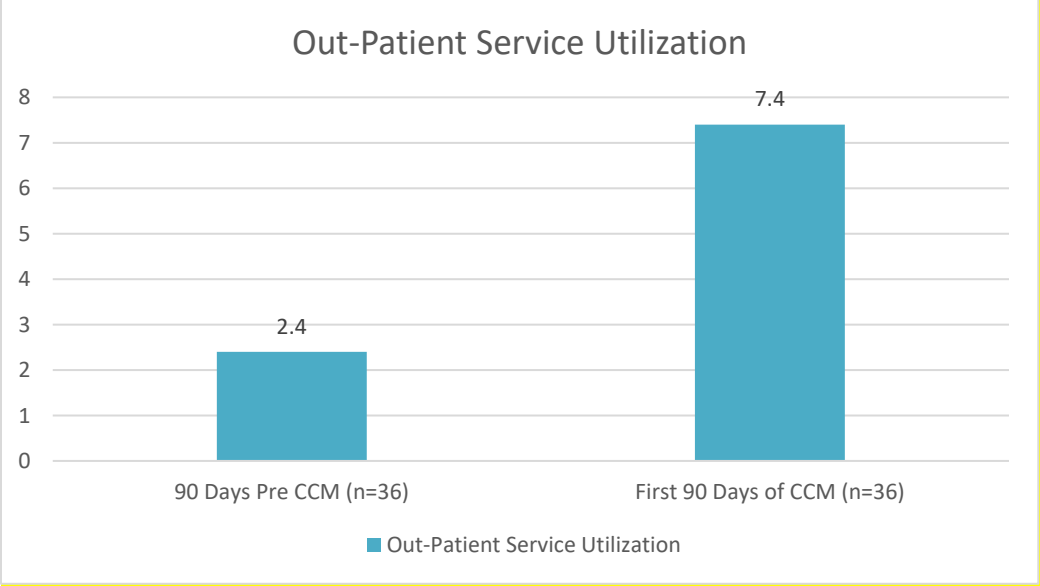
To achieve the goal of a 10% reduction in Emergency Department visits and inpatient admissions for FY2026, Complex Case Management will enhance member education about DWIHN's Crisis Center and Mobile Crisis Unit at program enrollment, thereby reducing unnecessary Emergency Department visits and admissions. Complex Case Managers will work closely with Crisis Center staff to ensure proper follow-up appointments are scheduled before a member's discharge.

In addition to reviewing crisis plans, Complex Case Managers will provide further education on medical and behavioral health care to members following their first visit to the Emergency Department and/or hospital discharge, while they are enrolled. Educational materials will cover medication management, the importance of attending provider appointments, follow-up appointments, the benefits of peer support, effective symptom management, and crisis interventions. Complex Case Managers will also continue conducting hospital rounds to provide additional support.

Utilization of Outpatient Services

DWIHN analyzed members' claims regarding outpatient behavioral health service utilization for the 90 days prior to participating in CCM services and the 90 days following the commencement of CCM services. This analysis focused on members enrolled in CCM for at least 60 days at the time of closure.

The average number of outpatient behavioral health services utilized during the 90 days preceding the initiation of CCM services was 2.4. After initiating CCM services, the average number of outpatient behavioral health services increased to 7.4. This represents a 67% increase in outpatient service utilization within the first 90 days of receiving CCM services (See the chart below).



Qualitative Analysis and Trending of Measures

A total of 36 members were included in the average for outpatient behavioral health services for the 90 days preceding the initiation of Complex Case Management (CCM) services and for the 90 days following the start of CCM services. These members were enrolled in CCM for at least 60 days or more at the time of closure. Sixteen members were excluded from this analysis because they had not been enrolled in CCM for at least 60 days. Additionally, 12 members were excluded because their CCM cases were still active and scheduled to close after October 2025 at the time of the review.

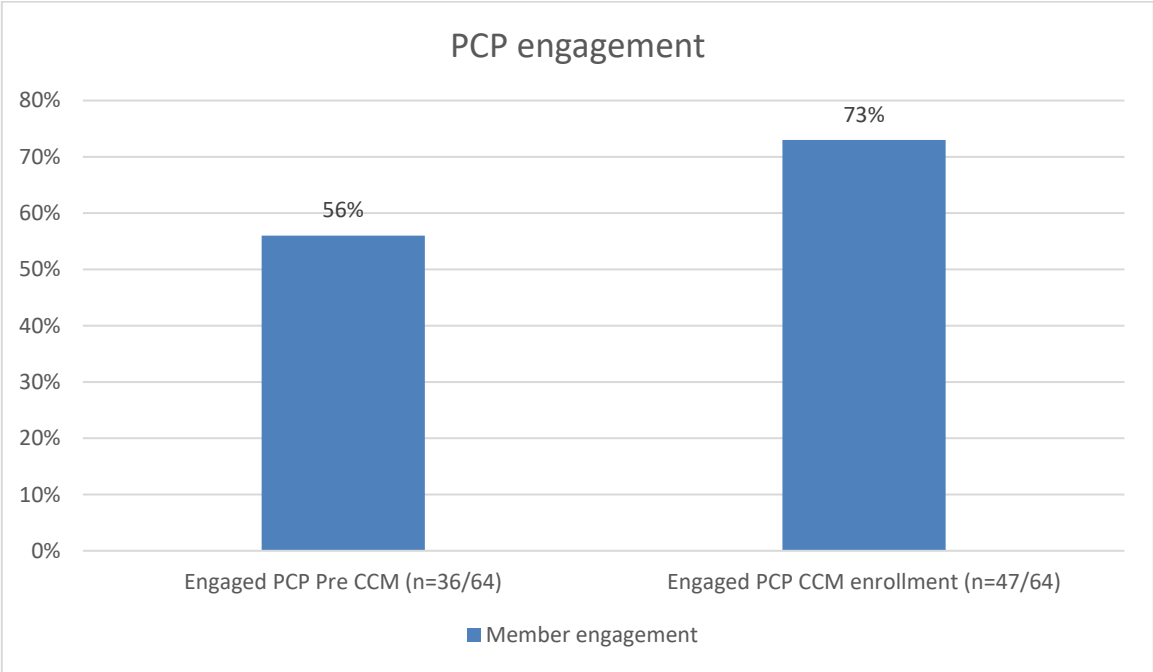
Out of the 36 members, 35 (97%) achieved the goal of a 10% increase in outpatient behavioral health services from the 90 days preceding to the 90 days following the initiation of CCM services. Only one member showed a decrease in outpatient visits during this period. All other members, except for one, exhibited increases in outpatient attendance.

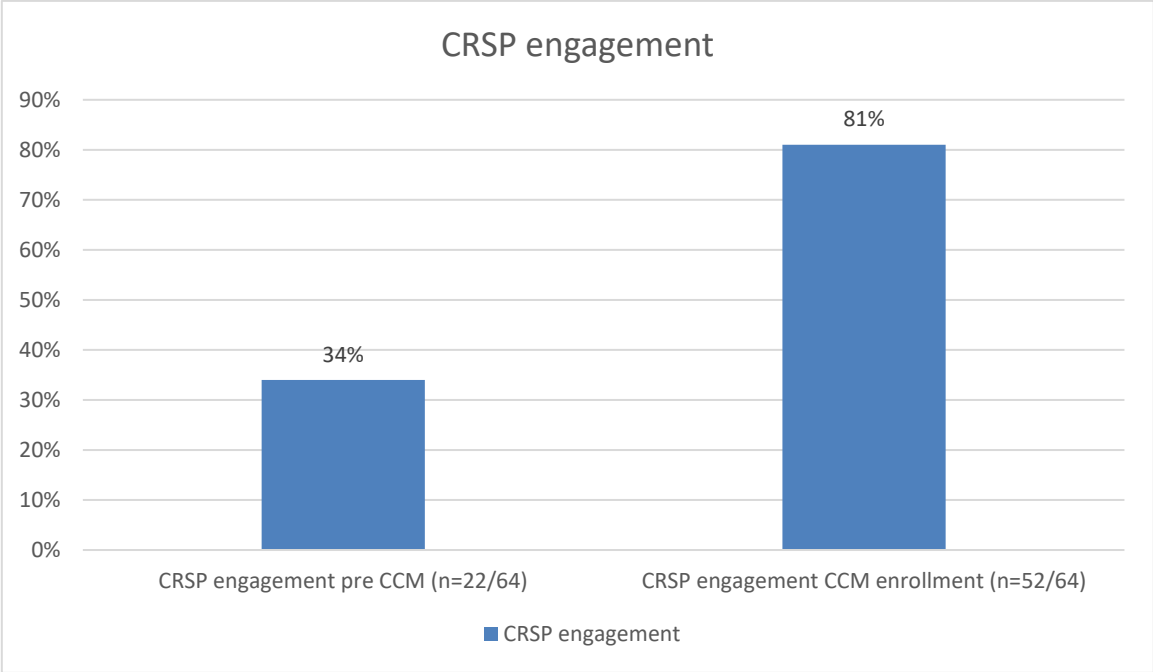
DWIHN also monitors the number of members who attended at least two outpatient behavioral health appointments within 60 days of starting CCM services, provided they were enrolled in CCM for at least 60 days, and their cases were closed by October 2025. Out of 37 members, 35 (95%) attended two or more outpatient behavioral health services within 60 days of commencing CCM services. Fifteen members were excluded from this measure because they had not been enrolled in CCM for 60 days at the time of the report. Additionally, 12 members were excluded from the denominator because their CCM cases remained active and open after October 2025 at the time of the review.

DWIHN also tracks members who attended two outpatient behavioral health services within 60 days following the closure of CCM services. Among the 34 members eligible to participate in two outpatient services after the closure of their CCM case, 26 (76%) attended two or more outpatient services. Fifteen members were excluded from this measure because they were not enrolled in CCM services for at least 60 days at the time of the report. Eighteen members were excluded from the denominator because their Complex Case Management cases were still active and were expected to close after October 2025 during the review. Three out of the 34 members included in the report from FY2024 had not had their cases closed for 60 days at the time of the 2024 review (31 from FY2025 and 3 from FY2024).

Starting in FY2025, DWIHN began monitoring members who attended two outpatient behavioral health services within 90 days of the closure of their CCM services. Of the 31 members eligible to participate in two outpatient services after their CCM case was closed, 23 (74%) attended at least 2 outpatient services. Fifteen members were excluded from this measure because they were not enrolled in Complex Case Management services for 60 days at the time of the report. Twelve members were excluded from the denominator because their CCM cases remained active and were expected to close after October 2025 during the review. Three out of six members included from FY2024 had not had their cases closed for 60 days at the time of the review.

Engaging with a Primary Care Physician (PCP) is crucial to ensure that medical issues are addressed; untreated health problems can significantly impact overall behavioral health. Regular visits with medical providers promote greater stability among members, reduce the likelihood of inpatient admissions, and increase the chances of consistent follow-up with behavioral health outpatient appointments. Complex Case Management also tracked member engagement with a Community Resource and Support Provider (CRSP) upon enrollment and compared it to their engagement with the CRSP during their participation in CCM. (See the charts below).


PCP engagement
80%
70%
60%
50%
40%
30%
20%
10%
0%
56%
73%
Engaged PCP Pre CCM (n=36/64)
Engaged PCP CCM enrollment (n=47/64)
Member engagement


CRSP engagement
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
34%
81%
CRSP engagement pre CCM (n=22/64)
CRSP engagement CCM enrollment (n=52/64)
CRSP engagement

Evaluation of Effectiveness

For FY25, we achieved a 10% overall increase in outpatient behavioral health visit attendance. Ninety-five percent of Complex Case Management (CCM) members attended two or more behavioral health sessions within 60 days of starting CCM services, an increase from 90% in FY2024. Additionally, 97% of members reported an increase in outpatient behavioral health services from 90 days prior to the start of CCM to 90 days after its initiation.

Seventy-one percent of members attended two or more outpatient visits within 60 days after the CCM program closure, while 74% attended two or more outpatient visits within 90 days post-closure. We aim to achieve this improvement in at least 85% of our members and will continue to monitor progress and provide interventions to meet these goals.

Barriers preventing members from attending appointments 60 days after program closure may include symptom relapses, challenges in self-managing appointments, substance use, limited access to phones, and lack of trust in outpatient providers. Social determinants of health—such as food insecurity, housing instability, financial strain, recent crises, major life changes, transportation issues, lack of childcare, and caregiving responsibilities—can also play a significant role. Provider and treatment-related barriers include long wait times, limited appointment availability, and failures to confirm members' contact information for appointment reminders. These issues can hinder outpatient follow-up.

Complex Case Managers continue to work on reducing barriers for members, promoting stability, and improving compliance with both behavioral and medical care. They collaborate with members to re-establish or connect with their primary care physicians and behavioral health providers. Engagement with primary care will remain a focal point for FY25 and FY26, with 73% of CCM members engaging with a primary care provider (PCP) and 81% engaging with outpatient behavioral health providers.

Complex Case Managers help members develop strategies to stay organized and remember their outpatient appointments, such as setting reminders or using calendars. They also provide resources and education to support ongoing outpatient visits, even after participants have exited the CCM program. Additionally, they conduct follow-up check-ins at two intervals—2 to 3 weeks and 30 days after program closure—to coordinate care and address barriers to attending appointments. Finally, they work with members and support staff, including Case Managers, Support Coordinators, and Therapists, to schedule future appointments post-CCM and encourage continued attendance.

Satisfaction Surveys
Satisfaction surveys were distributed to all members upon completion of their Complex Case Management (CCM) services. Members were informed that completing the surveys was optional, but they were encouraged to provide feedback about their CCM experience.

Qualitative Analysis and Trending of Measures
During fiscal year 2025 (FY2025), 64 cases were initiated for CCM services, and 52 of those members had their services closed within that period. It's important to note that 16 of these members were in service for less than 60 days, so they did not receive satisfaction surveys. Additionally, two member surveys from fiscal year 2024 (FY24) were included in this report, as they were received after the reporting period due to the timing of service closure.

Of the 36 eligible members, 22 (61%) completed and returned their satisfaction surveys. Our goal is to achieve an 85% satisfaction rate, and I'm pleased to report that the overall satisfaction rate for FY2025 was 97.8%.

Evaluation of Effectiveness
The satisfaction rate goal was raised to 85% starting in FY2024, and we are pleased to report that we exceeded this target, achieving an overall satisfaction rate of 97.8%. However, we still face challenges in reaching our members, as some are unable to respond to our outreach efforts or have changed or disconnected their phone numbers.

From FY2024 to FY2025, survey response rates decreased, with FY2024 recording the highest rates for both submissions and satisfaction. Due to limited responses in FY2025, we have discontinued the electronic CCM Satisfaction Survey. We received only 5 returns in FY2024 and none in FY2025.

Several barriers may prevent members from completing the electronic survey, including a lack of email access, limited internet connectivity, difficulties accessing accounts, or issues with remembering passwords. Other obstacles to completing the survey include member disengagement, early discontinuation of services, misplaced paper surveys, ineffective follow-up reminders, and prioritization of other tasks over survey completion.

To address these challenges, Complex Case Managers will be encouraged to discuss potential incentives for survey completion with members before closing their cases. Moving forward, Complex Case Management will continue to use only the paper survey form and will maintain outreach efforts to increase the completion and return rates of satisfaction surveys.

Comparison of Previous Reviews

The results of the FY2025 analysis of CCM services can be compared to those from previous fiscal years, specifically FY24 and FY23. This comparison includes several key areas: PHQ scores, WHO-DAS scores, emergency department visits, hospital admissions, outpatient behavioral health engagement, and Satisfaction Survey results.

The baseline PHQ scores in FY2023 were lower than those in the other two fiscal years. In FY2024, the baseline WHO-DAS scores were also lower than in other years. Conversely, baseline scores for both PHQ and WHO-DAS were highest in FY2025. Additionally, the average scores for the PHQ and WHO-DAS consistently decreased as participants engaged in CCM services for longer periods across all three fiscal years.

The highest number of members achieved a 20% reduction in their PHQ and WHO-DAS scores in fiscal year 2024 (FY2024). Beginning in FY2024, the goal for both WHO-DAS and PHQ was raised to 20%. In FY2025, 82% of members met the PHQ goal, while 75% met the WHO-DAS goal. However, seven out of 28 members had unchanged WHO-DAS scores during their participation in the Chronic Care Management (CCM) program. In FY2026, we will focus on further assessing members whose scores have not changed. Additionally, we will continue to compare outcomes against this increased goal in the upcoming fiscal years.

Over the past two fiscal years, only one member has had an inpatient admission within 90 days of starting CCM services. Due to insufficient data, inpatient admissions could not be evaluated as a goal for fiscal years 2023 and 2024. In FY2025, 16 members experienced inpatient admissions, and we will compare these data with inpatient admissions in FY2026.

In FY2025, 56% of members successfully reduced their Emergency Department utilization by 10%. Overall, Emergency Department usage decreased from FY2024 to FY2025, with FY2025 recording the largest reduction over the past three fiscal years. For a more detailed causal analysis, please refer to the Complex Case Management Annual Review of Outcomes and Program Effectiveness for Fiscal Year 2025.

Opportunities for Improvement

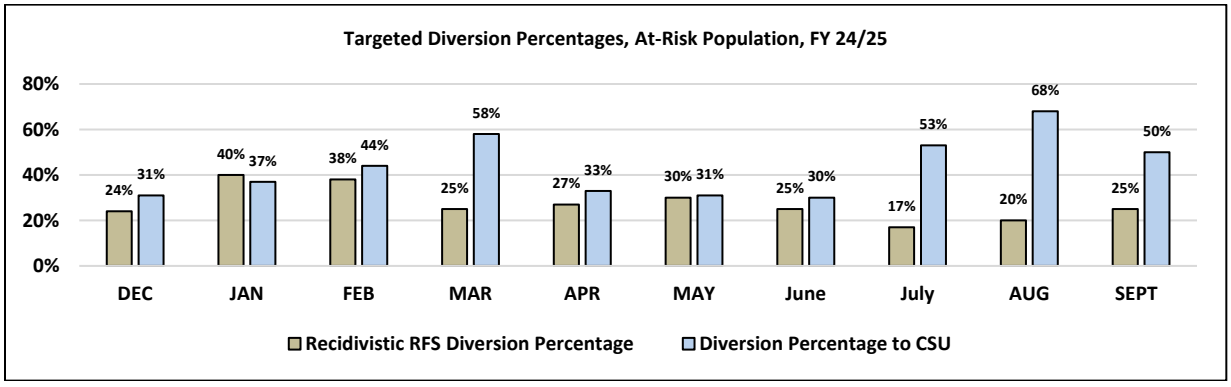
Complex Case Managers help members create Crisis Plans. These plans identify warning signs that require attention, enabling members to determine whether they need care at a crisis center or a hospital. This way, they can manage their health without relying on emergency department visits. The Complex Case Management program uses a system that reviews claims and alerts on member admissions and discharges, care gaps, and repeat hospitalizations. This helps identify members who need early support and access to CCM services. They also provide information about resources, such as DWIHN's Crisis Center, Mobile Crisis Unit, Peer Support Services, and the ACCESS helpline, all of which help reduce emergency department visits. This will remain a primary focus for fiscal year 2026.

Another area for improvement is getting members to engage more with their Primary Care Physician (PCP). Better engagement helps manage health conditions, especially because members with behavioral health issues often have higher rates of other health problems. When behavioral health and medical conditions overlap, more PCP engagement leads to better health outcomes and fewer healthcare visits. Regular PCP visits also improve communication between healthcare teams, reducing fragmented care. Complex Case Managers will keep working with members and support them in attending their PCP appointments to promote better health.

African American members face the biggest racial disparities in our population, especially among African American males. We will continue to work on these issues. These disparities may be due to historical mistrust, community conditions, insurance barriers after hospitalization, limited care coordination, and bias in healthcare. African Americans also suffer from more chronic diseases, as shown by DWIHN Population Assessments in recent years. This increases the risk of hospitalization. If proper follow-up care isn't established, repeat hospitalizations will likely rise.

Crisis Services

In December 2024, the PIHP Crisis Services Department implemented an intervention to reduce recidivism and unnecessary inpatient hospitalizations. The department focused on an at-risk population: individuals who had been discharged from an inpatient facility and subsequently returned to an emergency department for screening within 30 days. This group is particularly vulnerable to repeated inpatient hospitalizations. To address this issue, the team aimed to increase the number of individuals diverted to less restrictive environments, specifically targeting crisis stabilization units.



Timeliness of Crisis Screenings

The PIHP Crisis Services Department works to ensure that crisis screenings occur in a timely manner and that dispositions comply with state guidelines. The team meets regularly with contracted screening agencies to ensure the 95% standard is met from the time a request for service is received by the PAR Dispatch Team until a disposition is reached and communicated. The team has met the 95% goal in each of the 4 quarters this fiscal year (2-hour timeframe for adults, 3-hour timeframe for children).

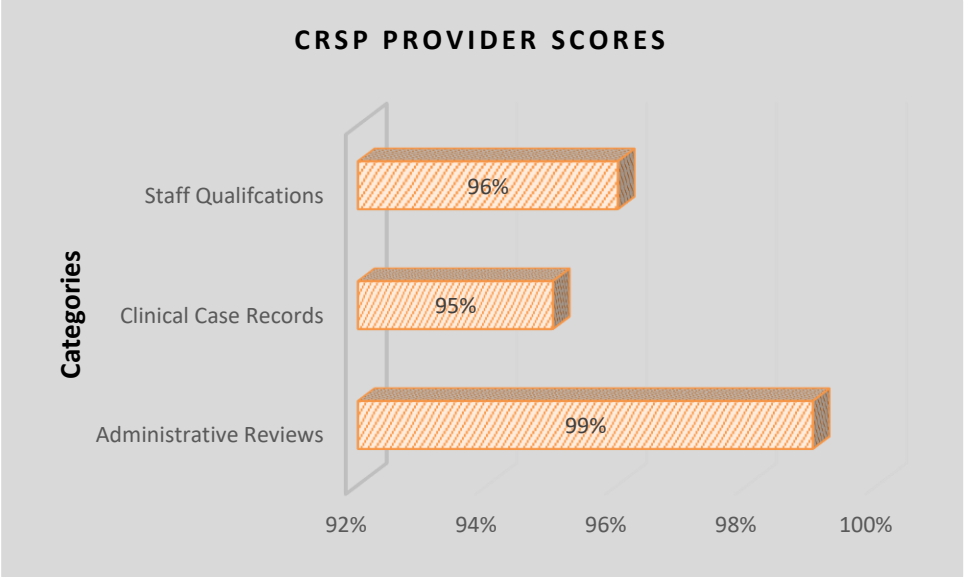
PI#1	Adults	Children	Total
1st Q 2025	97.28%	97.06%	97.24%
2nd Q 2025	95.13%	99.12%	95.98%
3rd Q 2025	97.20%	98.27%	97.45%
4th Q 2025	97.59%	99.16%	97.91%

Workforce Pillar

During the fiscal year 2025, the Quality Improvement Performance Monitoring team undertook an extensive review of 399 clinical case records to gain insights into the effectiveness of the services we provide to our patients. This detailed analysis involved a systematic evaluation of each case to identify strengths and areas for improvement in our care delivery.

In parallel with the case reviews, we conducted a thorough validation of the qualifications of 607 staff members, ensuring that every individual is not only well-trained but also possesses the essential skills and knowledge required to provide exemplary care. This validation process included checking certifications, assessing training completion, and evaluating practical competencies.

The findings from these comprehensive evaluations demonstrated an exceptional level of care and professionalism among our staff, resulting in an impressive compliance score of 96%. This high score reflects our unwavering commitment to upholding superior standards in care and highlights our dedication to continuous improvement in the quality of services we provide.



Credentialing and Re-Credentialing

Quantitative Analysis and Trending of Measures

In FY25, the Credentialing Unit made significant strides in strengthening provider networks and ensuring compliance. The team successfully welcomed 27 new outpatient and residential providers, expanding access to quality care. Additionally, the unit processed and presented 1,137 credentialing applications, including 907 practitioners and 230 facilities, demonstrating a commitment to thorough, timely review.

To promote consistency, accuracy, and adherence to credentialing requirements, the unit also conducted comprehensive training sessions for providers, reinforcing best practices and compliance standards across the network. Measurable impacts include:

- 27 credentialing denials recorded, ensuring adherence to quality standards.
- 7 credentialing appeals processed, with 3 appeals approved, reflecting transparency and fairness in decision-making.
- Completion of 195 site visits, strengthening oversight and compliance across facilities.

These efforts underscore the Credentialing Unit's dedication to maintaining a robust, compliant provider network while supporting providers through education and engagement.

Opportunities for Improvement

To enhance operational efficiency, the Credentialing Unit will schedule additional Provider Meetings and Training Refreshers throughout 2026. These sessions will aim to reinforce credentialing requirements, policy expectations, and process updates.

- The Credentialing Unit is also focused on improving communication among providers. While email remains the primary communication method, staff members are encouraged to make more phone calls to facilitate clearer and more efficient interactions.
- DWIHN will continue to implement policy updates and communicate any changes to providers promptly and consistently, ensuring alignment with regulatory and contractual requirements.
- We are advancing our efforts toward Universal Credentialing to streamline processes, improve consistency, and enhance operational efficiency.
- Before credentialing and re-credentialing providers, Provider Network Managers will review the Disclosure and Ownership forms. Additionally, checks will be conducted with the Office of Inspector General (OIG) and the System for Award Management (SAM) to ensure that owners are not excluded from Medicare or Medicaid funding sources.

Building Workforce Capacity and Training Infrastructure

Workforce development remained a central focus for the department. NICE provided Mental Health First Aid training to 980 participants and Question, Persuade, Refer (QPR) suicide prevention training to 873 individuals. This included staff from DWIHN, community members, law enforcement, and service providers.

During the fiscal year, the department hosted 118 live training sessions and conferences, comprising 27 in-person and 91 virtual events, attended by over 4,500 people. Out of these sessions, 51 were approved for Continuing Education Units (CEUs). Notable conferences included the Annual Trauma Conference, the Self-Care Conference, and the Co-Occurring Disorders Mini Conference, which collectively trained more than 600 professionals on trauma-informed practices, clinician wellness, and integrated care approaches.

The department's student internship program expanded to include 59 students from Michigan State University, Wayne State University, and the University of Michigan. These interns came from various fields, including social work, psychology, IT, and communications. DWIHN also partnered with Michigan AHEC and MDHHS fellowship programs to place trainees in underserved communities, thereby supporting the development of the workforce pipeline. Additionally, multiple providers received technical assistance to renew or maintain National Health Service Corps site certification, ensuring the sustainability of skilled behavioral health staffing across Wayne County.

In collaboration with other internal departments, NICE supported Home and Community-Based Services (HCBS) training for 1,335 staff members and co-hosted the Compliance Academy, which trained 330 providers across 20 sessions. The team resolved over 1,775 helpdesk requests related to DWC platform operations, transcripts, and training registrations, underscoring NICE's commitment to providing responsive workforce support.

Opportunities for Improvement

As we look ahead to FY26, the NICE Department at DWIHN will focus on several key initiatives. Our commitment to leading innovation, building workforce capacity, and promoting equity-driven, person-centered care for all residents of Wayne County remains strong.

Key priorities include:

- Expanding data integration
- Strengthening the Zero Suicide framework
- Enhancing mobile outreach
- Increasing culturally responsive and trauma-informed care throughout Wayne County

We will continue to grow our workforce development efforts by offering new continuing education units (CEUs), expanding internship opportunities, and improving the Detroit Wayne County (DWC) platform. Through these strategic priorities, we aim to cultivate a healthier and more equitable community for all.

Verification of Services

In addition to our monitoring efforts, we implemented essential activities to verify Medicaid claims. In the first two quarters of the fiscal year, our team successfully completed an impressive 1,300 claims reviews, ensuring accuracy and accountability in our billing processes. As part of a new initiative, the third and fourth quarters focused on verifying Medicaid claims associated with corrective action plans issued to providers the previous year. This led to an additional 404 claims being reviewed, reflecting our commitment to continuous improvement and providing accountability.

Our efforts produced remarkable results, with a significant increase in average scores among CRSP providers. The scores reached an outstanding 99% for administrative reviews, indicating exceptional management practices; 95% for clinical case records, highlighting the effectiveness and appropriateness of care provided; and 96% for staff qualifications, demonstrating our workforce's dedication to excellence and professionalism. Through these initiatives, we aim to enhance the quality of care and improve health outcomes for the individuals and families we serve.

Noted trends

The review identified ongoing issues that mirror concerns noted in FY2024, indicating that corrective actions have not yet fully resolved these areas. Specifically, recurring problems were observed with invalid Individual Plans of Service (IPOS), which compromise the accuracy and effectiveness of care planning. Additionally, insufficient training for direct care staff regarding member IPOS remains a significant challenge, limiting staff's ability to implement individualized plans appropriately. These persistent deficiencies highlight the need for strengthened oversight, enhanced staff education, and systematic quality checks to ensure compliance and improve service delivery.

Comparison of Fiscal Years and Effectiveness of the CAP

DWIHN observed significant improvements in its Corrective Action Plan (CAP) process and in tracking the providers issued CAPs during this fiscal year. A year-over-year comparison reveals a 34% decrease in the number of service providers requiring a CAP from fiscal year 2024 to fiscal year 2025. However, these results should be interpreted with caution. Among the 28 providers that no longer required a CAP after the Q3–Q4 follow-up review, 12 had previously required a CAP earlier in FY2025, following the Q1–Q2 review. This fluctuation complicates the assessment of overall progress.

Additional challenges also impacted the evaluation of CAP effectiveness. While the current tracking systems reliably identify which providers received CAPs, they do not consistently capture the specific findings that triggered each CAP. This gap makes it difficult to determine whether the required remediation addressed recurring issues or introduced new, unrelated findings.

Systemic Remediation Plan

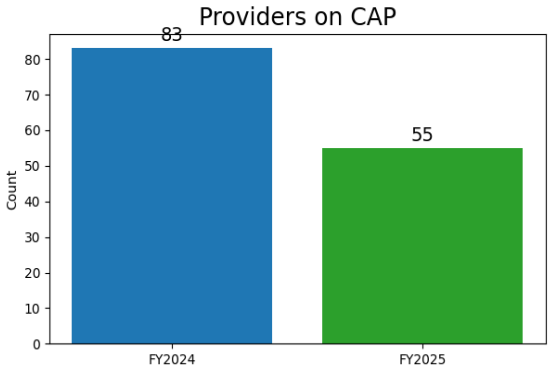
To enhance the effectiveness of remediation efforts and ensure the delivery of high-quality services within the Medicaid framework, DWIHN is committed to strengthening its oversight of Corrective Action Plans (CAPs). This initiative will involve several key improvements:

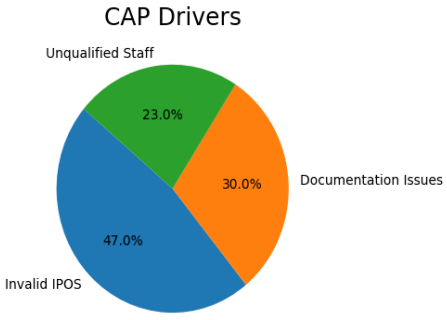
1. Improved Tracking Systems: DWIHN plans to implement advanced tracking systems that will allow for more precise connections between specific deficiencies identified in service delivery and their corresponding CAPs. This approach aims to create a clearer understanding of how each CAP addresses issues within the system.
2. Refined Follow-Up Review Protocols: The organization will adopt more thorough follow-up review protocols. These protocols will focus on accurately distinguishing between genuine, sustained improvements in service quality and temporary compliance that may not reflect a long-term commitment to quality enhancement.
3. Targeted Root-Cause Analyses: For providers exhibiting inconsistent CAP statuses, DWIHN will mandate the completion of targeted root-cause analyses. This requirement will ensure that providers delve deeply into the underlying issues contributing to non-compliance, thereby fostering a deeper understanding of the challenges they face.
4. Internal Dashboard Development: To further support these efforts, DWIHN is contemplating the creation of an internal dashboard. This digital tool will visualize trends and metrics related to CAP implementations, enabling stakeholders to easily monitor progress and gain valuable insights into systemic patterns. Such a dashboard will enhance decision-making processes and promote accountability across the organization.
5. Role-Based Training: Training will be offered both through the learning management system as well as through live sessions on IPOS interpretation, service authorization matching, and note standards.

   Through these strategic enhancements, DWIHN aims to create a robust framework for overseeing corrective actions and ultimately improving the quality of service provided to individuals within the Medicaid system.

FY2025 Corrective Action Plan (CAP)
Performance & Compliance Overview

Key Highlights:
• 34% decrease in providers requiring CAP vs FY2024
• Ongoing Issues: IPOS documentation defects & insufficient staff training
• Recoupment Exposure: $1,946.57 (11 claims; 109 units)



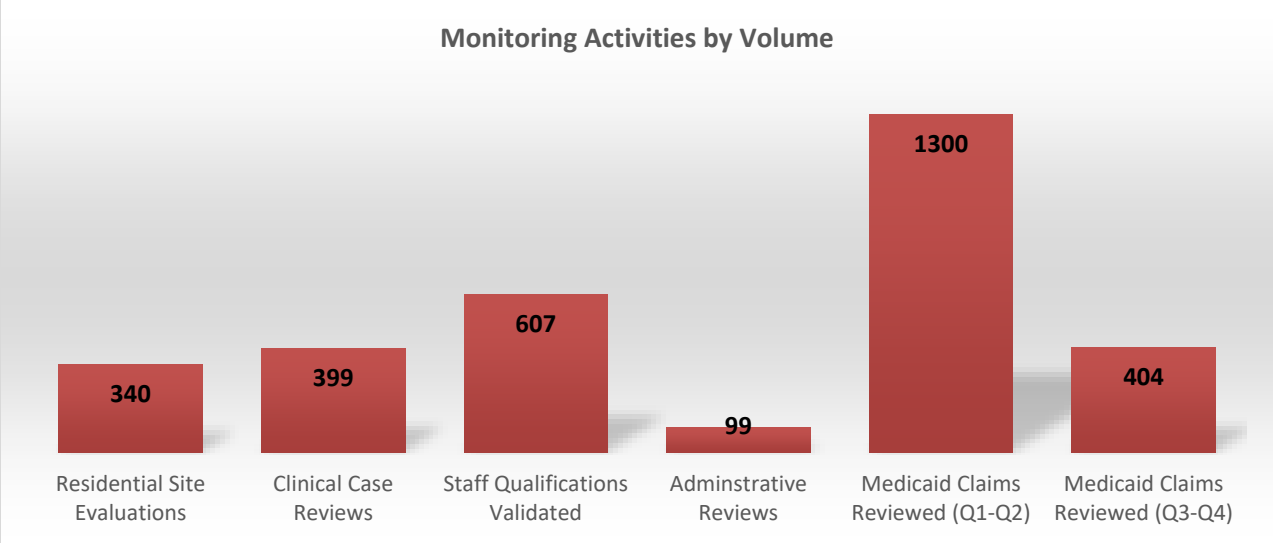


Metric	FY2024	FY2025
Providers on CAP	83	55
Providers removed	-	28
Claims tested	-	406
Units tested	-	3880
Dollars tested	-	$77,416.99
Recouped ($)	-	$1,946.57
Recouped Claims	-	11

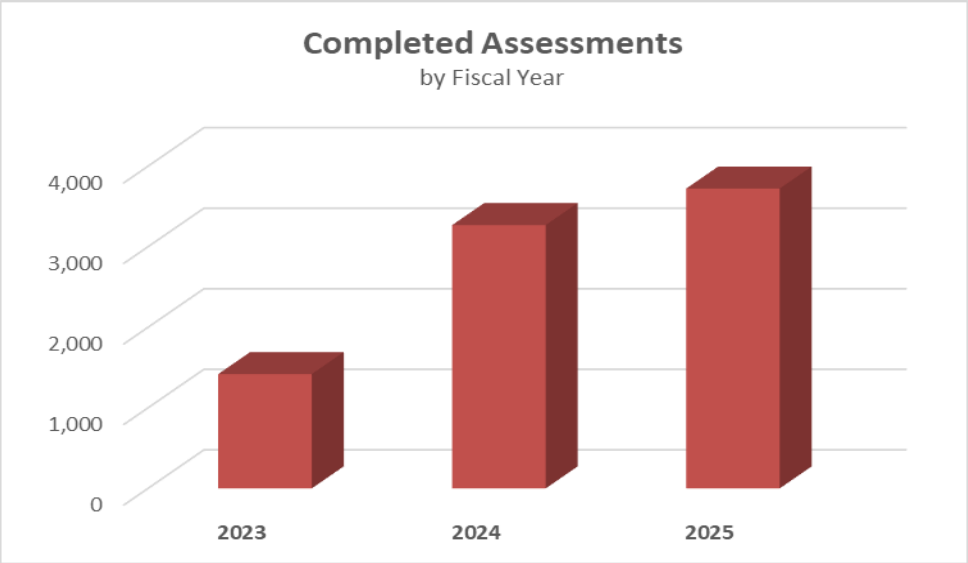
Strategic Actions:
1. IPOS Hard Stops in EHR workflows
2. Role-based training & competency validation
3. Pre-bill audit automation
4. CAP lifecycle standardization
5. Internal dashboard for real-time CAP tracking
6. Improved training programs for direct care staff

Quality Pillar
Provider Network
Quantitative Analysis and Trending of Measures
In FY25, DWIHN completed 340 residential site assessments to ensure compliance with quality-of-care standards and conducted 399 clinical case record evaluations. The number of case record reviews increased by 76 compared to FY24 (from 323 to 399), reflecting a 23.5% year-over-year growth in review activity. This upward trend indicates an expanded review capacity and strengthens oversight of clinical documentation and service delivery. While the site assessments remained robust, the higher volume of case record evaluations suggests a strategic focus on clinical quality and adherence to care standards.

This year, we expanded our evaluations to include providers that offer treatment for substance use disorders (SUD), autism services, B3/(i)SPA services, and inpatient hospital settings. Among the evaluated SUD providers, 20 met the compliance standards. However, 9 providers fell below the 95% compliance threshold, highlighting a need for improvement. In the area of autism services, total enrollment reached 2,483 youth in FY 2025, with 1,252 newly enrolled participants.



Authorization for Residential Services
Qualitative Analysis and Trending of Measures
In FY25, the Residential Department completed 3,722 residential assessments, of which 2,007 were conducted for adults. The chart below illustrates the yearly trends in completed assessments and reveals several noteworthy patterns. Overall, the volume of assessments remained relatively stable throughout the year, with slight increases observed from 2023 to 2025. These fluctuations may reflect seasonal variations in service demand or discharge cycles. Adult assessments consistently accounted for the majority of completed evaluations, totaling more than half of the total each month, indicating a sustained need for adult residential services. Periods of heightened activity suggest effective coordination between referral sources and the department's capacity to manage increased demand.
These trends underscore the importance of maintaining adequate staffing and resource allocation to ensure timely assessments, particularly during peak months.



Fiscal Year	2023	2024	2025
Completed Assessments	1,419	3,269	3,722

Opportunities for Improvement

- The Residential Department is committed to utilizing advanced technology to improve the residential referral process significantly. This initiative involves a thorough evaluation of referral appropriateness, with careful consideration of less restrictive living environments. Furthermore, we are exploring implementing a user-friendly referral portal to streamline submissions and facilitate communication among stakeholders.
- The Residential Department will be launching a comprehensive Residential Risk Matrix designed to systematically track and analyze data collected from various residential providers. This strategic tool will equip the department with critical insights necessary for informed resource allocation, ensuring that our support is directed where it is needed most.
- The Residential Department aims to improve overall efficiency and enhance the member experience by significantly increasing both the volume and quality of completed residential assessments. These assessments are crucial for identifying the most suitable living arrangements for our members. Additionally, we will focus on improving placement efficiency by strengthening the quality of our service network. This will ensure that our members have timely access to the best available resources and support systems.

Autism Services

Quantitative Analysis and Trending of Measures

During fiscal year 2025, a total of 3,310 youths were enrolled in Autism Services, of whom 887 were newly enrolled. **Figure 1** shows that the average enrollment was approximately 458.75 members per quarter, peaking in the third quarter with 564 members. This increase in Q3 was likely due to improvements in network capacity, including the addition of 4 new ABA providers from the Qualified List.

Figure 2 illustrates the significant changes implemented during this fiscal year, including the creation of the EDT form (Enrollment, Discharge, and Transfer form). Previously, enrollments were tracked as "open/enrollment," but this could mean different things. According to the pie chart, 64% of the enrollments in blue were new entries into ABA programs (i.e., individuals who had never been diagnosed with ASD or had received ABA therapy before), while 17% in pink represented families discharging or transferring to a different ABA provider. The remaining segment indicated individuals returning to an ABA program after being out for at least three months.

Figure 3 presents the discharges that were tracked as "closed/discharged." This category also encompasses various situations, as shown in the bar graph below. The green bar indicates that 54% of discharges were due to a lack of interest in continuing ABA services. The second largest group, represented by the blue bar, accounted for 12% of families who were unresponsive, while the third-largest reason cited was inadequate staffing. Close behind, the pink bar revealed that 6% of members achieved their treatment goals.

Figure 4 illustrates the improvement made by DWIHN, which extended the allowable reporting window for ASD diagnoses from 10 to 15 business days. This change maintained the existing 7-day requirement for non-spectrum evaluations. In fiscal year 2024, the average on-time completion rate was 84%. By the third quarter of fiscal year 2025, this rate improved significantly to 558 out of 572 reports, achieving a remarkable 98% on-time rate.

Figure 1

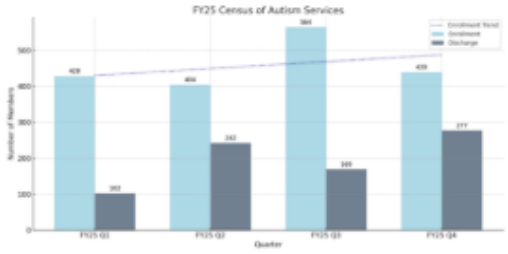


Figure 2

Figure 3

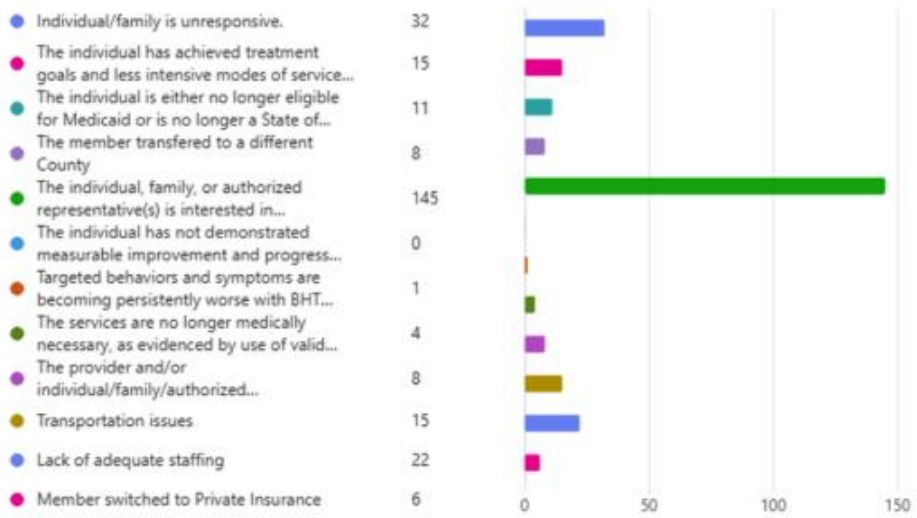


Figure 4

Fiscal Year/Quarter	Timely Access to ABA Services (Numerator)	Total Requests for ABA Services (Denominator)	Percentage of Reports On Time
FY 24 / Q1	285	427	67%
FY 24 / Q2	325	384	85%
FY 24 / Q3	527	578	91%
FY 24 / Q4	479	525	94%
FY 25 / Q1	411	465	88%
Performance Measure Modification			
FY 25 / Q2	513	528	97%
FY 25 / Q3	558	572	98%
FY 25 / Q4	650	667	97%

Identified Barriers

- Difficulty in finding ABA service providers with available time slots.
- Limited or no afternoon availability from ABA service providers.
- Challenges in identifying the support coordinator or case manager needed to request authorizations.
- Inconsistent responses from Community Resource Service Providers (CRSPs).
- Difficulty in obtaining required documentation from CRSPs.
- Delays in CRSPs completing the annual Individual Plan of Service (IPOS).
- Delays in CRSPs submitting ABA authorizations for approval.
- Delays from CRSPs in responding to returned authorizations.
- Delays in CRSPs providing IPOS training to Board Certified Behavior Analysts (BCBA) and Behavior Technicians (BT).
- Issues with CRSPs closing member cases without notifying ABA providers.
- Lack of capacity to provide autism services within the provider network, alongside staffing shortages.
- A low number of units/hours approved for the Behavioral Assessment and Treatment Plan compared to other Prepaid Inpatient Health Plans (PIHPs) and commercial insurance.

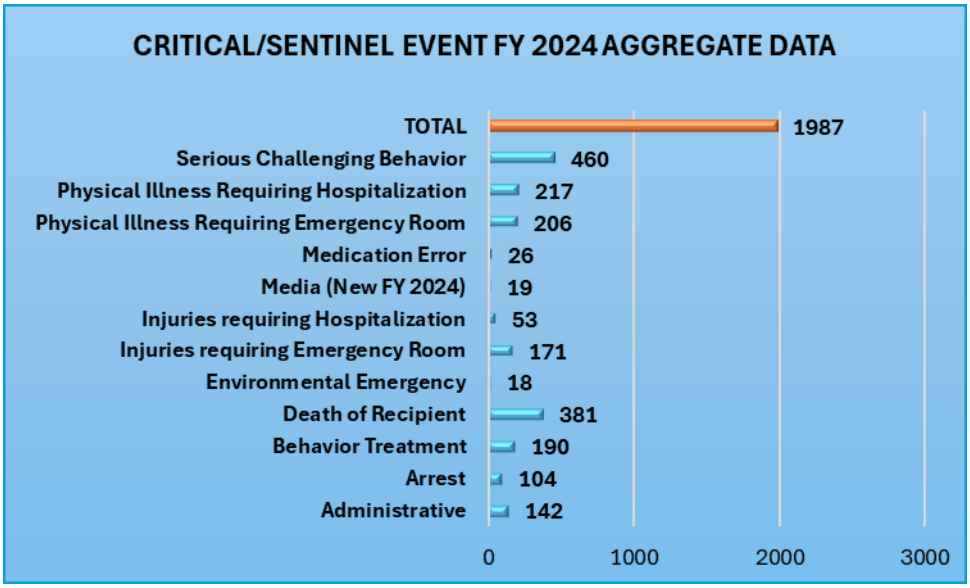
Opportunities for Improvement

- Develop and deploy a Best Practice Diagnostic Evaluation Report Template to ensure consistency, clarity, and completeness across all diagnostic reports.
- Require diagnostic evaluators to conduct self-audits using the report template and corresponding rubric to ensure accuracy, compliance, and adherence to best practices before submission.
- Mandate targeted continuing education for diagnostic evaluators that focuses on identified barriers and clinical needs specific to the Wayne County demographic profile, including disparities in access, cultural responsiveness, and diagnostic accuracy.
- Implement feedback sessions and modify data to create a more effective warm transfer following a diagnosis.
- Require diagnostic evaluators to conduct self-audits on documentation and reporting expectations.
- Redesign intake and referral workflows to provide a faster, more efficient pathway to Applied Behavior Analysis (ABA) and supportive services.
- Improve communication protocols among providers, families, and the Community Rehabilitation Services Program (CRSP) to ensure seamless coordination of care and timely initiation of services.
- Create a centralized system to track treatment plans, service progress, and goal attainment.
- Analyze the relationship between the number of treatment goals and achieved outcomes to identify treatment planning gaps, guide provider training, and strengthen quality oversight.
- Utilize outcome data to inform program-wide improvement initiatives and provide specific technical assistance to providers.
- Strengthening onboarding and continuing education requirements for new ABA providers to ensure consistent quality in treatment planning and adherence to evidence-based standards.
- Deliver targeted training across providers on case conceptualization, functional assessment, and data-driven treatment planning.
- Advocate for the creation of a Treatment Plan Oversight Specialist position within the Autism Services Team to support ongoing review of behavior assessments, monitor treatment plan quality, and facilitate provider coaching and consultation.
- Increase communication and coordination within the network regarding the recruitment of appropriate professionals and the timely initiation of treatment.

Critical/Sentinel, Unexpected Deaths, and Risk Reporting

Quantitative Analysis and Trending of Measures

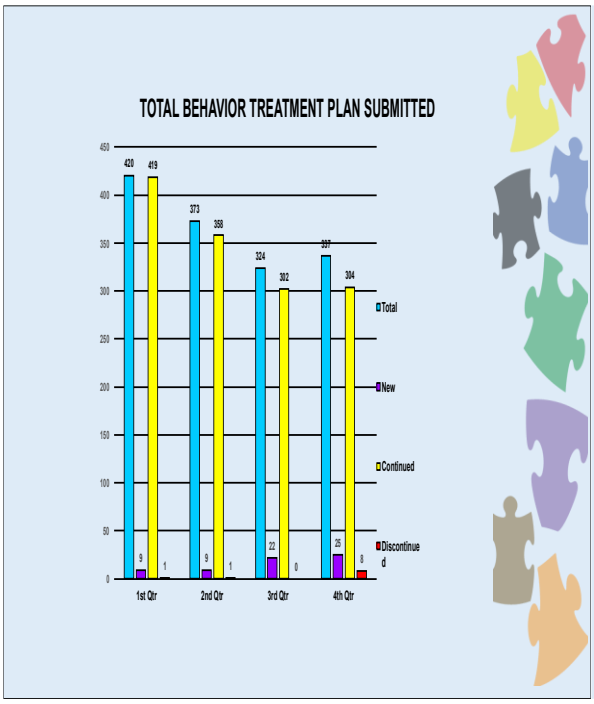
In FY25, a total of 1,987 critical events were entered into the reporting system, as illustrated in the chart below. This volume underscores the ongoing need for robust monitoring and response protocols to ensure member safety and regulatory compliance. Compared to FY24, the data indicates a consistent trend in reporting, with slight fluctuations across quarters that may correspond to seasonal variations or changes in service utilization. The sustained high number of critical events underscores the importance of continued staff training, timely documentation, and proactive risk mitigation strategies. Moving forward, tracking event types and root causes will be essential to identify patterns and implement targeted interventions to reduce recurrence and enhance overall quality of care.

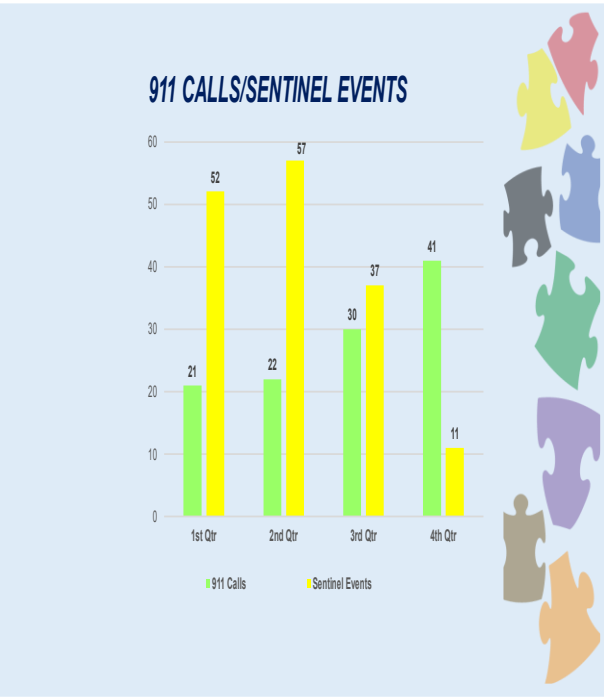


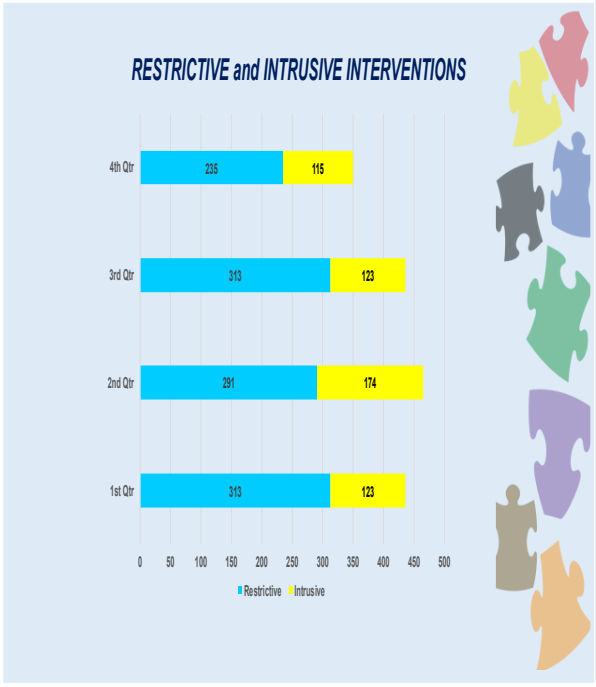
Behavior Treatment Review

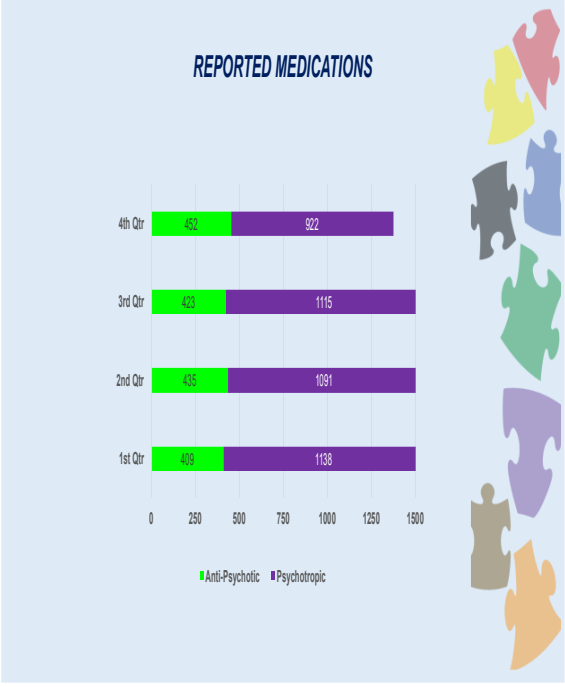
Quantitative Analysis and Trending of Measures

In FY25, a total of 1,454 Behavior Treatment Plans (BTPs) were reviewed, representing a decrease of 143 plans, or approximately 8.9%, compared to the previous year. This decline may indicate improved stability in treatment approaches or reduced need for plan revisions, though further analysis is warranted to confirm underlying causes. The charts below provide detailed insights into the utilization of intrusive and restrictive techniques applied during treatment, offering visibility into intervention patterns and compliance with behavioral standards. Additionally, the data includes the number of 911 calls associated with critical events reported during the same period, highlighting the importance of monitoring crisis escalation and ensuring timely intervention. These measures collectively serve as key indicators of treatment quality, member safety, and adherence to best practices.


TOTAL BEHAVIOR TREATMENT PLAN SUBMITTED
420
419
373
359
324
302
307
304
9
1
9
1
22
0
25
8
1st Qtr
2nd Qtr
3rd Qtr
4th Qtr
Total
New
Continued
Discontinued


911 CALLS/SENTINEL EVENTS
60
50
40
30
20
10
0
21
52
22
57
30
37
41
11
1st Qtr
2nd Qtr
3rd Qtr
4th Qtr
911 Calls
Sentinel Events


RESTRICTIVE and INTRUSIVE INTERVENTIONS
4th Qtr
235
115
3rd Qtr
313
123
2nd Qtr
291
174
1st Qtr
313
123
0
50
100
150
200
250
300
350
400
450
500
Restrictive
Intrusive


REPORTED MEDICATIONS
4th Qtr
452
922
3rd Qtr
423
1115
2nd Qtr
435
1091
1st Qtr
409
1138
0
250
500
750
1000
1250
1500
Anti-Psychotic
Psychotropic

Opportunities for Improvement

Under-Reporting:

- Critical indicators such as 911 calls, deaths, emergency treatments, and the use of physical management are under-reported.
- The Quality Improvement (QI) team is making targeted efforts with providers to enhance reporting accuracy, particularly for 911 calls involving beneficiaries of Behavior Treatment Plans.

EHR System Limitations:

- The electronic health record systems used by network Behavioral Treatment Provider and Resource Centers (BTPRCs) do not interface with the DWIHN Patient Care Encounter (PCE) system (MHWIN), contributing to reporting gaps. A primary obstacle to accurate reporting is the lack of integration, which prevents seamless data sharing essential to the timely capture and reporting of relevant information.

Reporting Errors:

- Misclassification of incident types continues to be a barrier. Incorrect categorization complicates the overall analysis and response to behavior treatment cases. To address this issue, a new 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 data collected on Behavior Treatment beneficiaries, thereby enhancing the organization's ability to monitor and evaluate outcomes more effectively.

Staffing Challenges:

- There is an ongoing shortage of clinicians who meet the Michigan Department of Health and Human Services (MDHHS) credentialing requirements for BTPRC participation, which affects compliance and the capacity for timely reviews.
- To address this issue, DWIHN is actively engaging with network providers to enforce the requirement that staff possess the MDHHS-mandated credentials for BTPRC review. This challenge has become increasingly difficult, as the shortage of qualified professionals limits the ability to develop behavior treatment plans and provide essential training and oversight, both critical for maintaining high standards of care.

Performance Improvement Projects (PIPs)

The DWIHN Departments are actively implementing a range of process improvement initiatives to enhance the quality of care provided to our clients. A significant portion of these initiatives is structured as Quality Improvement Projects (QIPs), which are meticulously overseen by two essential groups. The first group, the Improving Practices Leadership Team, focuses on establishing strategic direction and long-term goals for improvement across the organization. The second group, the Quality Improvement Steering Committee, plays a crucial role in ensuring that each project is closely aligned with the organization's overarching objectives and compliance standards.

In our commitment to enhancing operational efficiency, DWIHN has identified 9 Performance Improvement Projects (PIPs). These projects are specifically tailored to address various aspects of our operations, aiming to streamline processes and improve service delivery. However, this document will concentrate on a detailed evaluation of three selected PIPs, providing insights into their implementation and impact on organizational performance.

Improving Compliance with Doctor Visits for Youth Prescribed ADHD Medications

This is an important initiative for the DWIHN organization and our members, as 15.43% of our members fall under the SED (Serious Emotional Disturbance) disability designation. Within this percentage, 10% have been diagnosed with ADHD and are prescribed medication for it. ADHD consistently ranks among the top five behavioral health diagnoses for DWIHN children and adolescents. Without active monitoring, individuals receiving treatment may fall through the cracks, leading to issues at school, at home, or with friends.

From March 1, 2020, to February 28, 2021, only 12.98% of our members aged 6 to 12 years old who were prescribed ADHD medication completed a follow-up visit with a practitioner who has prescribing authority. Furthermore, only 13% of these members attended two follow-up visits within 210 days after the initiation phase of their treatment.

As a result, for fiscal year 2021, DWIHN has set an initial goal of achieving a 50% completion rate for both HEDIS (Healthcare Effectiveness Data and Information Set) measures. The Improving Practices Leadership Team has approved a quality improvement project designed to enhance these rates.

Quantitative Analysis and Trending of Measures (Chart 1: Percentage of children between 6-12 years of age who were diagnosed with ADHD and had one follow-up visit with a practitioner with prescribing authority within 30 days of their first prescription of ADHD medication.)

Measurement Period	Measurement	Numerator	Denominator	Rate	Comparison Goal	Statistical Significance
3/1/2022 – 2/28/2023 ****New Baseline****	Remeasurement 2	681	1154	59.01%	46.1%	Above Goal
3/1/2023 – 2/28/2024	Remeasurement 3	706	1152	61.28%	58.95%	Above Goal
3/1/2024 – 2/28/2025	Remeasurement 4	396	664	63.14%	64%	Below Goal

Baseline Measurement: (3/1/2022 – 2/28/2023)

During the initial Baseline reporting period from March 1, 2020, to February 28, 2021, 145 out of 1,117 youth aged 6 to 12 years who received ADHD medication completed the initial doctor visit. This resulted in a 12.98% compliance rate; thus, after reviewing the data, DWIHN set the baseline goal at 50%. A new baseline measurement period has been established for March 1, 2022, to February 28, 2023, during which 681 out of 1,154 eligible youth aged 6 to 12 years who were prescribed attention-deficit hyperactivity disorder medication completed an initial doctor visit. This resulted in a compliance rate of 59.01%, and the goal was subsequently changed to 46.01% in October 2022, in

accordance with regional data from Quality Compass. The compliance rate for the second remeasurement period was 3.31 percentage points higher than the first remeasurement period and 46.03 percentage points higher than the baseline data.

Remeasurement 1: (3/1/2023 – 2/28/2024)
The first remeasurement covers the time from March 1, 2023, to February 28, 2024, during which the new benchmark was set at 58.95% as of April 2023, in accordance with the HEDIS 95th percentile regional benchmark for this measure. However, due to the organization's sustained improvement in two previous remeasurements, IPLT recommended and approved increasing the goal for Remeasurement 3 to 64% in December 2023.

Remeasurement 2: (3/1/2024 – 2/28/2025) Preliminary
The second remeasurement covers the time from March 1, 2024, to February 28, 2025. As of September 2024, the new benchmark is 64%, up from 59.65%. This is currently below the 64% goal; however, the data is still preliminary. Thirteen out of 22 (59%) Children's Providers met the goal.

Chart 2: The percentage of children aged 6 to 12 who received a prescription for ADHD medication and continued using the medication for at least 210 days, as well as having at least two follow-up visits with a practitioner within the nine months following the initiation phase.

Measurement Period	Measurement	Numerator	Denominator	Rate	Comparison Goal	Statistical Significance
3/1/2022 – 2/28/2023 ****New Baseline****	Remeasurement 2	188	264	71.21%	62.04%	Above Goal
3/1/2023 – 2/28/2024	Remeasurement 3	227	328	69.21%	70.25%	Below Goal
3/1/2024 – 2/28/2025	Remeasurement 4	233	327	71.25%	76%	Below Goal

Baseline: (3/1/2022 – 2/28/2023)
During the initial baseline reporting period from March 1, 2021, to February 28, 2022, 59 of 454 youth aged 6 to 12 years receiving ADHD medication completed their ongoing doctor visits. This resulted in a compliance rate of 12.99%. After reviewing this data, DWIHN set a baseline goal of 50%. The new baseline period is from March 1, 2022, to February 28, 2023, during which 188 of 264 eligible youth who were prescribed ADHD medication completed an ongoing doctor's visit. This resulted in a compliance rate of 71.21%. Although the initial target was set at 50%, in October 2022, the goal for Remeasurement 2 increased to 62.04%, taking into account regional data from Quality Compass, as well as the challenges posed by COVID-19 and workforce issues. The compliance rate for Remeasurement 2 was 1.21 percentage points higher than that of Remeasurement 1 and 58.22 percentage points higher than the baseline, successfully exceeding the benchmark.

Remeasurement 3: (3/1/2023 – 2/28/2024)
The third remeasurement covers the period from March 1, 2023, to February 28, 2024. Initially, the goal was raised to 68.57% in April 2023, based on the HEDIS 95% regional benchmark. However, the IPLT committee revised it to 76% in December 2023, due to continued and sustained progress from the previous two remeasurements. During this reporting period, the compliance rate was 69.21%, below the new goal and a slight decrease from the previous reporting period.

Remeasurement 4: (3/1/2024 – 2/28/2025)

The fourth remeasurement covers the period from March 1, 2024, to February 28, 2025, with a new goal of 76%. While the data is currently preliminary, it indicates an improvement from the previous rating period with a compliance rate of 71.25%. Currently, 7 out of 14 Child Providers have met the goal, representing a compliance rate of 50%.

Evaluation of Effectiveness

The most effective interventions that contributed to increased compliance included:

- Increasing Awareness and Education for Children Providers: During various meetings, we focused on educating Children Providers about HEDIS measure expectations. This intervention proved effective, as providers were unaware of these expectations during the baseline reporting period. Presenting the barriers and solutions at IPLT in February 2022 was crucial.
- Training on Data Access in the MHWIN System: We provided education to Children Providers on how to view and monitor quarterly data using the scorecard in the MHWIN system. This intervention addressed the lack of awareness among providers about how to access data for their respective agencies during the baseline reporting period.
- Correcting Data in the Vital Data System: By correcting data in the vital data system, DWIHN was able to establish meaningful goals based on accurate information. Consequently, the goal shifted from the baseline reporting period to the national goal after the correct data was identified.
- HEDIS Newsletter: In December 2023, we developed a HEDIS Newsletter that contained educational information about ADHD medication for children, including the importance of follow-up doctor visits for initial and ongoing care. This newsletter was distributed to providers and featured in the Persons Point of View publication.
- Child Mental Health Lecture Series: In July 2024, DWIHN's Chief Medical Officer, Dr. Faheem, presented a training session titled "Psychotropic Medications in Children and Adolescents." This lecture educated providers about common psychiatric medications for children, including those for ADHD.

Identified Barriers

- The initial issues arose when the state changed the pharmacy codes. Consequently, DWIHN needed to collaborate with Vital Data to address the data discrepancies.
- Child providers were unaware of the expectations regarding the HEDIS ADHD Medication measure.
- Child providers also did not know how to view and monitor data for this HEDIS measure.
- Members and families were not informed about the importance of attending follow-up visits while taking ADHD medications.
- Transportation challenges prevented some members from attending follow-up doctor visits.
- The total number of eligible youths decreased during the COVID-19 pandemic in the Remeasurement 1 reporting period.
- There was a shortage of ADHD medication, resulting in members being unable to refill their prescriptions.
- Child provider staff were in short supply.
- Members were unable to complete more than one Medicaid service on the same day.

Opportunities for Improvement

- Educate families about this HEDIS measure (e.g., through a flyer).
- Review data for each provider and follow up with them regarding action steps.
- Discuss HEDIS progress and barriers with Children's Providers.
- Educate families about transportation options for attending doctor appointments.
- Include discussions in Medical Director meetings.
- Provide transportation resources and track the number of times members access them on the DWIHN mobile app.
- Update the DWIHN HEDIS website with the Children Initiative HEDIS Info Sheet and monitor the number of views.
- Include the Children Initiative HEDIS Info Sheet in the FY 24 Q1 Provider quarterly newsletter.
- Feature the Children Initiative HEDIS Info Sheet in the Winter 2024 issue of the "Persons Point of View" newsletter.
- Develop a Provider HEDIS Feedback Survey for providers to complete quarterly, which will include questions about barriers and interventions implemented
- Determine whether the prescriber is a Child Psychiatrist or a Primary Care Doctor.
- Begin including Chief Medical Officers in quarterly data reports and HEDIS communications.

Increasing Metabolic Monitoring for Children and Adolescents Taking Antipsychotics

In 2004, the American Diabetes Association, in conjunction with the American Psychiatric Association, the American Association of Clinical Endocrinologists, and the North American Association for the Study of Obesity, released treatment guidelines recommending metabolic screening for children and adolescents before and after the initiation of second-generation antipsychotics. Studies conducted after the publication of these guidelines showed a slight increase in glucose testing among children and adolescents; however, this increase was not sustained, and follow-up was limited.

Within the DWIHN population, 16% of children are classified as having serious emotional disturbances (SED). The most common diagnoses for youths aged 1-17 years in DWIHN include Adjustment Disorder, Autism Spectrum Disorder, Major Depressive Disorder, and Oppositional Defiant Disorder. Given the risks associated with not completing blood glucose and cholesterol testing for children and youth taking antipsychotic medications, DWIHN focused on improving this HEDIS measure in 2020 to support integrated healthcare.

Quantitative Analysis and Trending of Measures (Chart 1: Percentage of youth ages 1 to 11 with ongoing antipsychotic medication with complete metabolic testing for blood glucose and cholesterol levels)

Measurement Period	Measurement	Numerator	Denominator	Rate	Comparison Goal	Statistical Significance
1/1/2023 – 12/31/2023	NEW Baseline	136	695	19.57%	23.36%	Below Goal
1/1/2024 – 12/31/2024	Remeasurement 1	120	723	16.6%	23.36%	Below Goal
1/1/2025 – 12/31/2025 (As of November 2025)	**Remeasurement 2**	**109**	**699**	**15.59% (+)**	**23.36%**	**Below Goal**

New Baseline:
The rating period has been adjusted to reflect the previous two years of reporting, setting the new baseline from January 1, 2023, to December 31, 2023. Out of 695 eligible youth prescribed antipsychotic medication, 136 completed metabolic testing, which represents 19.57%. This marks an increase from the second remeasurement period and exceeds the baseline rate.

Remeasurement 1:
During the rating period from January 1, 2024, to December 31, 2024, the goal remained at 23.36%. However, the compliance rate dropped to 16.6%, down from the previous rating period, and was still below the established goal. It's important to note that the number of youths requiring metabolic testing increased to 723, up from the previous year.

Remeasurement 2: (preliminary data as of November 2025)
The rating period from January 1, 2025, to December 31, 2025, also maintained the 23.36% goal. The compliance rate increased to 15.59% from the previous year, although it still falls short of the goal.

Chart 2: Percentage of youth aged 12 to 17 receiving ongoing antipsychotic medication who have completed metabolic testing for blood glucose and cholesterol levels.

Measurement Period	Measurement	Numerator	Denominator	Rate	Comparison Goal	Statistical Significance
1/1/2023 12/31/2023	NEW Baseline	449	1439	31.2%	32.7%	Below Goal
1/1/2024 12/31/2024	Remeasurement 1	444	1474	30.12%	32.7%	Below Goal
1/1/2025 12/31/2025 (As of Nov 2025)	**Remeasurement 2**	**313**	**1356**	**23.08%**	**32.7%**	**Below Goal**

New Baseline:
The new baseline was established for the rating period of January 1, 2023, to December 31, 2023, to reflect the data from the last two years. We achieved a rate of 31.2%, slightly below the 32.7% goal.

Remeasurement 1:
During the rating period of January 1, 2024, to December 31, 2024, we achieved a rate of 30.12%. This represented a slight decrease from the previous year and remained below the 32.7% goal.

Remeasurement 2: (preliminary as of November 2025)
During the rating period of January 1, 2025, to December 31, 2025, we achieved a rate of 23.08%. This is below the 32.7% goal and lower than the previous year's rate.

Evaluation of Effectiveness

As of November 10, 2025, two of nineteen providers met the 23.36% goal for Measurement 1, while five of twenty-four providers met the 32.7% goal for Measurement 2. Effective interventions include:

- In December 2023, a HEDIS Newsletter was created to provide educational information about antipsychotic medications for children and the benefits of metabolic testing. This newsletter was distributed to providers and included in the "Persons' Point of View" publication.
- In July 2024, Dr. Faheem, the Chief Medical Officer of DWIHN, conducted a training session as part of the Child Mental Health Lecture Series titled "Psychotropic Medications in Children and Adolescents." This training focused on common psychiatric medications used for children, including antipsychotic medications, and highlighted the importance of metabolic testing.
- On February 5, 2024, a memorandum was sent to providers of SED and IDD Children, informing them about HEDIS resource information and the outcomes of HEDIS goals across the network. Starting in January 2024, providers must complete a quarterly feedback survey if they do not meet the established goals.
- Beginning in May 2025, HEDIS measure information was incorporated into the Core Competency Trainings for both new and seasoned clinicians. The Initial Core Competency Training for new clinicians took place on May 8, 2025, while the Booster Core Competency Training for seasoned clinicians was held on August 14, 2025. This training is mandatory for SED Providers, and from 2025 onward, IDD Children Providers have also been invited to attend.

Identified Barriers

- Initial issues arose when the state changed the pharmacy codes, which required DWIHN to collaborate with Vital Data to resolve data discrepancies.
- Children's providers were not informed about the expectations for the HEDIS Antipsychotic Medication measure.
- Children's providers lacked knowledge on how to view and monitor data related to this HEDIS measure.
- Members and families were unaware of the benefits of completing metabolic testing.
- Transportation challenges prevented members from attending follow-up doctor visits.
- More than one staff member is needed to complete bloodwork.

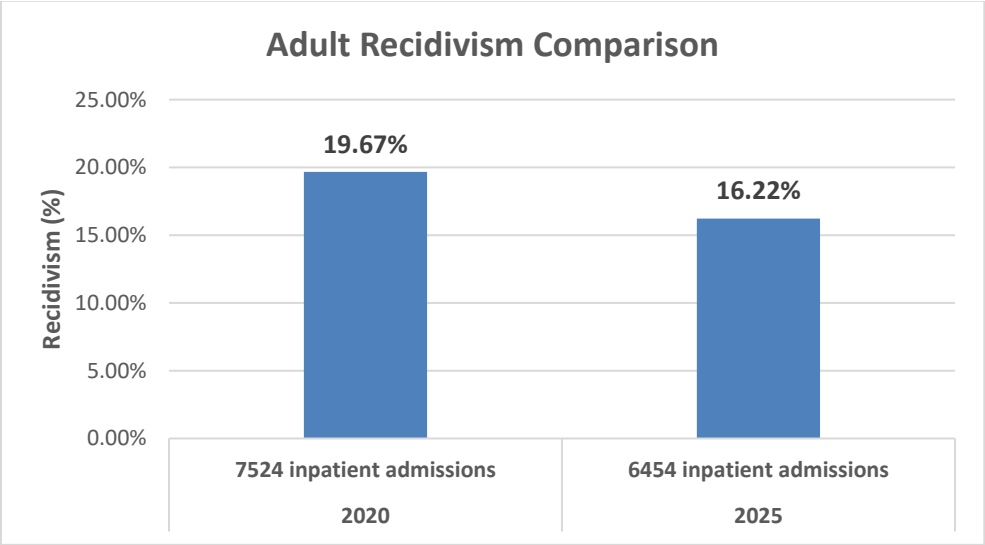
Opportunities for Improvement

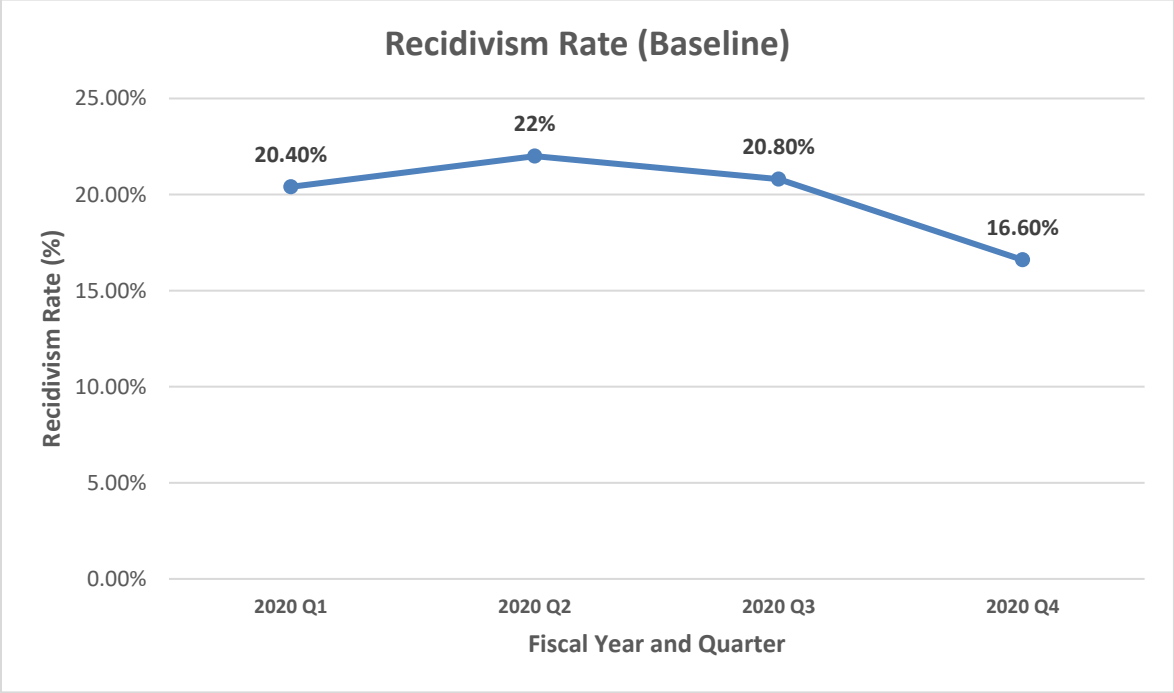
- Include transportation resources and track the number of times members view them on the DWIHN mobile app.
- Update the DWIHN HEDIS website with the Children Initiative HEDIS Info Sheet and track the number of times the website is viewed.
- Include the Children Initiative HEDIS Info Sheet in the FY 24, Q1 Provider quarterly newsletter.
- Include the Children Initiative HEDIS Info Sheet in the Winter 2024 edition of the Persons Point of View newsletter. Develop a Provider HEDIS Feedback Survey for providers to complete quarterly. This survey will include questions about barriers and interventions implemented:
- Determine if the member has a psychosis diagnosis.
- Determine if more than one staff member is needed to complete bloodwork.
- Start including CRSP Chief Medical Officers and the Quality Director in quarterly data reports and HEDIS communications.
- Recommend maintaining the goal at 23.36% for Measurement #1 (this is still below the overall goal, and we can review it after 12/31/2023).
- Recommend maintaining the goal at 32.7% for Measurement #2 (although there has been progress above the goal, the estimated year-end measurement is projected to decrease, and we can review it after 12/31/23).

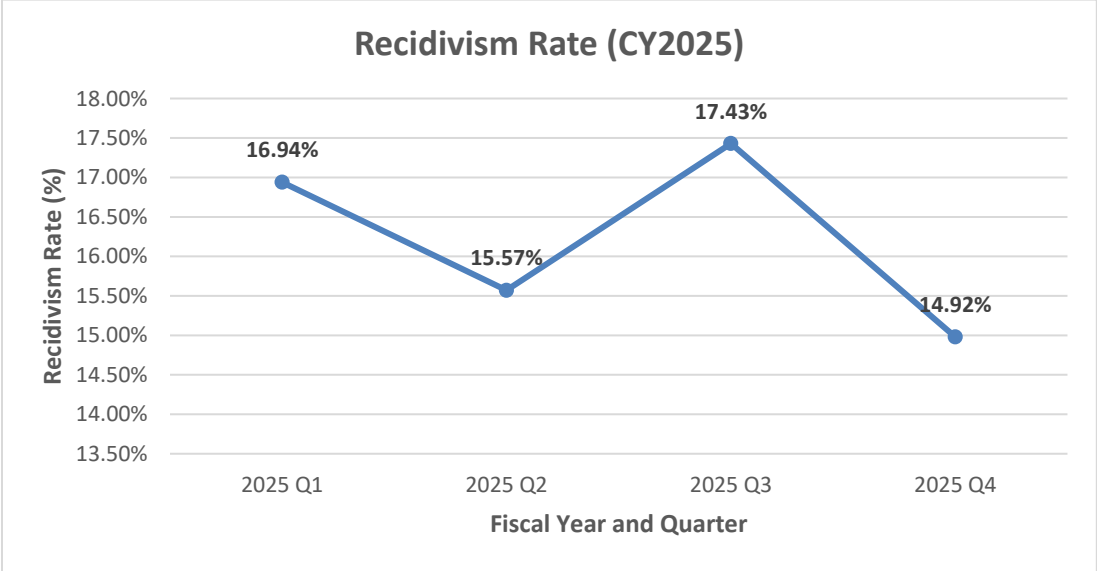
- Providers should develop an alert system in the EHR when antipsychotic medication is prescribed for young people. Explore barriers by determining whether the metabolic order was written by the CRSP or whether the member followed up to complete the metabolic testing.
- CRSPs should look to partner with an in-house lab to complete bloodwork.
- Implement a complex case management referral.

Reducing the Number of Adult Members Readmitted within 30 Days of Discharge from an Inpatient Psychiatric Unit Quantitative Analysis and Trending of Measures

DWIHN aims to reduce psychiatric hospital admissions and readmissions by providing safe, timely, and high-quality treatment alternatives. To analyze the data relative to the baseline year, it is important to note that in FY2020, there were 7,524 inpatient admissions among adult members aged 18 and over with Mental Illness (MI) and Developmental Disabilities (DD). Out of these admissions, 1,480 adults (19.67%) were readmitted. By FY2025, the total number of inpatient admissions in the same demographic had decreased to 6,454, with 1,047 adults (16.22%) being readmitted. Although the overall number of inpatient admissions has declined, the readmission rate remains above the target of 15% or less for the adult population. However, preliminary data for Q4 of FY2025 indicates a compliance rate of 14.92%. The charts below visually illustrate these trends and measurements over the years.




Recidivism Rate (Baseline)
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
Recidivism Rate (%)
20.40%
22%
20.80%
16.60%
2020 Q1
2020 Q2
2020 Q3
2020 Q4
Fiscal Year and Quarter


Recidivism Rate (CY2025)
18.00%
17.50%
17.00%
16.50%
16.00%
15.50%
15.00%
14.50%
14.00%
13.50%
Recidivism Rate (%)
16.94%
15.57%
17.43%
14.92%
2025 Q1
2025 Q2
2025 Q3
2025 Q4
Fiscal Year and Quarter

Identified Barriers and Interventions

Several barriers contribute to the challenge of reducing recidivism rates within behavioral health populations. These include limited access to timely crisis intervention services, gaps in care coordination across providers, and insufficient engagement strategies that address members' unique needs and social determinants of health. Additionally, fragmented communication between systems and inconsistent follow-up after acute episodes often result in individuals cycling back into crisis. Recognizing these challenges, DWIHN is actively expanding the continuum of crisis services and implementing innovative approaches to enhance member engagement, ensuring that individuals receive comprehensive, person-centered support throughout their recovery journey.

To address these barriers and meet the goal of reducing recidivism to **15% or less**, DWIHN has established measurable objectives:

- Expand 24/7 crisis service availability by increasing mobile crisis response teams by 15% within the next fiscal year.
- Enhance member engagement through proactive outreach.
- Implement peer support programs in crisis stabilization, with a target of 80%-member participation.
- Improve care coordination by integrating real-time data sharing across providers, with 90% compliance with the care plan updates within 30 days.
- Monitor and report recidivism rates quarterly, ensuring continuous progress toward achieving the 15% baseline goal.

Finance Pillar

Quality Referrals for Recoupment in FY25

At the end of FY25, the Quality Department referred 21 cases to the Corporate Compliance Department for review. These referrals led to a total recoupment of $8,430.43 from both open and closed cases during the fiscal year. This outcome reflects the department's ongoing commitment to ensuring compliance and mitigating financial risk by proactively identifying and reporting potential issues. Although no previously identified concerns were noted, the results demonstrate effective collaboration between the Quality and Compliance teams.

Moving forward, the focus will be on maintaining this level of diligence while exploring opportunities to enhance the referral process and increase recovery outcomes in future years. Recommended actions include:

- Implementing a quarterly review process to identify potential compliance risks more quickly.
- Providing targeted training for staff to improve detection and documentation practices.
- Leveraging data analytics to identify patterns and prioritize high-risk cases for timely intervention.

External Quality Reviews

DWIHN takes part in comprehensive external quality reviews conducted by the Health Services Advisory Group (HSAG). These reviews are essential for ensuring compliance with all regulatory requirements outlined in its contract with the Michigan Department of Health and Human Services (MDHHS).

Performance Improvement Project (PIP)

Quantitative Analysis and Trending of Measures

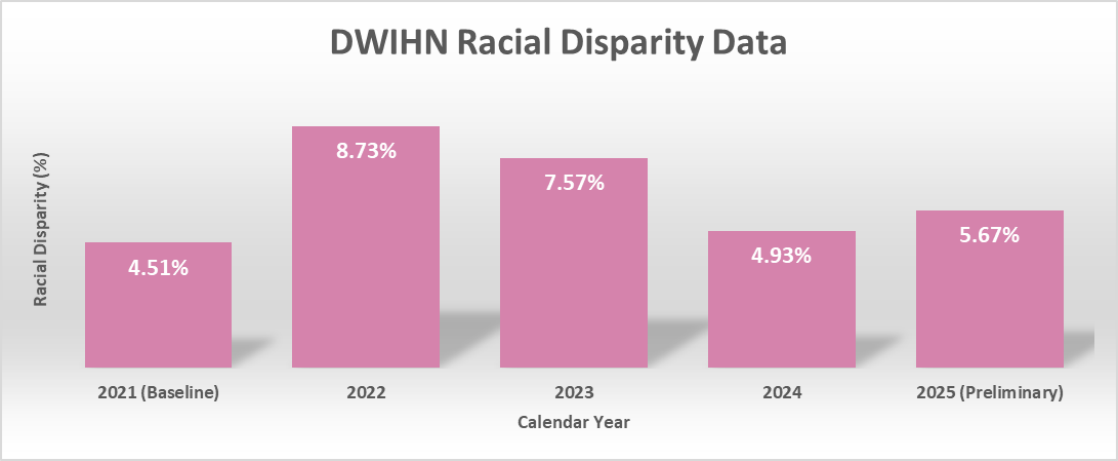
DWIHN initiated a three-year initiative to address racial disparities in follow-up hospitalization after discharge, with a baseline gap of 4.51%. This measure tracks differences in follow-up rates within 7 days of hospitalization across racial groups, aiming to reduce inequities and improve continuity of care.

Performance Trends

- 2023: The disparity gap peaked at 7.57%, significantly above the baseline (+3.06 percentage points, or +67.8% higher than baseline), indicating systemic challenges in equitable access to follow-up care.
- 2024: Targeted interventions led to a substantial improvement, reducing the gap to 4.93% (−2.64 percentage points, a 34.9% year-over-year improvement), bringing the measure closer to baseline.
- 2025: The gap increased slightly to 5.67% (+0.74 percentage points, or +15.0% compared to 2024), signaling partial regression and highlighting the need for sustained efforts.

Overall Progress

From 2023 to 2025, the disparity gap decreased by 1.90 percentage points (−25.1% improvement overall), but remains 1.16 percentage points above baseline, underscoring the need for continued focus on equity-driven strategies.



Performance Measures Validation (PMV)

For four consecutive years, DWIHN has consistently achieved full compliance during the HSAG Performance Measurement Validation (PMV) review, demonstrating our strong commitment to quality, accuracy, and accountability in performance reporting. Each annual review confirmed that DWIHN met all required standards for data integrity, methodology, and reporting processes, ensuring that performance measures accurately reflect the care and services provided to our members.

While achieving full compliance, HSAG provided minor recommendations to enhance operational efficiency and streamline internal processes. These recommendations focused on improving documentation workflows, refining data validation procedures, and leveraging technology to optimize reporting timeliness. DWIHN has proactively addressed these recommendations, integrating best practices to strengthen our infrastructure and maintain excellence in performance measurement.

This sustained record of compliance underscores DWIHN's dedication to transparency, continuous improvement, and the delivery of high-quality behavioral health services to the communities we serve.

Compliance Review

Quantitative Analysis and Trending of Measures

DWIHN achieved an impressive overall score of 97% in its second-year compliance review by HSAQ, successfully meeting 140 out of 145 criteria. This represents a significant improvement over fiscal year 2024, highlighting DWIHN's commitment to raising its standards and practices. The data below presents the compliance scores from 2021 and 2022, 2024, in comparison to the scores from 2025:

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard II – Emergency and Post stabilization Services	13	13	13	0	0	**100% (100%)**
Standard VII—Provider Selection	16	16	12	4	0	**75% (100%) +25**
Standard VIII—Confidentiality	11	11	10	1	0	**91% (91%)**
Standard IX—Grievance and Appeal Systems	38	38	32	6	0	**84% (92%) +8**
Standard X—Sub contractual Relationships and Delegation	5	5	4	1	0	**80% (100%) +20**
Standard XI—Practice Guidelines	7	7	6	1	0	**86% (100%) +14**
Standard XII—Health Information Systems	12	11	9	2	1	**82% (100%) +18**
Standard XIII—Quality Assessment and Performance Improvement Program	30	30	25	5	0	**83% (100%) +17**
Total	**119**	**118**	**98**	**20**	**1**	**83% (97%) +14**

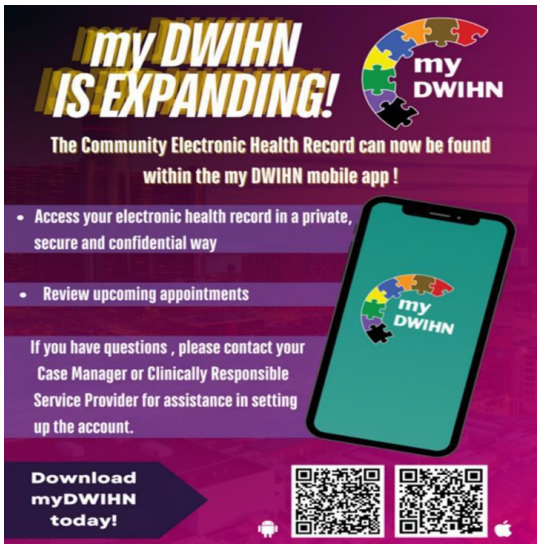
Fiscal year 2024 standards	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Member Rights and Member Information	24	22	18	4	2	**82% (we were 84% in 2021) -2**
Standard III—Availability of Services	20	18	17	1	2	**94% (we were 86% in 2021) +8**
Standard IV—Assurances of Adequate Capacity and Services	11	9	9	0	2	**100% (we were 0% in 2021) +100**
Standard V—Coordination and Continuity of Care	16	15	15	0	1	**100% (we were 79% in 2021) +21**
Standard VI—Coverage and Authorization of Services	23	22	17	5	1	**77% (we were 64% in 2021) +13**
Total	**94**	**86**	**76**	**10**	**8**	**88% (we were 77% in 2021) +11**

Advocacy Pillar

Community Outreach

The myDWIHN community mobile app provides valuable resources related to mental health, substance use disorders, disabilities, and services available for children. With the app, users can easily locate any of our 400 service providers. The myDWIHN app is free for everyone to download.

We have enhanced the Community Electronic Health Record based on valuable feedback and contributions from the individuals we serve. This improvement not only integrates their insights but also aims to better meet their needs and enhance the overall quality of care provided in our community.



Media Outreach

In the 2025 fiscal year, the Communications team continued to use Critical Mention, a comprehensive online platform specializing in media analytics, monitoring, and search. This powerful tool enables the team to effectively assess the impact of earned media by quantifying the reach and engagement of published stories. Additionally, it allows for the collection of broadcast clips and print articles, ensuring that all relevant media mentions are captured for analysis. Furthermore, Critical Mention offers an extensive search function for media contacts, empowering the team to expand their outreach and connect with a diverse range of media outlets. This ultimately enhances their communication efforts and visibility.

Media Analytics

DWIHN received 373 mentions, with the majority from paid advertising. Below are the metrics gathered:

55.5k Total TV Audience	**55.5k** Local Audience	**$8.122k** Total TV Publicity	**$8.122k** Local Publicity
131k Total Radio Audience		**$154** Total Radio Publicity	
20.1M Total Online Audience		**$59.2k** Total Online Publicity	

Social Media

DWIHN posts that highlight the diverse communities we serve and the dedicated staff members who engage in direct, face-to-face interactions consistently outperform other types of content. For example, stories featuring staff who go above and beyond to support local families or initiatives create a strong connection with our audience. This type of content not only demonstrates the tangible impact of our work but also showcases our team's genuine care and commitment. As a result, these posts generate significantly higher engagement and are shared more frequently across platforms, amplifying our message and encouraging community involvement.

Sharing Information

Ask the Doc

DWIHN's Chief Medical Officer, Dr. Shama Faheem, continues to educate the public through her bimonthly newsletter and videos that address mental health-related questions submitted by staff, stakeholders, and the individuals we serve. This past year, we have also featured our Medical Director of Crisis Services, Dr. Dalia Mammoto, in these videos. The information is distributed to providers and stakeholders and is also posted on the DWIHN website and social media platforms. Additionally, the Communications Team has transitioned the newsletter into a digital format. For more information, please visit our website.

DWIHN produces and distributes quarterly newsletters specifically designed for our members and providers. The primary objective of these newsletters is to keep members informed about the latest developments regarding the programs and services available to them. Additionally, we aim to provide providers with critical updates on regulatory changes, recent reports, and contractual requirements that may impact their operations within our network.

Through these newsletters, the Quality Improvement unit shares a variety of important information, including updates on quality initiatives, emerging best practices in service delivery, changes in healthcare policies, and resources for enhancing member outcomes. Our goal is to deliver comprehensive insights that help both members and providers navigate the evolving healthcare landscape effectively.

Meeting documents, reports, and evaluations, including QISC minutes, the QAPIP description plan, evaluation, and Home and Community-Based Services (HCBS) information, are available on the DWIHN website.

Utilization Management

The Annual Utilization Management (UM) Program for Fiscal Year 2025 is detailed in a separate document. To support its UM initiatives, the DWIHN UM department maintains a comprehensive Utilization Management Program Description. This document outlines the specific procedures and methodologies for assessing medical necessity criteria and describes the processes for reviewing and approving mental health and substance use disorder services. It serves as a foundational guide to ensure a consistent and fair assessment of service utilization, fulfilling several critical functions.

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 executing 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 actively engages with the Quality Improvement Steering Committee (QISC), which plays a crucial role in guiding and monitoring the progress of quality improvement efforts across 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 implementing the Quality Assurance and Performance Improvement Plan (QAPIP), which outlines the framework for quality improvement activities. The IT Unit is responsible for providing comprehensive data analysis and management services that are crucial for evaluating organizational performance. These services support various functions, including business modeling, strategic planning, and targeted quality initiatives. The IT Unit's responsibilities encompass managing business operations, including 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 outcome data to determine the significance of changes 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 examine potential relationships among 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 detailed reports, informative summaries, actionable recommendations, and visual representations (e.g., charts and graphs). These outputs not only facilitate communication with stakeholders but also enhance the effectiveness of Quality Improvement Activities, driving DWIHN toward greater success in its quality improvement efforts.

The chart below provides a detailed overview of the internal staff members on 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 improving service and process quality, 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 fiscal year 2025 has been conducted. This comprehensive assessment included a detailed review of trends in various QI measures over a specific timeframe, facilitating in-depth comparisons with established performance objectives. It encompassed both quantitative and qualitative analyses of completed and ongoing QI activities. Overall, significant improvements were achieved across the planned QI initiatives, which address both clinical and service-related aspects. Furthermore, several programs 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, along with the FY2024 Work Plan (refer to Attachment A for details). The implementation of the FY2024 QI Work Plan has progressed as planned, adhering to the established timeline and objectives. The indicators assessed in this plan span a broad spectrum, including metrics on the quality of clinical care, service delivery, and safe clinical practices. These QI initiatives are directly aligned with the needs and preferences of Wayne County residents and closely reflect DWIHN's overarching mission and vision.

Moreover, DWIHN's organizational structure and resource allocation have proven adequate and effective in supporting the QI process. To assess the quality of available resources, DWIHN evaluates the percentage of key activities completed in relation to the associated goals. Following a thorough review of the Quality Program's performance, DWIHN has determined that it possesses sufficient staffing resources to meet its current program goals, which emphasize the importance of highly educated and trained personnel.

DWIHN has conducted a comprehensive assessment of data integrity, personnel capabilities, and software functionality to ensure its health information system can efficiently collect, analyze, and integrate essential data to support the effective implementation of the QI program. The IT department at DWIHN has successfully designed, rigorously tested, and implemented the Provider Risk Matrix dashboard, which is based on measurable, scientifically grounded goals tailored for CRSP providers. Additionally, a new Business Intelligence platform utilizing Microsoft Power BI has been introduced. This platform enables DWIHN to seamlessly connect its diverse data sources and disseminate information among staff and providers, allowing them to focus on delivering high-quality care efficiently.

Furthermore, 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 comprehensively manage both Behavioral and Physical Health services. The Chief Medical Officer (CMO) of DWIHN plays a pivotal role by chairing the Quality Improvement Steering Committee (QISC) alongside the Quality Improvement Administrator. As the designated senior official, the CMO is responsible for the successful implementation and oversight of the QAPIP.

DWIHN actively promotes the use 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. Additionally, the Chief Medical Officer participates in several crucial committees that help improve clinical practices and member safety. These roles underscore the CMO's commitment to enhancing service quality and ensuring that DWIHN meets its performance objectives while addressing the needs of the communities it serves. Key committees include:

- Improving Practices Leadership Team (IPLT)
- Sentinel Events Peer Review Committee (SEPRC)
- Behavior Treatment Advisory Committee (BTAC)
- Credentialing Committee
- Compliance Committee

Committee Structure

After a careful evaluation of the Quality Improvement (QI) program committee's structure, the participation and involvement of the Detroit Wayne Integrated Health Network (DWIHN) committees are more than sufficient. Each committee member consistently attends meetings and actively engages in discussions and initiatives during the Quality Improvement Steering Committee (QISC) meetings. This level of engagement underscores DWIHN's commitment to fostering a culture of quality improvement.

DWIHN's dedication to enhancing quality is evident at all levels of the organization, from leadership to frontline staff, ensuring that quality improvement initiatives are universally embraced. The existing governance structure effectively supports strategic oversight and aligns with key organizational initiatives, providing comprehensive guidance. This alignment is crucial for DWIHN, as it works diligently to achieve its defined goals and objectives.

Given this strong foundation and effective collaboration, no changes are anticipated for fiscal year 2026. The current setup is considered optimal for continuing to promote excellence in quality improvement practices across the organization.

Practitioner Participation

DWIHN is dedicated to incorporating substantial practitioner feedback through our ongoing Quality Improvement and Safety Committee (QISC) and the Quality Operations Workgroup, as well as through various ad hoc provider advisory workgroups formed as needed. This active participation underscores the collaborative efforts between our extensive provider network and practitioner leadership.

Practitioners are essential at all stages of program development, including planning, design, implementation, and evaluation. Their involvement encompasses thorough data collection and analysis, ensuring that all programs are grounded in evidence-based practices. This comprehensive approach effectively manages the health and well-being of the overall population, fostering collaboration with key stakeholders, including health plans, care delivery systems, and community partners.

In addition to their contributions to QISC, DWIHN actively seeks practitioner input on key initiatives, allowing diverse perspectives to inform our decision-making. We regularly assess the level of practitioner involvement to ensure that it aligns with our program objectives. Based on this evaluation, we are confident that the current level of engagement and consultation is adequate to achieve the goals of our Quality Program. Therefore, no changes are anticipated for fiscal year 2026.

QI Program Effectiveness FY2025

The program's effectiveness is evaluated based on goal achievement, opportunities for improvement, organizational performance, and efficiency. In the Fiscal Year 2025 (FY2025) work plan, we established an ambitious target of 36 goals to advance our strategic initiatives. We successfully assessed 32 of these goals, while 4 remain unassessed due to insufficient data. This results in a completion rate of 88.9%, indicating significant progress toward our objectives.

However, it is essential to emphasize that the goals that were not met or only partially met are critical to our strategic priorities. These goals are vital to our mission and vision; therefore, we will carry them over into the Fiscal Year 2026 (FY2026) work plan. By doing this, we aim to ensure that our organizational objectives continue to be supported, and we can make the necessary adjustments to achieve these important targets in the future. Below is a breakdown of the assessed goals.

Summary of Assessed Goals

- Met: 31% (10 out of 32)
- Not Met: 50% (16 out of 32)
- Partially Met: 19% (6 out of 32)

Areas for Improvement

- Address unmet goals through targeted corrective action plans that identify root causes and outline specific steps for resolution.
- Implement Performance Improvement Projects (PIPs) focused on high-priority gaps to drive measurable progress.
- Strengthen data collection and monitoring processes to ensure timely evaluation of all goals.
- Enhance stakeholder engagement and accountability to support the successful implementation of improvement strategies.

Overall Assessment

The QI Program successfully promoted quality initiatives and ensured compliance, resulting in significant evaluations and measurable improvements. To enhance its effectiveness in the upcoming fiscal year, the program will focus on goals that have not been fully achieved and those that are partially met. These goals will be reviewed and assessed in fiscal year 2026.

Goals and Objectives FY2026

The primary focus for FY2026 is to strengthen quality improvement initiatives that drive measurable outcomes, enhance operational efficiency, and align with organizational priorities. Our approach emphasizes data-driven decision-making, stakeholder engagement, and sustainable process improvements.

Key Goals and Focus Areas

1. **Enhance Quality Metrics and Reporting**
    - Implement advanced analytics to monitor performance indicators.
    - Standardize reporting processes for greater transparency and accuracy.
    - Develop dashboards for real-time tracking of quality outcomes.
2. **Strengthening Compliance and Accreditation Readiness**
    - Conduct quarterly audits to ensure adherence to regulatory standards.
    - Prepare for upcoming accreditation reviews with proactive gap analysis.
    - Provide training and resources to maintain compliance excellence.
3. **Improve Member Experience**
    - Launch initiatives to reduce waiting times and improve delivery service.
    - Collect and analyze feedback to identify areas for improvement.
    - Incorporate person-centered care principles into the assessment workflows.
4. **Foster Staff Engagement and Development**
    - Provide targeted training on quality improvement methodologies.
    - Create recognition programs for staff contributions to quality goals.
    - Encourage a culture of accountability and innovation.

QAPIP Work Plan

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for Each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
Customer Pillar	**Member Experience**						
Goal I (Members' Experience and Quality of Service)	**Enhance Member Experience Through Services**						
I.1	ECHO Annual Satisfaction Surveys (Adult and Children)	Director of Customer Service	FY 2024-2025 (October 1, 2024, through September 30, 2025).	Monitoring identified areas for improvement aims to enhance the experience of both adult and child members and increase member involvement in their care. These efforts will focus on: Improving Communication, Expanding Engagement Opportunities, and Incorporating member feedback into care planning and quality initiatives. These actions will strengthen member satisfaction, improve outcomes, and align with our commitment to quality of care.	Key areas for improvement include member engagement, collaboration on treatment options, and reducing scheduling delays for the first appointment after the initial request.	The 2025 survey results are pending analysis, which will be shared with QISC in Q3 FY2026 for feedback on quality improvement and strategic planning.	Quarterly reports will be submitted to the PCC, and the Annual Evaluation Report for FY 2025 will be presented to QISC and PCC in the second quarter of FY 2026.

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for Each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
I.2	Provider and Practitioner Satisfaction Survey	Director of Strategic Operations	FY 2023-2024 (October 1, 2023, through September 30, 2024).	Monitoring identified issues to address gaps in low survey participation, documentation, and redundancy.	Key areas for improvement that require follow-up include documentation volume and redundancy.	In the 2024 Fiscal Year, DWIHN distributed 237 surveys to contracted providers and received 74 completed surveys, resulting in a 31% response rate. This goal will continue in FY2026, with Effective strategies to improve provider survey response rates by shortening and simplifying the survey, personalizing communication, and offering possible incentives.	Quarterly reports will be submitted to the PCC, and the Annual Evaluation Report for FY 2025 will be presented to QISC and the PCC in the second quarter of FY 2026.

QAPIP Work Plan

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for Each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
I.3	Member Grievance/Appeals	Director of Customer Service	FY 2024-2025 (October 1, 2024, through September 30, 2025).	Monitoring previously identified issues regarding accessibility of services and gaps in communication.	Key issues include delayed appointments, provider availability, and transportation barriers.	In FY25, the unit recorded 3,729 complaints and 79 formal grievances, resolving 50 on time. While compliant volume remains steady, the low escalation rate suggests effective early interventions. Key issues include service accessibility and communications gaps, underscoring the need for improved provider education and member outreach.	Quarterly reports will be submitted to the PCC, and the Annual Evaluation Report for FY 2025 will be presented to QISC and PCC in the second quarter of FY 2026.

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for Each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
I.4	Timeliness of Utilization Decisions within 14 calendar days.	Director of Utilization Management	FY 2024-2025 (October 1, 2024, through September 30, 2025).	Monitoring previously identified issues to meet the 14-day requirement.	There are no previously identified issues that require follow-up.	The 95% timeliness requirement for non-urgent authorization requests was not met in three of the four quarters of FY2025.	Quarterly reports will be submitted to the PCC, and the Annual Evaluation Report for FY 2025 will be presented to QISC and PCC in the second quarter of FY 2026.
I.5	Practice Guidelines	Chief Medical Officer	FY 2024-2025 (October 1, 2024, through September 30, 2025).	There are no previously identified issues to monitor.	There are no previously identified issues that require follow-up.	During the HSAG review, DWIHN received a 100% compliance score for sharing practice guidelines with providers at least annually or as required by national standards.	Quarterly reports will be submitted to the PCC, and the Annual Evaluation Report for FY 2025 will be presented to QISC and PCC in the second quarter of FY 2026.

QAPIP Work Plan

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for Each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
Access Pillar	**Quality and Safety of Clinical Care**						
Goal	**Enhance members' access to services, improve the quality of clinical care, and ensure 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 2024-2025 (October 1, 2024 through September 30, 2025).	There are no previously identified issues to monitor.	There are no previously identified issues that require follow-up.	The target goal was met at 97% in FY2025.	Quarterly reports will be submitted to the PCC, and the Annual Evaluation Report for FY 2025 will be presented to QISC and PCC in the second quarter of FY 2026.

QAPIP Work Plan

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for Each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
II.2	Indicator 2(a) and 2(b) - Percentage of persons (Children and Adults) receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.	Director of Quality Improvement	FY 2024-2025 (October 1, 2024 through September 30, 2025).	Monitoring previously identified issues addresses existing gaps in appointment availability.	The previously identified issue was the lack of available appointments for the children's population.	The target goal was not met. Performance Indicator #2a: overall population rate of 53.82%, below the 57% standard. We faced challenges in meeting the DD/ child standards throughout the year, recording quarterly rates of 35.84% in Q1, 34.14% in Q2, 36.57% in Q3, and 34.69% in Q4. This goal will continue into FY2026.	Quarterly reports will be submitted to the PCC, and the Annual Evaluation Report for FY 2025 will be presented to QISC and PCC in the second quarter of FY 2026.
II.3	Indicator 3(a) and 3(b) - Percentage of persons (Children and Adults) needing ongoing service within 14 days of a non-emergent assessment with a professional.	Director of Quality Improvement	FY 2024-2025 (October 1, 2024 through September 30, 2025).	There are no previously identified issues to monitor.	There are no previously identified issues that require follow-up.	The target goal was met. DWIHN recorded a 93.65% PI#3 rate in FY2025, exceeding the 87% standard and ranking among Michigan's best.	Quarterly reports will be submitted to the PCC, and the Annual Evaluation Report for FY 2025 will be presented to QISC and PCC in the second quarter of FY 2026.

QAPIP Work Plan

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for Each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
II.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 2024-2025 (October 1, 2024 through September 30, 2025.	There are no previously identified issues to monitor.	There are no previously identified issues that require follow-up.	In FY25, DWIHN scheduled follow-up appointments for 96.84% of members within seven days of discharge from psychiatric care, exceeding the 95% standard.	Quarterly reports will be submitted to the PCC, and the Annual Evaluation Report for FY 2025 will be presented to QISC and PCC in the second quarter of FY 2026.
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 2024-2025 (October 1, 2024 through September 30, 2025).	There are no previously identified issues to monitor.	There are no previously identified issues that require follow-up.	The target goal for Post Substance Use Disorder Detox was met at 96.69% in all quarters of FY2025, surpassing the 95% standard.	Quarterly reports will be submitted to the PCC, and the Annual Evaluation Report for FY 2025 will be presented to QISC and PCC in the second quarter of FY 2026.

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for Each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
II.6	Indicator 10 (a) and 10 (b) - Percentage of readmissions (Children and Adults) to inpatient psychiatric units within 30 days of discharge.	Director of Quality Improvement	FY 2024-2025 (October 1, 2024 through September 30, 2025).	Monitoring previously identified issues aims to reduce recidivism among members.	The adult recidivism rate is above 15%, exceeding the state standard.	The target was partially met. In 2025, the children's rate was 12.64%, below the MDHHS standard of 15%, while the adult rate was 16.24%, surpassing the requirement for three quarters.	Quarterly reports will be submitted to the PCC, and the Annual Evaluation Report for FY 2025 will be presented to QISC and PCC in the second quarter of FY 2026.

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for Each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
II.7	Complex Case Management	Director of Integrated Health Care	FY 2024-2025 (October 1, 2024 through September 30, 2025).	Monitoring previously identified issues is addressing existing gaps.	The previously identified issue requiring follow-up is the reduction in emergency visits among CCM members.	In FY24, 25% of CCM members reduced emergency department visits by 10%. This improved to 56% in FY25. Reducing ED visits will remain a focus in FY26.	Quarterly reports will be submitted to the PCC, and the Annual Evaluation Report for FY 2025 will be presented to QISC and PCC in the second quarter of FY 2026.

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for Each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
II.8	Crisis Services	Director of Utilization Management, Director of Crisis Services	FY 2024-2025 (October 1, 2024 through September 30, 2025).	Monitoring previously identified issues aims to reduce the number of repeat hospitalizations.	The adult recidivism rate is above 15%, exceeding the state standard.	The goal was not met; adult recidivism exceeded 15% in three of the four quarters of FY25.	Quarterly reports will be submitted to the PCC, and the Annual Evaluation Report for FY 2025 will be presented to QISC and PCC in the second quarter of FY 2026.

QAPIP Work Plan
FY 2024 - 2025 (October 1, 2024, through September 30, 2025)
Workforce Pillar - Ensure and maintain a Competent Workforce within the Network (Quality Service)

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 Quality Improvement	FY 2024-2025 (October 1, 2024 through September 30, 2025).	Monitor previously identified issues to ensure direct support staff are trained in the IPOS.	The follow-up will address the gaps identified.	In FY2025, a total of 607 staff qualifications were validated, achieving a score of 96%. However, direct care staff still face challenges in receiving required training on the IPOS.	Quarterly reports will be submitted to the PCC, and the Annual Evaluation Report for FY 2025 will be presented to QISC and PCC in the second quarter of FY 2026.
Finance Pillar	**(Quality of Service)**						
Goal IV	**Optimize Efficiency and Manage Costs**						
IV.1	Verification of Services	Director of Quality Improvement, Corporate Compliance Officer	FY 2024-2025 (October 1, 2024 through September 30, 2025).	Monitor issues to reduce noncompliance.	The follow-up will address the gaps identified.	In fiscal year 2025, claim verification efforts resulted in a 34% decrease in the number of providers requiring Corrective Action Plans compared to fiscal year 2024, indicating improved compliance. However, issues like IPOS documentation defects and insufficient staff training persist.	Quarterly reports will be submitted to the PCC, and the Annual Evaluation Report for FY 2025 will be presented to QISC and PCC in the second quarter of FY 2026.

QAPIP Work Plan
FY 2024 - 2025 (October 1, 2024, through September 30, 2025)
Quality Pillar - Enhance quality performance, ensure member safety, and uphold member rights throughout the entire system (Safety of Clinical Care)

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
	Quality of Service						
V.1	Provider Network Performance Monitoring - Clinically Responsible Service Provider (CRSP)	Director of Quality Improvement	FY 2024-2025 (October 1, 2024 through September 30, 2025).	Monitor identified issues to ensure compliance.	The follow-up will address the gaps identified.	In FY2025, we reviewed 399 clinical case records. The CRSP providers had a 95% success rate for these records.	Quarterly reports will be submitted to the PCC, and the Annual Evaluation Report for FY 2025 will be presented to QISC and PCC in the second quarter of FY 2026.
V.2	Residential Treatment Providers	Director of Quality Improvement	FY 2024-2025 (October 1, 2024 through September 30, 2025).	Monitor identified issues to ensure compliance.	The follow-up will address the gaps identified.	In FY2025, 340 residential sites were completed, an increase of 82 from the previous year, ensuring compliance with HCBS requirements.	Quarterly reports will be submitted to the PCC, and the Annual Evaluation Report for FY 2025 will be presented to QISC and PCC in the second quarter of FY 2026.
V.4	Provider Network Self-Monitoring (Inter-Rater Reliability)	Director of Quality Improvement	FY 2024-2025(October 1, 2024 through September 30, 2025).	Monitoring previously identified issues increases providers' involvement in the self-monitoring reviews each quarter.	The follow-up will address the gaps identified.	In FY2025, providers conducted fewer self-monitoring reviews than in the previous year, which are essential for ensuring inter-rater reliability and consistent quality assessments.	Quarterly reports will be submitted to the PCC, and the Annual Evaluation Report for FY 2025 will be presented to QISC and PCC in the second quarter of FY 2026.
V.5	Autism Services	Director of Quality Improvement, Director of Children's Initiatives	FY 2024-2025 (October 1, 2024 through September 30, 2025).	Monitoring is needed to improve providers' clinical documentation.	The follow-up will address the gaps identified.	In FY2025, clinical documentation for Autism cases showed significant gaps, impacting treatment planning and quality compliance. To address these issues, targeted training and enhanced monitoring will be implemented in FY2026.	Quarterly reports will be submitted to the PCC, and the Annual Evaluation Report for FY 2025 will be presented to QISC and PCC in the second quarter of FY 2026.

V.6	Critical/Sentinel/Unexpected Death and Risk Reporting	Director of Quality Improvement	FY 2024-2025 (October 1, 2024 through September 30, 2025).	Monitor identified issues to ensure timely reporting.	There were no previously identified issues.	The target goal was met. All critical sentinel events were reported to the state within the required timeframes.	Quarterly reports will be submitted to the PCC, and the Annual Evaluation Report for FY 2025 will be presented to QISC and PCC in the second quarter of FY 2026.

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for Each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V.7	Behavior Treatment Review	Director of Quality Improvement, Chief Medical Officer	FY 2024-2025 (October 1, 2024 through September 30, 2025).	Monitoring previously identified issues is addressing existing gaps.	The follow-up will address the gaps identified.	The data reporting requirements to the state were met, but providers struggled with the clinical aspects of the Behavior Treatment Technical requirements. This underscores the need for better training and monitoring to ensure compliance in FY2026.	Quarterly reports will be submitted to the PCC, and the Annual Evaluation Report for FY 2025 will be presented to QISC and PCC in the second quarter of FY 2026.

QAPIP Work Plan
FY 2024 - 2025 (October 1, 2024, through September 30, 2025)
Quality Improvement Projects (QIPs) – Enhancing the Quality of Care

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
	Quality of Service						
V.8a	Improving the availability of a follow-up appointment with a Mental Health Professional within 7 days after Hospitalization for Mental Illness.	Director of Integrated Health Care Director of Quality Improvement	The measurement period for this evaluation will be Calendar Year 2024 (January 1, 2024 – December 31, 2024).	Monitoring previously identified issues is addressing existing gaps	The follow-up will address the gaps identified.	The 2024 target was not met. The measurement rates were as follows: 33.47% for ages 18-64 (24.53 points below the goal), 23.02% for adults 65 and older (34.98 points below the goal), and 44.55% for children aged 6-17 (25.45 points below the goal). This goal will continue into FY2025.	Quarterly reports will be submitted to the PCC, and the Annual Evaluation Report for FY 2025 will be presented to QISC and PCC in the second quarter of FY 2026.

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for Each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V.8b	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Director of Integrated Health Care Director of Quality Improvement	The measurement period for this evaluation will be Calendar Year 2024 (January 1, 2024 – December 31, 2024).	Monitoring previously identified issues is addressing existing gaps	The follow-up will address the gaps identified.	The target goal was not met. From January 1 to December 31, 2024, the measurement rate was 47.71%, which is 18.57 percentage points below the goal. This goal will continue into FY2026.	Quarterly reports will be submitted to the PCC, and the Annual Evaluation Report for FY 2025 will be presented to QISC and PCC in the second quarter of FY 2026.

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for Each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V.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	The measurement period for this evaluation will be Calendar Year 2024 (January 1, 2024 – December 31, 2024).	Monitoring previously identified issues is addressing existing gaps	The follow-up will address the gaps identified.	The target goal was not met for the period from January 1 to December 31, 2024. The chronic condition measurement rate was 16.76%, which is 33.95 percentage points below our goal and 3% lower than last year's 19.64%. The acute condition measurement rate was 39.89%, down 27.04 percentage points from the goal and 3.99% lower than last year's 43.88%. This goal will carry over into FY2026.	Quarterly reports will be submitted to the PCC, and the Annual Evaluation Report for FY 2025 will be presented to QISC and PCC in the second quarter of FY 2026.

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for Each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V.8d	Improving Diabetes Monitoring for People with Schizophrenia and Bipolar Disorder	Director of Integrated Health Care, Director of Quality Improvement	The measurement period for this evaluation will be Calendar Year 2024 (January 1, 2024 – December 31, 2024).	Monitoring previously identified issues is addressing existing gaps	The follow-up will address the gaps identified.	The target goal was not met. During the reporting period from January 1 to December 31, 2024, the diabetes monitoring measurement rate was 70.3%. This rate was 10.69 percentage points below the goal. This goal will continue into FY2026.	Quarterly reports will be submitted to the PCC, and the Annual Evaluation Report for FY 2025 will be presented to QISC and PCC in the second quarter of FY 2026.

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for Each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V. 8h	Children's Metabolic Screening for Children on Antipsychotics. (APM)	Director of Children's Initiative	The measurement period for this evaluation will be Calendar Year 2024 (January 1, 2024 – December 31, 2024).	Monitoring previously identified issues is addressing existing gaps	The follow-up will address the gaps identified.	The target goal was not met. During the period from January 1, 2024, to December 31, 2024, the rating for Measurement 1, which tracks children ages 1-11, was 16.6% for FY24. This figure was 6.76 percentage points below the established goal. For Measurement 2, focusing on children ages 12-17, the rating was 30.12% for FY24, falling short of the goal by 2.58 percentage points. This goal will continue into FY2026.	Quarterly reports will be submitted to the PCC, and the Annual Evaluation Report for FY 2025 will be presented to QISC and PCC in the second quarter of FY 2026.

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for Each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V. 8i	Follow up for Children on ADHD medication.	Director of Children's Initiative	The measurement period for this evaluation will be Calendar Year 2024 (January 1, 2024 – December 31, 2024).	Monitoring previously identified issues is addressing existing gaps.	The follow-up will address the gaps identified.	This goal was partially met. From March 1, 2023, to February 28, 2024, Measurement 1 was rated at 61.28%, which is 2.33% above the goal. Measurement 2 was rated at 69.21%, 1.02% below the goal. For the period from March 1, 2024, to February 28, 2025, Measurement 1 is at 63.14%, 1.86% above the goal. Measurement 2 is at 71.25%, which is 1% above the goal. This goal will continue into FY2026.	Quarterly reports will be submitted to the PCC, and the Annual Evaluation Report for FY 2025 will be presented to QISC and PCC in the second quarter of FY 2026.

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for Each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V. 8j	Reducing racial and ethnic disparity with African Americans for the percentage of discharges from a psychiatric inpatient unit that were seen for follow-up care within 7 days.	Director Of Quality Improvement	The measurement period for this evaluation will be Calendar Year 2024 (January 1, 2024 – December 31, 2024).	Monitoring previously identified issues is addressing existing gaps.	The follow-up will address the gaps identified.	The goal was partially met. For Calendar Year 2024, the percentage gap is 4.93%, exceeding the target of 4.51%. The follow-up compliance rate for Black/African American members at their 7-day appointments is 38.73%, falling short of the 40% goal by 1.27 percentage points. In contrast, White/Caucasian members exceeded their goal with a follow-up rate of 43.66%. This will continue to be monitored in FY2026.	Quarterly reports will be submitted to the PCC, and the Annual Evaluation Report for FY 2025 will be presented to QISC and PCC in the second quarter of FY 2026.

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for Each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V.8l	PHQ-9 Implementation	Director of Clinical Practice Improvement	The measurement period for this evaluation will be Calendar Year 2024 (January 1, 2024 – December 31, 2024).	We will continue to monitor the situation for new opportunities in this area.	The follow-up will address the gaps identified.	The goals for FY24 were not met. Measure 1 reached 99.5%, falling short of the 100% target, and Measure 2 achieved 66.25%, 28.75 percentage points below its goal. These goals will continue into FY2026.	Quarterly reports will be submitted to the PCC, and the Annual Evaluation Report for FY 2025 will be presented to QISC and PCC in the second quarter of FY 2026.
V.8m	PHQ-A Implementation	Director of Children's Initiative	The measurement period for this evaluation will be Calendar Year 2024 (January 1, 2024 – December 31, 2024).	We will continue to monitor the situation for new opportunities in this area.	The follow-up will address the gaps identified.	The target goal was not met during the period from October 1, 2024, to September 30, 2025. Measurement 1 was rated at 99.80%, falling 0.20% short of the goal. Measurement 2 was at 69.5%, 25.5% below the goal, but it improved from last year's 65.6%. This goal will continue into FY2026.	Quarterly reports will be submitted to the PCC, and the Annual Evaluation Report for FY 2025 will be presented to QISC and PCC in the second quarter of FY 2026.

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for Each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V.8n	Decreasing Wait for Autism Services	Director of Children's Initiative	The measurement period for this evaluation will be Calendar Year 2024 (January 1, 2024 – December 31, 2024).	Monitoring identified issues involves addressing existing gaps to decrease waiting times.	The previously identified issue requiring follow-up is the 67.5% completion rate.	Data was not available when we prepared this report.	Quarterly reports will be submitted to the PCC, and the Annual Evaluation Report for FY 2025 will be presented to QISC and PCC in the second quarter of FY 2026.
	Advocacy Pillar						
Goal VI.	**Promote Community Inclusion and Integration.**						
VI.1	Home and Community-Based Services (HCBS)	Director of Quality Improvement	FY 2024-2025 (October 1, 2024 through September 30, 2025).	Monitoring previously identified issues involves settings that are not in compliance with Home and Community-Based Services.	The identified issues requiring follow-up involve CAP settings to ensure full compliance with HCBS standards.	Compliance across the network was not achieved. Efforts will continue in FY2026 to address gaps and meet standards.	Quarterly reports will be submitted to the PCC, and the Annual Evaluation Report for FY 2025 will be presented to QISC and PCC in the second quarter of FY 2026.

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

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 2024-2025 (October 1, 2024 through September 30, 2025).	Monitoring previously identified issues is the clinical area highlighted in the 2022 review.	The areas highlighted in the 2022 report require follow-up to ensure compliance.	DWIHN's next Annual Review is set for March 11, 2026.	Quarterly reports will be submitted to the PCC, and the Annual Evaluation Report for FY 2025 will be presented to QISC and PCC in the second quarter of FY 2026.

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for Each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
VII.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	Data reporting will be collected, reviewed, and analyzed from January 1, 2022, to January 1, 2025, during the required look-back period.	Monitoring of previously identified issues refers to areas where we did not receive all the available points.	Previously identified issues requiring follow-up are areas with low scores.	DWIHN reaccreditation year is fiscal year 2027.	Quarterly reports will be submitted to the PCC, and the Annual Evaluation Report for FY 2025 will be presented to QISC and PCC in the second quarter of FY 2026.

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for Each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
VII.3	Health Services Advisory Group (HSAG)-Performance Measurement Validation (PMV)	Director of Quality Improvement	FY 2024-2025 (October 1, 2024 through September 30, 2025).	Monitoring of previously identified issues related to PI#2a: Access and Timeliness of Requests for Services.	The identified issues requiring attention are the recommendations from the previous review.	The target goals, along with the recommendations, were fully met.	Quarterly reports will be submitted to the PCC, and the Annual Evaluation Report for FY 2025 will be presented to QISC and PCC in the second quarter of FY 2026.

QAPIP Work Plan

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for Each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
VII.4	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 2024-2025 (October 1, 2024 through September 30, 2025).	Monitoring identified issues involves addressing the 83% low score in FY2022, with six elements below the 95% compliance threshold.	The identified issues that need to be addressed include improving the FY2024 score (88%).	DWIHN achieved a remarkable 97% score in its second-year compliance review, meeting 140 of 145 criteria, a significant improvement over fiscal year 2024.	Quarterly reports will be submitted to the PCC, and the Annual Evaluation Report for FY 2025 will be presented to QISC and PCC in the second quarter of FY 2026.

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for Each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
VII.5	Health Services Advisory Group (HSAG)- Performance Improvement Projects (PIP)	Director of Quality Improvement	FY 2024-2025 (October 1, 2024 through September 30, 2025).	Monitoring previously identified issues aims to reduce the disparity to meet or be below the baseline of 4.51.	The issue identified earlier showed a 7.75% disparity in 2023, which decreased to 4.93% in 2024, a drop of 2.64 percentage points.	Target goals were not met. December 15 analysis of 2025 data showed a rate of 5.67%, exceeding the baseline of 4.51%.	Quarterly reports will be submitted to the PCC, and the Annual Evaluation Report for FY 2025 will be presented to QISC and PCC in the second quarter of FY 2026.

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for Each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
VII.6	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 and NCQA standards and complies with 42 CFR federal regulations.	Director of Quality Improvement	Fiscal Years 2024 through 2025.	No previously identified issues were noted during the 2024 review period.	No previously identified issues were noted during the review period.	The Board will review the QAPIP Description in FY26 to align with regulatory requirements, organizational priorities, and recent improvements, incorporating changes from quality assessments and stakeholder feedback for continued relevance and effectiveness.	Present the QAPIP description to the QISC, PCC, and Full Board during the first quarter of FY2026.
VII.7	The QAPIP Evaluation is a comprehensive annual report prepared and finalized at the end of each fiscal year. This evaluation assesses the effectiveness of the Quality Assurance Performance Improvement Plan (QAPIP) and offers insights into the progress made throughout the year. It includes detailed analyses of performance metrics, outcomes, and areas for improvement, which help inform future strategies and ensure continuous quality enhancement within the organization.	Director of Quality Improvement	Fiscal Year 2024	Monitoring previously identified issues aims to improve outcomes for goals that were only partially achieved or not met in the previous year.	Previously identified issues requiring follow-up are goals that were partially achieved or unmet, ensuring accountability and progress.	Partially achieved or unmet goals will be carried over to FY2026 for completion and improvement.	Present the QAPIP description to the QISC, PCC, and Full Board in the first quarter of fiscal year 2026.

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for Each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
VII.8	The QI work plan is developed by reviewing the previous year's plan. It is continuously assessed and updated to reflect the status of the goals.	Director of Quality Improvement	The QAPIP Work Plan will be developed each year to outline specific goals and objectives for the upcoming period. This plan will detail strategies to ensure the organization continuously enhances its quality of care and operational efficiency.	Monitoring previously identified issues aims to improve outcomes for goals that were only partially achieved or not met in the previous year.	The previously identified issues that require follow-up are the performance improvement projects that did not meet their goals.	The target goals were not met. Seven of the nine PIPs were either not met or partially met.	Present the QAPIP description to the QISC, PCC, and Full Board in the first quarter of FY 2026.
END							

QAPIP Work Plan

FY 2025- 2026 (October 1, 2025, through September 30, 2026)

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	**Member Experience**						
Goal I (Members' Experience and Quality of Service)	**Enhance Member Experience Through Services**						
I.1	ECHO Annual Satisfaction Surveys (Adult and Children)	Director of Customer Service	The measurement period for this evaluation will be Calendar Year 2025 (January 1, 2025 – December 31, 2025.	Monitoring identified areas for improvement aims to enhance the experience of both adult and child members and increase member involvement in their care. These efforts will focus on the following: Improving Communication, Expanding Engagement Opportunities, and Incorporating member feedback into care planning and quality initiatives. These actions will strengthen member satisfaction, improve outcomes, and align with our commitment to quality of care.	Key areas for improvement include increasing member engagement, encouraging collaboration on treatment options, and reducing scheduling delays for the first appointment after the initial request. This goal will continue into FY26.		Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY 2026.

QAPIP Work Plan
FY 2025 - 2026 (October 1, 2025, through September 30, 2026)

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	FY 2025-2026 (October 1, 2025, through September 30, 2026).	Monitoring identified issues to address gaps in low survey participation, documentation, and redundancy.	Key areas for improvement that require follow-up include the volume and redundancy of documentation, which will continue into FY2026.		Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY2026.

QAPIP Work Plan

FY 2025 - 2026 (October 1, 2025, through September 30, 2026)

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	Member Grievance/Appeals	Director of Customer Service	FY 2025-2026 (October 1, 2025, through September 30, 2026).	Monitoring previously identified issues regarding accessibility of services and gaps in communication.	Key issues include delays in appointments, provider availability, and transportation difficulties. This goal will continue into FY2026.		Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY2026.

QAPIP Work Plan FY 2025 - 2026 (October 1, 2025, through September 30, 2026)

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 Decisions within 7 calendar days.	Director of Utilization Management	FY 2025-2026 (October 1, 2025, through September 30, 2026).	Monitoring previously identified issues to meet the 7-day requirement.	The 95% timeliness requirement for non-urgent authorization requests was not met in three of the four quarters of FY2025. The goal changed in 2026 to 7 calendar days.		Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY2026.
I.5	Practice Guidelines	Chief Medical Officer	FY 2025-2026 (October 1, 2025, through September 30, 2026).	There are no previously identified issues to monitor.	There are no previously identified issues that require follow-up. This goal was met in fiscal year 2025.	.	Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY2026.

QAPIP Work Plan

FY 2025 - 2026 (October 1, 2025, through September 30, 2026)

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
Access Pillar	**Quality and Safety of Clinical Care**						
Goal	**Enhance members' access to services, improve the quality of clinical care, and ensure health and safety.**						
	Michigan Mission-Based Performance Indicators (MMBPI)						
II.1	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 2025-2026 (October 1, 2025 through September 30, 2026).	Monitoring previously identified issues addresses existing gaps in appointment availability.	The previously identified issue was the lack of available appointments for children. This goal was not met in FY2025 and will continue into FY2026.		Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY2026.

QAPIP Work Plan
FY 2025 - 2026 (October 1, 2025, through September 30, 2026)

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
	HEDIS Measures						
III.1	Follow-Up After Hospitalization for Mental Illness-Within 30 Days After Discharge – Adults (FUH)	Director of Quality Improvement	The measurement period for this evaluation will be Calendar Year 2025 (January 1, 2025 – December 31, 2025).	This is a new goal for the fiscal year 2026.	There are no issues that require follow-up.		Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY2026.
III.2	Follow-Up After Hospitalization for Mental Illness-Within 30 Days After Discharge – Children (FUH)	Director of Quality Improvement	The measurement period for this evaluation will be Calendar Year 2025 (January 1, 2025 – December 31, 2025).	This is a new goal for the fiscal year 2026.	There are no issues that require follow-up.		Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY2026.

III.3	Follow-up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication	Director of Quality Improvement	The measurement period for this evaluation will be Calendar Year 2025 (January 1, 2025 – December 31, 2025).	This is a new goal for the fiscal year 2026.	There are no issues that require follow-up.		Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY2026.

QAPIP Work Plan
FY 2025 - 2026 (October 1, 2025, through September 30, 2026)

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.4	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	Director of Quality Improvement	The measurement period for this evaluation will be Calendar Year 2025 (January 1, 2025 – December 31, 2025).	This is a new goal for the fiscal year 2026.	There are no issues that require follow-up.		Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY2026.
III.5	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	Director of Quality Improvement	The measurement period for this evaluation will be Calendar Year 2025 (January 1, 2025 – December 31, 2025).	This is a new goal for the fiscal year 2026	There are no issues that require follow-up.		Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY2026.

QAPIP Work Plan
FY 2025 - 2026 (October 1, 2025, through September 30, 2026)

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.6	Follow-up After Emergency Department Visit for Substance Use (FUA)	Director of Quality Improvement	The measurement period for this evaluation will be Calendar Year 2025 (January 1, 2025 – December 31, 2025).	This is a new goal for the fiscal year 2026.	There are no issues that require follow-up.		Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY2026.

III.7	Follow-up After Emergency Department Visit for Mental Illness (FUM)	Director of Quality Improvement	The measurement period for this evaluation will be Calendar Year 2025 (January 1, 2025 – December 31, 2025).	This is a new goal for the fiscal year 2026.	There are no issues that require follow-up.		Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY2026.

III.8	Initiation and Engagement into Substance Use Disorder Treatment Initiation (IET) - within 14 days	Director of Quality Improvement	The measurement period for this evaluation will be Calendar Year 2025 (January 1, 2025 – December 31, 2025).	This is a new goal for the fiscal year 2026.	There are no issues that require follow-up.		Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY2026.

III.9	Initiation and Engagement into Substance Use Disorder Treatment Engagement (IET) – Within 34 days	Director of Quality Improvement	The measurement period for this evaluation will be Calendar Year 2025 (January 1, 2025 – December 31, 2025).	This is a new goal for the fiscal year 2026.	There are no issues that require follow-up.		Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY2026.

III.10	Adherence to Anti-Psychotic Medications for Individuals with Schizophrenia: Ages 18 or Older (SAA)	Director of Quality Improvement	The measurement period for this evaluation will be Calendar Year 2025 (January 1, 2025 – December 31, 2025).	This is a new goal for the fiscal year 2026.	There are no issues that require follow-up.		Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY2026.

III.11	Diabetes Screening for People with Schizophrenia or bipolar disorder who are using Anti-Psychotic Medications: Ages 18 to 64 (SSD)	Director of Quality Improvement	The measurement period for this evaluation will be Calendar Year 2025 (January 1, 2025 – December 31, 2025).	This is a new goal for the fiscal year 2026.	There are no issues that require follow-up.		Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY2026.

QAPIP Work Plan
FY 2025 - 2026 (October 1, 2025, through September 30, 2026)

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
IV.1	Complex Case Management	Director of Integrated Health Care	FY 2025-2026 (October 1, 2025 through September 30, 2026).	Monitoring previously identified issues is addressing existing gaps.	Reducing ED visits will remain a priority in FY2026.		Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY2026.

QAPIP Work Plan
FY 2025 - 2026 (October 1, 2025, through September 30, 2026)

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
IV.2	Crisis Services	Director of Utilization Management, Director of Crisis Services	FY 2025-2026 (October 1, 2025 through September 30, 2026).	Monitoring previously identified issues aims to reduce the number of repeat hospitalizations.	The adult recidivism rate is above 15%, exceeding the state standard.		Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY2026.

QAPIP Work Plan
FY 2025 - 2026 (October 1, 2025, through September 30, 2026)
Workforce Pillar - Ensure and maintain a Competent Workforce within the Network (Quality Service)

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	Maintain Competent Workforce	Director of Quality Improvement	FY 2025-2026 (October 1, 2025 through September 30, 2026).	Monitor previously identified issues to ensure direct support staff are trained in the IPOS.	The follow-up will address the gaps identified.		Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY2026.
Finance Pillar	**(Quality of Service)**						
Goal IV	**Optimize Efficiency and Manage Costs**						
VI.1	Verification of Services	Director of Quality Improvement, Corporate Compliance Officer	FY 2025-2026 (October 1, 2025 through September 30, 2026).	Monitor issues to reduce noncompliance.	The follow-up will address the gaps identified.		Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY2026.

QAPIP Work Plan
FY 2025 - 2026 (October 1, 2025, through September 30, 2026)
Quality Pillar - Enhance quality performance, ensure member safety, and uphold member rights throughout the entire system (Safety of Clinical Care)

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
	Quality of Service						
VII.1	Provider Network Performance Monitoring - Clinically Responsible Service Provider (CRSP)	Director of Quality Improvement	FY 2025 -2026 (October 1, 2025 through September 30, 2026).	Monitor identified issues to ensure compliance.	The follow-up will address the gaps identified.		Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY2026.
VII.2	Residential Treatment Providers	Director of Quality Improvement	FY 2025-2026 (October 1, 2025 through September 30, 2026).	Monitor identified issues to ensure compliance.	The follow-up will address the gaps identified.		Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY2026.
VII.4	Provider Network Self-Monitoring (Inter-Rater Reliability)	Director of Quality Improvement	FY 2025 -2026 (October 1, 2025 through September 30, 2026).	Monitoring previously identified issues increases providers' involvement in the self-monitoring reviews each quarter.	The follow-up will address the gaps identified.		Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY2026.
VII.5	Autism Services	Director of Quality Improvement, Director of Children's Initiatives	FY 2025-2026 (October 1, 2025 through September 30, 2026).	Monitoring is needed to improve providers' clinical documentation.	The follow-up will address the gaps identified.		Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY2026.

VII.6	Critical/Sentinel/Unexpected Death and Risk Reporting	Director of Quality Improvement	FY 2025-2026 (October 1, 2025 through September 30, 2026).	Monitor identified issues to ensure timely reporting.	There were no previously identified issues.		Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY2026.

QAPIP Work Plan
FY 2025 - 2026 (October 1, 2025, through September 30, 2026)

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
VIII.1	Behavior Treatment Review	Director of Quality Improvement, Chief Medical Officer	FY 2025-2026 (October 1, 2025 through September 30, 2026).	Monitoring previously identified issues is addressing existing gaps.	The follow-up will address the gaps identified in the clinical aspects of the Behavior Treatment Technical requirements.		Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY2026. .

QAPIP Work Plan
FY 2025 - 2026 (October 1, 2025, through September 30, 2026)
Quality Improvement Projects (QIPs) – Enhancing the Quality of Care

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
	Quality of Service						
IX.1	Improving the availability of a follow-up appointment with a Mental Health Professional within 7 days after Hospitalization for Mental Illness.	Director of Integrated Health Care Director of Quality Improvement	FY 2025-2026 (October 1, 2025 through September 30, 2026).	Monitoring previously identified issues is addressing existing gaps	The follow-up will focus on addressing the identified gaps. The goal was not met in FY2025.		Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY2026.

QAPIP Work Plan
FY 2025 - 2026 (October 1, 2025, through September 30, 2026)

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
IX.2	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Director of Integrated Health Care Director of Quality Improvement	FY 2025-2026 (October 1, 2025 through September 30, 2026).	Monitoring previously identified issues is addressing existing gaps	The follow-up will focus on addressing the identified gaps. The goal was not met in fiscal year 2025.		Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY2026.

QAPIP Work Plan
FY 2025 - 2026 (October 1, 2025, through September 30, 2026)

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
IX.3	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	FY 2025-2026 (October 1, 2025 through September 30, 2026).	Monitoring previously identified issues is addressing existing gaps	The follow-up will focus on addressing the identified gaps. The goal was partially met in fiscal year 2025.		Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY2026.

QAPIP Work Plan
FY 2025 - 2026 (October 1, 2025, through September 30, 2026)

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
IX.4	Improving Diabetes Monitoring for People with Schizophrenia and Bipolar Disorder	Director of Integrated Health Care, Director of Quality Improvement	FY 2025-2026 (October 1, 2025 through September 30, 2026).	Monitoring previously identified issues is addressing existing gaps	The follow-up will focus on addressing the identified gaps. The goal was not met in fiscal year 2025.		Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY2026.

QAPIP Work Plan
FY 2025 - 2026 (October 1, 2025, through September 30, 2026)

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
IX. 5	Children's Metabolic Screening for Children on Antipsychotics. (APM)	Director of Children's Initiative	FY 2025-2026 (October 1, 2025 through September 30, 2026).	Monitoring previously identified issues is addressing existing gaps	The follow-up will focus on addressing the identified gaps. The goal was not met in fiscal year 2025.		Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY2026.

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

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Staff Members Responsible for Each Activity	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
IX. 6	Follow up for Children on ADHD medication.	Director of Children's Initiative	The reporting period is from March 1, 2024, to February 28, 2025.	Monitoring previously identified issues is addressing existing gaps.	The follow-up will focus on addressing the identified gaps. The goal was partially met in fiscal year 2025.		Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY2026.

QAPIP Work Plan
FY 2025 - 2026 (October 1, 2025, through September 30, 2026)

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
IX.7	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 2025-2026 (October 1, 2025 through September 30, 2026).	Monitoring previously identified issues is addressing existing gaps.	The follow-up will focus on addressing the identified gaps. The goal was partially met in fiscal year 2025.		Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY2026.

QAPIP Work Plan
FY 2025 - 2026 (October 1, 2025, through September 30, 2026)

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
IX.8	PHQ-9 Implementation	Director of Clinical Practice Improvement	FY 2025-2026 (October 1, 2025 through September 30, 2026).	Monitoring identified issues requires addressing existing gaps.	The follow-up will focus on addressing the identified gaps. The goal was not met in FY2025.		Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY2026.
IX.9	PHQ-A Implementation	Director of Children's Initiative	FY 2025-2026 (October 1, 2025 through September 30, 2026).	Monitoring identified issues requires addressing existing gaps.	The follow-up will focus on addressing the identified gaps. The goal was not met in FY2025.		Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY2026.

QAPIP Work Plan
FY 2025 - 2026 (October 1, 2025, through September 30, 2026)

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
IX.10	Decreasing Wait for Autism Services	Director of Children's Initiative	FY 2025-2026 (October 1, 2025 through September 30, 2026).	Monitoring identified issues involves addressing existing gaps to decrease waiting times.	The previously identified issue that requires follow-up is decreasing wait times.		Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY2026.
	Advocacy Pillar						
Goal VI.	**Promote Community Inclusion and Integration.**						
X.1	Home and Community-Based Services (HCBS)	Director of Quality Improvement	FY 2025-2026 (October 1, 2025 through September 30, 2026).	Monitoring previously identified issues involves settings that are not in compliance with Home and Community-Based Services.	The identified issues requiring follow-up involve CAP settings to ensure full compliance with HCBS standards.		Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY2026.

QAPIP Work Plan
FY 2025 - 2026 (October 1, 2025, through September 30, 2026)
External Quality Reviews

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
XI.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 2025-2026 (October 1, 2025 through September 30, 2026).	Monitoring previously identified issues is the clinical area highlighted in the 2022 review.	The areas highlighted in the 2022 report require follow-up to ensure compliance.		Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY2026.

QAPIP Work Plan
FY 2025 - 2026 (October 1, 2025, through September 30, 2026)

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
XI.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	Data reporting will be collected, reviewed, and analyzed from January 1, 2022, to January 1, 2025, during the required look-back period.	Monitoring of previously identified issues refers to areas where we did not receive all the available points.	Previously identified issues requiring follow-up are areas with low scores.		Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY2026.

QAPIP Work Plan
FY 2025 - 2026 (October 1, 2025, through September 30, 2026)

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
XI.3	Health Services Advisory Group (HSAG)-Performance Measurement Validation (PMV)	Director of Quality Improvement	FY 2025-2026 (October 1, 2025 through September 30, 2026).	Monitoring of previously identified issues related to PI#2a: Access and Timeliness of Requests for Services.	The identified issues needing attention are recommendations from the last review. The goal was achieved in FY2025.	.	Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY2026.

QAPIP Work Plan

FY 2025- 2026 (October 1, 2025, through September 30, 2026)

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
XI.4	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 2025-2026 (October 1, 2025 through September 30, 2026).	Monitoring identified issues requires addressing the existing gaps.	There are no identified issues that require follow-up. The goal was achieved in FY2025.		Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY2026.

QAPIP Work Plan
FY 2025 - 2026 (October 1, 2025, through September 30, 2026)

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
XI.5	Health Services Advisory Group (HSAG)- Performance Improvement Projects (PIP)	Director of Quality Improvement	FY 2025-2026 (October 1, 2025 through September 30, 2026).	Monitoring previously identified issues aims to reduce the disparity to meet or be below the baseline of 4.51.	The identified issue that requires follow-up aims to reduce the disparity. The goal was partially met in fiscal year 2025.		Quarterly reports on the effectiveness of the QAPIP Work Plan will be submitted to the PCC. The 2026 Work Plan will be presented to the QISC and PCC in the second quarter of FY2026.

QAPIP Work Plan
FY 2025- 2026 (October 1, 2025, through September 30, 2026)

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
XII.1	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 and NCQA standards and complies with 42 CFR federal regulations.	Director of Quality Improvement	Fiscal Years 2026 through 2028.	No previously identified issues were noted during the 2024 review period.	No previously identified issues were noted during the review period.		Present the QAPIP description to the QISC, PCC, and Full Board during the first quarter of FY2026.
XII.2	The QAPIP Evaluation is a comprehensive annual report prepared and finalized at the end of each fiscal year. This evaluation assesses the effectiveness of the Quality Assurance Performance Improvement Plan (QAPIP) and offers insights into the progress made throughout the year. It includes detailed analyses of performance metrics, outcomes, and areas for improvement, which help inform future strategies and ensure continuous quality enhancement within the organization.	Director of Quality Improvement	Fiscal Year 2025	Monitoring previously identified issues aims to improve outcomes for goals that were only partially achieved or not met in the previous year.	Previously identified issues requiring follow-up are goals that were partially achieved or unmet, ensuring accountability and progress.		Present the QAPIP description to the QISC, PCC, and Full Board in the first quarter of fiscal year 2026.

QAPIP Work Plan
FY 2025 - 2026 (October 1, 2025, through September 30, 2026)

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
XII.3	The QI work plan is developed by reviewing the previous year's plan. It is continuously assessed and updated to reflect the status of the goals.	Director of Quality Improvement	For the 2026 fiscal year, the QAPIP Work Plan will be developed to outline goals and strategies for improving the quality of care and operational efficiency.	Monitoring previously identified issues aims to improve outcomes for goals that were only partially achieved or not met in the previous year.	The previously identified issues that require follow-up are the performance improvement projects that did not meet their goals.		Present the QAPIP description to the QISC, PCC, and Full Board in the first quarter of FY 2026.
END							