DETROIT WAYNE INTEGRATED HEALTH NETWORK
QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT PLAN (QAPIP)
FOR FISCAL YEARS 2026-2028

Approved:

Approved by Quality Improvement Steering Committee (QISC)	**1/27/2026**
Approved by Program Compliance Committee (PCC)	**2/11/2026**
Approved by the Full Board of Directors	**2/18/2026**

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Introduction

The Detroit Wayne Integrated Health Network (DWIHN) operates as a Managed Behavioral Health Organization (MBHO) and is accredited by the National Committee for Quality Assurance (NCQA). This accreditation underscores DWIHN's dedication to delivering exceptional behavioral health services. As both the Pre-Paid Inpatient Health Plan (PIHP) and the Community Mental Health Service Provider (CMHSP) for the Detroit and Wayne County regions, DWIHN is the largest provider of community mental health services in Michigan. This prominent position enables DWIHN to significantly influence the region's mental health landscape and address the complex needs of its diverse population.

To fulfill its mission of delivering superior care and ensuring exceptional service, DWIHN has developed a comprehensive Quality Assessment Performance Improvement Plan (QAPIP). This strategic plan outlines the necessary structural and governance frameworks for systematically evaluating and enhancing healthcare quality and appropriateness. By implementing a robust quality assurance strategy, DWIHN aims not only to improve clinical outcomes but also to promote better overall health in the communities it serves. In accordance with state and federal regulations, DWIHN, as a PIHP, is required to implement and maintain an ongoing quality-assessment and performance-improvement program. This initiative rigorously evaluates the effectiveness of services provided to its members and identifies critical areas needing improvement, adaptation, or innovative solutions. Through this continuous improvement process, DWIHN strives to meet the evolving needs of its members and foster a healthier, more resilient community.

The QAPIP is fully operational and meets the requirements outlined in the Quality Assessment and Performance Improvement Programs for Specialty Prepaid Inpatient Health Plans (PIHP) contract. The QAPIP is effective from October 1, 2026, to September 30, 2028. Each year, the Board of Directors conducts an annual review of the QAPIP to ensure its ongoing relevance and effectiveness, making any necessary updates or changes. This review process confirms that the Governing Body has approved both the plan and its annual assessment. Upon the conclusion of the initial term, the existing QAPIP will remain in effect until the DWIHN Board of Directors formally approves a new version at the start of the following year. The DWIHN Board of Directors will oversee the approval of all current and future policies and procedures related to QAPIP, ensuring a consistent commitment to quality and effective service delivery. DWIHN QAPIP is available on the DWIHN website.

The Michigan Department of Health and Human Services (MDHHS) requires DWIHN to submit an approved written copy of its QAPIP, endorsed by the Board of Directors, by February 28 of the approved year. According to the contract, DWIHN must conduct an annual review to assess the effectiveness of its QAPIP. This effectiveness is tracked through the QAPIP work plan and evaluation, focusing on whether quality assessment and improvement activities lead to meaningful enhancements in the healthcare and services provided to members.

The annual review provides a comprehensive analysis of service delivery trends and health outcomes over time. It also monitors progress toward achieving specified performance goals and objectives. The QAPIP is evaluated quarterly to assess the effectiveness of the methods used to monitor and assess quality improvement processes. These evaluations incorporate feedback from various stakeholders, including members, healthcare providers, the Quality Improvement Steering Committee (QISC), the Program Compliance Committee (PCC) of the Detroit Wayne Integrated Health Network (DWIHN) Board of Directors, and other relevant parties. The QAPIP description includes performance measures established by the Michigan Department of Health and Human Services (MDHHS) in areas like access, efficiency, and outcomes.

In addition to these ongoing evaluations, DWIHN is required to submit an improvement plan based on the findings of any external reviews. Documentation of any accreditation by a private, independent accrediting entity is also necessary. This documentation must encompass information regarding the following aspects of the review, if applicable:

1. Accreditation status, survey type, and level (if applicable).
2. Recommended actions or improvements, corrective action plans, and summaries of findings.
3. Expiration date of the accreditation.

Quality Assessment Performance Improvement Plan (QAPIP) Description

The Quality Assessment and Performance Improvement Plan (QAPIP) is a comprehensive framework designed to significantly enhance the quality, safety, and efficiency of clinical care within our organization. This essential plan establishes a clear structure and governance model that facilitates systematic evaluation and continuous improvement of healthcare services, ultimately leading to better health outcomes for the diverse populations we serve.

The QAPIP outlines the processes for measuring performance using standardized indicators based on the ongoing collection and analysis of valid and reliable data. Additionally, it defines the authority and responsibilities of the Quality Improvement (QI) program, specifying the roles of the committees and individuals involved in its implementation. This clarity ensures that every participant understands the significance of their contributions to the initiative's success. Promoting a culture of improvement requires active participation and engagement from all members in both the development and ongoing monitoring of DWIHN's QAPIP.

The QAPIP closely aligns with the core functions of DWIHN's Board-approved Strategic Plan and is built on six foundational pillars that collectively reflect DWIHN’s commitment to continuously enhancing the quality and safety of the clinical care and services we provide. These functions do not operate in isolation; instead, they are executed in collaboration with our extensive network of contracted service providers, ensuring a cooperative approach to quality assurance. Furthermore, DWIHN is responsible for ensuring that the QAPIP complies with relevant regulations, including the Balanced Budget Act (BBA) of 1997 (Public Law 105-33) and the provisions outlined in 42 Code of Federal Regulations (CFR) 438.358 (2002). Adhering to these federal guidelines is crucial for maintaining the integrity and effectiveness of our services.

The QAPIP includes the following essential elements:

a. A well-defined organizational structure that facilitates clear administration and evaluation of the QAPIP.
b. The components and activities of the QAPIP, including those required by the Quality Assessment and Performance Improvement Program Technical Requirements. These requirements outline the measurable criteria that a healthcare organization must meet to demonstrate the effectiveness of its quality improvement processes. Key elements include data-collection methods, performance metrics, analysis techniques, and the development of action plans, all aimed at identifying and improving care areas.

c. The mechanisms and procedures for adopting and communicating processes and outcome improvements.
d. The responsibilities of the governing body for monitoring, evaluating, and improving care.
e. The objectives and timelines for implementation and achievement.
f. A description of a designated senior official responsible for QAPIP implementation.
g. Performance improvement projects addressing both clinical and non-clinical aspects of care, as directed by the state and the Detroit Wayne Integrated Health Network (DWIHN). Clinical areas include high-volume services, high-risk services, and the continuity and coordination of care. Non-clinical areas encompass grievances, appeals, complaints, and access to and availability of services.
h. The process for reviewing and following up on critical/sentinel events and incidents that may put members at risk of harm.
i. Periodic quantitative assessments (e.g., surveys) and qualitative assessments (e.g., focus groups) of member experiences with services, addressing issues related to the quality, availability, and accessibility of care.
j. The process for incorporating feedback from service recipients into the evaluation and analysis of data obtained from both quantitative and qualitative assessments.
k. Written procedures to determine whether physicians and other licensed healthcare professionals are qualified to provide their services.
l. Written procedures to ensure that non-licensed providers of care or support are qualified to perform their roles.

Governing Body

The QAPIP is a crucial component of DWIHN's commitment to delivering high-quality care. This plan is managed by the Governing Body, which oversees the monitoring, evaluation, and enhancement of care quality for members. Within this framework, the Program Compliance Committee (PCC) acts as the governing body for the QAPIP, ensuring that all processes align with the organization's objectives and care standards.

The PCC receives regular written reports that provide a comprehensive overview of the organization's quality improvement projects. These reports detail progress, the specific actions taken to address identified areas for improvement, and thorough evaluations of their effectiveness. This systematic documentation enables the PCC to maintain a clear understanding of both the advancements and challenges associated with quality improvement initiatives. The Director of Quality Improvement plays a vital role in supporting this process by providing the PCC with quarterly updates on ongoing quality improvement activities. This steady flow of information is crucial for informed decision-making, ensuring the PCC stays aware of emerging issues, trends, and opportunities for further improvement.

The PCC, as the governing body, is responsible for making informed decisions about major contracts and agreements that directly impact the delivery of healthcare services. The committee considers input from relevant clinical personnel to ensure a variety of perspectives are included and to align decisions with clinical best practices. The PCC demonstrates its commitment to the Quality Improvement Program through ongoing involvement in the organization's policy-making process. By engaging with various stakeholders and contributing to policy development, the PCC ensures that quality improvement initiatives remain a priority for the organization. Ultimately, the final approval of the QAPIP rests with DWIHN's full Board of Directors, highlighting the importance of comprehensive oversight and accountability in the continuous pursuit of excellence in care delivery.

Scope of the QAPIP

The framework comprises dedicated Standing Committees, each responsible for overseeing and implementing specific quality improvement initiatives. One key component is the Corporate Compliance Committee, which focuses on regulatory and corporate compliance matters. Its primary goal is to ensure that all services provided within the network comply with applicable laws, regulations, and organizational standards. The committee actively monitors compliance metrics and implements corrective actions as needed to maintain the integrity of the services offered. Another important team is the Improving Practices Leadership Team (IPLT), which plays a significant role in developing and monitoring clinical service areas. This team creates and evaluates clinical practice guidelines and evidence-based practices and oversees care integration processes. Additionally, the IPLT is responsible for planning transitions to Home and Community-Based Services, ensuring that members receive safe and effective care as their needs evolve. The overarching goal of the IPLT is to provide high-quality, safe clinical care while enhancing the overall experience for members utilizing these services.

The Credentialing Committee is another essential element of the QAPIP. This committee ensures that all network practitioners and healthcare providers have the necessary qualifications, licenses, and credentials to deliver safe and high-quality clinical care. By thoroughly vetting practitioners, the committee safeguards its members' well-being and fosters confidence in the care they receive.

The Quality Improvement Steering Committee (QISC) is responsible for analyzing performance indicator data and member satisfaction survey results. By continuously overseeing performance improvement projects, the QISC monitors and evaluates quality improvement plans to ensure that service delivery meets the highest possible standards. The committee's work is crucial for assessing member experience, identifying areas that need improvement, and implementing necessary interventions. The QISC acts as the main decision-making body for the QAPIP.

The Critical Sentinel Events Committee (CSEC) is dedicated to reviewing and monitoring critical and sentinel events, unusual occurrences that may indicate potential safety issues in clinical care. By analyzing these events, the CSEC aims to identify the root causes and develop strategies that enhance both safety and quality of care. The Utilization Management (UM) Committee addresses issues related to the use of services within the network. This committee conducts thorough assessments to identify patterns of underutilization, ensuring that members have timely access to the care they need. By analyzing service usage data, the committee strives to maintain the quality and safety of the clinical services it provides.

The quality improvement initiatives at DWIHN are supported by a well-defined infrastructure that involves key stakeholders, process owners, and cross-functional teams and committees. This structure is crucial for identifying the clinical and non-clinical processes necessary to deliver high-quality support and services to individuals within the system. To ensure a comprehensive approach, DWIHN requires all contracted Clinically Responsible Service Providers (CRSP) and substance use disorder service providers to develop quality improvement plans tailored to their specific services. The QAPIP is designed to be inclusive, engaging all demographic groups, various care settings, and a wide range of service types. This engagement is achieved by actively involving members, advocates, contracted service providers, and community groups throughout the quality improvement process, all guided by a Continuous Quality Improvement (CQI) perspective.

A designated senior official oversees the QAPIP and collaborates closely with the Chief Medical Officer (CMO) to ensure its effective implementation. It is essential for both service providers and individuals receiving services to actively participate and provide input, as their involvement is crucial to the success of the QAPIP processes. Additionally, external practitioners within the network play a vital role in process improvement, program planning, and overall evaluation through systematic data collection and analysis. To further enhance quality improvement, the QAPIP includes mechanisms to assess both underutilization and overutilization of services, ensuring that all members have access to the appropriate level of care tailored to their unique needs.

The Quality Improvement (QI) staff at DWIHN comprises a team of skilled and experienced professionals dedicated to enhancing the quality of services provided. Each staff member participates in ongoing training to stay up to date on best practices and emerging trends in the field. The QI team also holds regularly scheduled case consultations with the Chief Medical Officer of DWIHN. These consultations foster collaborative discussions about complex cases, enabling the exchange of insights and strategies that enhance overall service delivery. DWIHN is committed to fostering competency through continuous professional development activities, including training workshops, seminars, and courses designed to enhance staff skills and align with the organization's mission to deliver high-quality services to the community.

The following outlines the specific assigned activities and professional qualifications required of QI staff members, emphasizing their roles and contributions to the organization's ongoing efforts to improve service quality.

1. Board of Directors (BOD):
    - The BOD primary responsibility is to provide leadership, governance, and oversight of the region. The Board is a policy-setting body, the fiduciary of the Medicaid funds.
2. Chief Medical Officer (CMO):
    - 5 years of experience working in a state or community psychiatric hospital or outpatient setting, as a direct provider of mental health services.
    - At least 5 years of administrative experience as CMO in a Mental Health Program with experience in: policy writing; accreditation activities, staff development; peer review management of direct report staff (i.e., nurses, social workers, etc.).
    - Prior experience working with State and Community Hospitals.
    - Prior Managed Care experience, with the implementation of Evidence-Based Practices in psychiatry.
    - Completed medical school at an accredited university.
    - Completed an internship and psychiatric residency at an accredited program.
    - Thorough and up-to-date knowledge of psychiatric and medical practice.
    - At least three years' experience with peer and utilization review in a community mental health setting.
    - Active participation in professional organizations such as the American Psychiatric Association, the Michigan Psychiatric Society, the American Association of Community Psychiatrists, Wayne County Medical Society, Michigan State Medical Society, and Detroit Medical Society.
    - Must have a valid Michigan License to practice as a physician in Michigan.

      controlled substance license. Additionally, the candidate must have a valid and current Drug Enforcement Administration Registration. Board certification by the American Board of Psychiatry and Neurology as an adult psychiatrist is preferred but not required.

Responsibilities include:

- Chairing the Quality Improvement Steering Committee.
- Chairing the Peer Review Committee & Improving Practice Leadership Team (IPLT).
- Active Participation in the Sentinel Events Committee Activities.
- Active Participation in the Review of the Death Committee.
- Active Participation in the Executive Leadership Team (as needed).
- Review policies, procedures, and protocols for the delivery of psychiatric and medical services.
- Co-facilitate advisory committees of Chief Medical Officers of Providers to meet on a regular basis and provide input into psychiatric and medical standards, policies, procedures, and protocols.
- Provide technical assistance and psychiatric input where needed regarding the development of services, policies, and procedures.
- Provides leadership, support, and direction for the development of clinical and cost-effective programs that improve member access, reduce gaps in care, enhance customer satisfaction, lower costs, and maximize positive health outcomes.
- Serve as a clinical consultant to contractors and their subcontractors on difficult cases.
- Work collaboratively with other agency areas to increase the effectiveness of medical administration programs and promote the integration of all clinical programs.
- Provide consultation on the activities of DWIHN to advance workforce development, best, promising, and evidence-based practices, and integration of physical and mental health care.
- Function as a liaison with local, state, and national psychiatric and medical organizations for the purpose of information and networking to keep the Board of Directors and staff aware of trends in psychiatric and medical practice, research, training, and issues.
- Present to the Board of Directors and board subcommittee meetings (as needed).

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

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

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

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

7. **Psychologist (Behavior Treatment)**
   - Master's degree in psychology with a license as a Psychologist in the State of Michigan.
   - Conduct quarterly reviews and analyses of data from the Behavior Treatment Review Committee, where intrusive or restrictive techniques have been approved for use with members and where physical management or 911 calls to law enforcement have been used in an emergency behavioral crisis.
   - Review techniques permitted by the Technical Requirement for Behavior Treatment Plans and have been approved during person-centered planning by the member or his/her guardian, may be used with members.
   - Review the data on the number of interventions and the length of time the interventions were used per individual.
   - Chairing the Quality Improvement Steering Committee. Worked with MDHHS BTPRC on the MDHHS BTPRC FAQ document.
   - Preparing for the systemwide upcoming Behavior Treatment Training for DWIHN CAP for MDHHS HSW Review.
   - Ongoing Individual consultations with DWIHN departments (UM, ORR, Residential, Children's).
   - Review the referred cases for the SEC/PRC meeting.

8. **Senior Psychologist**
   - Master's degree in psychology with a license as a Psychologist in the State of Michigan.
   - Provide expert clinical consultation to QI staff, network providers, and DWIHN leadership on matters related to psychological assessment, diagnosis, treatment, and behavioral health best practices.
   - Provide guidance on complex clinical cases and ethical dilemmas.
   - Serve as a clinical resource for understanding and implementing evidence-based practices.
   - Participate in clinical audits and reviews, providing psychological insights and recommendations for improvement.
   - Provide expert clinical consultation to QI staff, network providers, and DWIHN leadership on matters related to psychological assessment, diagnosis, treatment, and behavioral health best practices.
   - Provide guidance on complex clinical cases and ethical dilemmas.
   - Serve as a clinical resource for understanding and implementing evidence-based practices.
   - Participate in clinical audits and reviews, providing psychological insights and recommendations for improvement.
   - Deliver clinical consultation, lead QI initiatives, analyze data, train staff, ensure regulatory compliance, and promote evidence-based practices to improve outcomes.

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

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

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

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

Quality Improvement Program (QIP)

The DWIHN Quality Improvement Program is based on the principles of Continuous Performance Improvement (CPI), which impacts all levels of the organization and nurtures a culture of ongoing enhancement and high standards of care. In line with federal regulations, the Centers for Medicare and Medicaid Services (CMS) Medicaid Bureau requires each Pre-Paid Inpatient Health Plan to implement a comprehensive Quality Improvement Plan (QIP). This requirement ensures that quality improvement initiatives are thoroughly documented and actively pursued to enhance service delivery for members.

DWIHN has multiple contracts with the Michigan Department of Health and Human Services (MDHHS) to provide various services, including Managed Specialty Supports and Services (Medicaid), General Fund resources, and waiver services to address mental health and substance abuse needs. DWIHN is required to comply with specific guidelines and frameworks, such as those outlined in the Medicaid Managed Specialty Supports and Services Concurrent 1915(b)(c) Waiver Program for the fiscal year 2019, as specified in Attachment P7.9.1. Additionally, the CMHSP Managed Mental Health Supports and Services Contract for FY19, detailed in Attachment C6.8.1.1, establishes the requirements for Quality Assessment and Performance Improvement Programs designed for Specialty Pre-Paid Inpatient Health Plans.

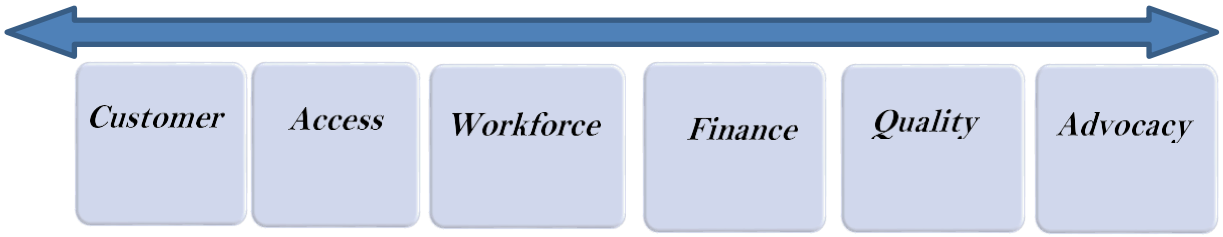
DWIHN has developed a Healthcare Effectiveness Data and Information Set (HEDIS) Scorecard in partnership with Vital Data Technology (VDT) to monitor and analyze care gaps for members. DWIHN promotes service coordination and integration, and this tool should serve as a resource for CRSP providers to coordinate care, improve overall health outcomes, and evaluate individuals receiving services.

Quality Improvement Program (QIP) Governance

The DWIHN Strategic Plan provides a detailed, comprehensive framework for achieving shared goals within the organization. This plan establishes clear agreements on intended outcomes, enabling ongoing evaluation and adjustment of the organization’s strategic direction in response to a dynamic environment. Complementing this framework is the Quality Improvement Plan (QIP), which outlines a systematic approach for assessing various services and identifying key areas for improvement. Through regular evaluations, the QIP ensures that DWIHN maintains and enhances the quality of its offerings. At the core of DWIHN's commitment to quality improvement are six essential pillars. These pillars represent critical focus areas that guide the organization in achieving its overall vision of excellence and delivering effective services. Each pillar is designed to address specific aspects of quality and performance, enabling DWIHN to target improvements methodically and achieve tangible results.

To support the successful implementation and integration of these pillars, robust Information Systems are essential. These systems provide the necessary technological infrastructure and data management capabilities that facilitate informed decision-making, enhance communication, and promote collaboration across all levels of the organization. By leveraging Information Systems, DWIHN can effectively track progress, measure outcomes, and refine its strategies to ensure continued success in fulfilling its mission.

Pillars



DWIHN's ability to understand and address the diverse health needs of our members is significantly enhanced by our advanced framework for accessing, integrating, and analyzing data from various sources. We have made substantial investments in technology and in understanding our members' requirements, which have paved the way for our industry-leading data analytics capabilities. Our team comprises experts in healthcare analytics and statistics who are dedicated to developing and refining standardized methodologies.

These methodologies are designed to deliver precise and targeted results that address the specific health issues our members face. By leveraging comprehensive data analysis, we can identify trends, support informed decision-making, and implement tailored interventions that improve our members' health outcomes. This holistic approach not only enhances our understanding of individual health needs but also empowers us to create more effective programs and services that ultimately contribute to the overall well-being of the communities we serve.

Framework for Quality Improvement

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

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

Key cultural components are essential for the success of improvement efforts within organizations. Several critical elements contribute to this success: active leadership involvement, implementation of data-informed practices, use of statistical tools for analysis, a proactive focus on prevention rather than just corrective measures, and a steadfast commitment to continuous quality improvement. Active involvement from leadership is particularly crucial. Support from the governing body and the Chief Executive Officer (CEO) fosters a culture that prioritizes quality improvement initiatives. This commitment ensures that efforts to enhance performance and prepare for audits are strategically aligned with the organization's broader mission, vision, values, and strategic plan, such as those of DWIHN. Successful quality improvement processes also establish feedback loops that leverage data to inform practices and evaluate outcomes. By consistently analyzing data, organizations can make informed decisions based on reality rather than assumptions. This reliance on information increases the likelihood of accurate decision-making, promoting a continuous cycle of improvement in the quality of care provided.

It is essential that quality improvement processes are not static; they require ongoing review and refinement. Regular assessments help identify what is working well and what may need adjustment, allowing for a responsive approach to quality improvement. Additionally, it is essential to acknowledge that small, incremental changes, when implemented thoughtfully, can have a profoundly positive impact. Providers and teams within the organization are encouraged to consistently seek out and explore opportunities to improve their practices, fostering an environment of continuous growth and enhanced service delivery.

Continuous Quality Improvement Activities

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

- Clinical Components: This section encompasses the entire continuum of care provided to members, starting with acute hospitalization and extending through various outpatient services. By monitoring clinical practices, DWIHN aims to promote best practices and improve health outcomes by enabling seamless transitions and coordination across different levels of care.
- Organizational Components: This framework addresses significant service delivery factors that directly impact care. It includes effective case management procedures, thorough discharge planning, timely prior authorizations, and other processes that affect overall access to and delivery of care. These elements are crucial for ensuring members receive timely and appropriate services.
- Processes Affecting Members and Care Providers: A range of operational processes plays a vital role in the quality of care provided. These include claims processing to ensure prompt reimbursement for members' services, interpreter services to facilitate communication for non-English-speaking members, enrollment processes to help members access essential care, customer service functions to provide support and address concerns, and credentialing and recredentialing processes to ensure that providers meet required standards. Additionally, utilization management processes monitor the appropriateness of the services that members access.
- Member Satisfaction: Measuring member satisfaction is essential for understanding the effectiveness of services provided. DWIHN actively seeks feedback to inform improvements and ensure their experiences align with expectations.
- Member Safety: Prioritizing member safety is central to DWIHN's quality initiatives. Continuous monitoring and enhancement of safety protocols are crucial for preventing harm and enhancing the overall healthcare experience.

Quality improvement activities are conducted within a structured framework that continuously enhances care and service delivery. This framework is embraced by DWIHN's leadership and effectively communicated throughout the organization. Continuous education programs and staff engagement at all levels ensure that performance improvement efforts are well understood and executed. Quality improvement encompasses two primary activities:

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

Director of Quality Improvement

The Director of Quality Improvement plays a crucial role in the successful implementation of the QAPIP. This position requires collaboration with a variety of stakeholders, including program participants, advocates, contracted service providers, and DWIHN staff. The key responsibilities of the Director of Quality Improvement include, but are not limited to, the following:

- Developing Quality Improvement Strategies. Designing and implementing comprehensive quality improvement initiatives that align with the goals of the QAPIP and adhere to best practices in health care quality assurance.
- Collaboration with Cross-Functional Teams. Facilitating collaboration between various departments, including clinical services, administrative support, and data analysis teams, to identify areas for improvement and deploy necessary changes.
- Monitoring Performance Metrics. Establishing, tracking, and analyzing performance metrics to assess the effectiveness of implemented strategies and ensure they meet organizational standards and member needs.
- Conducting Training and Workshops. Organizing training sessions and workshops for staff to promote a culture of quality improvement and ensure that all team members are equipped with the necessary skills and knowledge.
- Reporting and Compliance. Preparing detailed reports on quality improvement activities and outcomes for stakeholders and ensuring compliance with relevant regulations and standards set by governing bodies.
- Engaging Stakeholders. Engaging with stakeholders, including clients and community partners, to gather feedback and incorporate their perspectives into the quality improvement process.
- Continuous Evaluation. Regularly assessing and refining quality improvement processes to ensure ongoing enhancement of services and alignment with the organization's mission and strategic objectives.

Provider Network Monitoring

DWIHN has implemented a process to annually monitor its provider networks, including any affiliates or subcontractors responsible for managed care functions, such as service and support. These activities are incorporated into the work plan. DWIHN conducts a comprehensive annual review of its provider network, including both directly employed staff and affiliated organizations, as well as subcontractors that provide various managed care functions. This thorough evaluation follows established written procedures for assessing the qualifications and competencies of healthcare professionals.

During the review, special attention is focused on physicians and other licensed healthcare providers who are either employed by DWIHN or contracted through the Prepaid Inpatient Health Plan (PIHP). The assessment ensures these professionals meet the necessary licensure requirements and possess the expertise and credentials needed to deliver high-quality care.

DWIHN also emphasizes the importance of ensuring that non-licensed care and support providers are adequately qualified to perform their responsibilities. This involves a thorough review of their skills and training to ensure they can effectively meet the needs of the individuals they serve. Overall, DWIHN is committed to maintaining a high standard of care through rigorous evaluation and continuous monitoring of its provider network, adhering to established criteria such as:

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

The monitoring process employs a multi-tiered approach that includes standardized self-monitoring and self-regulation techniques. It begins at the individual service provider level, where frontline staff conduct self-assessments and track their performance against defined benchmarks. The data collected is then escalated through various levels of oversight, ultimately reaching DWIHN's Quality Improvement Team.

As part of this monitoring strategy, DWIHN has developed standardized tools and protocols to facilitate accurate documentation and reporting. These tools are essential for maintaining accountability and transparency throughout the monitoring process.

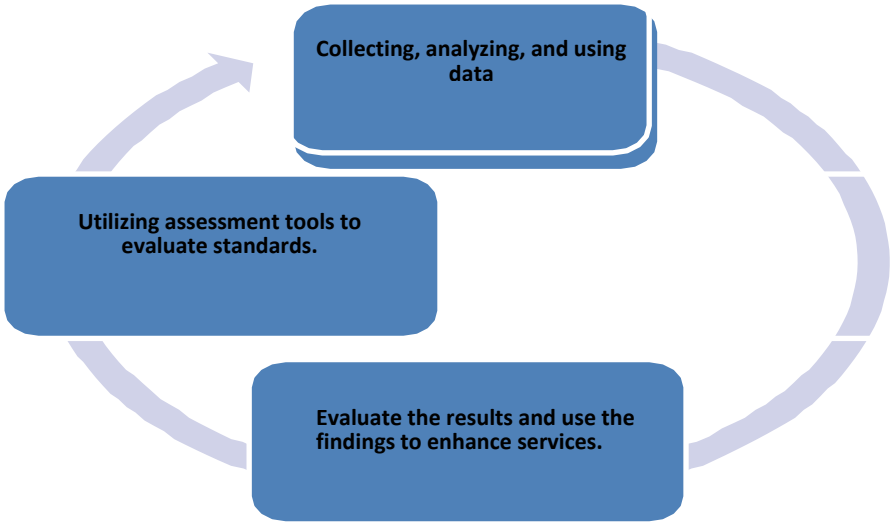
Starting in fiscal year 2026 (FY26), the Quality Unit will monitor HEDIS measures, assigning each measure to a Subject Matter Expert (SME) for implementing interventions. DWIHN has developed a Health Effectiveness Data and Information Set (HEDIS) Scorecard using Vital Data Technology (VDT). This scorecard is accessible to the Clinically Responsible Service Provider (CRSP) through the MHWIN platform, under the "Provider" link tab. It enables CRSP to effectively monitor and analyze gaps in member care.

DWIHN promotes service coordination and integration, and this tool will serve as a valuable resource for CRSP Providers to coordinate care, improve overall health outcomes, and evaluate services provided to individuals. CRSP Providers are required to establish a process for monitoring the scorecard, analyzing the data, and implementing strategies to enhance outcomes and meet HEDIS measure goals.

Performance Measurement

Performance measures play a critical role in the Plan-Do-Study-Act (PDSA) cycle, providing a structured method for evaluating a program's outcomes. These measures involve continuous data collection and analysis, enabling organizations to monitor their performance over time. The primary objectives of measurement and assessment are to identify areas for improvement, inform decision-making with empirical evidence, and ensure the program achieves its intended goals. By regularly reviewing performance data, teams can identify trends, assess the effectiveness of interventions, and make necessary adjustments to enhance the program's overall success.

Measurement and assessment ***involve***:



Performance Improvement

Performance Improvement is a systematic approach that analyzes performance metrics, identifies issues, and implements strategies to prevent, reduce, or eliminate waste. This process is crucial for enhancing the overall quality of services provided to individuals. To achieve this goal, a set of policy directives is established and uniformly applied across the entire system, including DWIHN and its network of affiliated service providers. It is essential for all service providers to follow specific policies that align with DWIHN's overarching directives. These policies are carefully crafted to address various areas as mandated by contractual obligations with MDHHS. They also outline detailed processes and procedures to ensure compliance with state and federal regulations. Before any policy is finalized, it undergoes a thorough public comment period, allowing stakeholders, including service providers, beneficiaries, and community members, to review and provide valuable feedback on proposed changes. Once the feedback is considered, each policy is approved and reviewed in Quality and Provider meetings with the DWIHN service provider network. After finalization, these policies are made publicly available on DWIHN's website to ensure transparency and accountability.

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

To effectively meet the regulatory requirements established by MDHHS and NCQA, DWIHN conducts Performance Improvement Projects (PIPs) that focus on both clinical and non-clinical service areas. These PIP activities are integrated into the overall work plan. Each PIP is rigorously approved by the Improving Practices Leadership Team (IPLT) and monitored by the Quality Improvement Steering Committee (QISC).

The primary goal of each PIP is to achieve measurable and sustainable improvements in both clinical outcomes and non-clinical services. This is accomplished through a methodology that emphasizes continuous measurement and intervention, which leads to significant and lasting improvements in various aspects of clinical services—such as high-volume services, high-risk services, and the continuity and coordination of care—as well as non-clinical services, including appeals, grievances, trends, patterns of substantiated member rights complaints, and access to and availability of services. These improvements aim to positively impact health outcomes and enhance individual satisfaction.

When selecting specific topics for projects, DWIHN will engage in a thoughtful, data-driven decision-making process. This process involves carefully considering the prevalence of health conditions among the populations served, as well as analyzing the demographic characteristics and health risks faced by consumers. Additionally, the organization will consider individuals expressed interests and preferences regarding the services to be addressed, ensuring their voices are integral to the decision-making process. Upon completion of performance assessments for the selected processes, each measure will undergo thorough evaluation and analysis. The insights gained from these evaluations will be instrumental in identifying DWIHN's defined initiatives for continuous quality improvement (CQI). The decision to pursue these initiatives will be based on DWIHN's priorities, reflecting a commitment to enhancing service delivery and promoting better outcomes for individuals served. The overarching goals of these initiatives are to improve the performance of existing services and to develop innovative new offerings that meet the evolving needs of the community.

DWIHN will employ analytical models for its initiatives, including the Focus-Plan-Do-Study-Act (PDSA) cycle, which promotes iterative testing and learning, and the Ishikawa Fishbone Diagram, which helps identify potential causes of issues within complex systems. These structured methodologies will enable a systematic approach to performance improvement. DWIHN requires all members of its provider network to actively participate in Performance Improvement Projects (PIPs) aligned with their specific programs and services. This involvement is particularly crucial for Substance Use Disorder Providers and Clinical Responsible Service Providers (CRSP), who are expected to participate in DWIHN's PIPs relevant to their areas of service. The Quality Improvement (QI) unit at DWIHN plays a vital role in overseeing and monitoring all functions within the quality improvement framework. Importantly, all quality improvement activities are managed internally, without any responsibilities delegated to external entities. DWIHN expects providers to independently conduct PIPs based on their self-assessment processes.

These assessments should evaluate their needs, risks, frequency, and performance within their respective settings. Furthermore, DWIHN's contractual agreement with the Michigan Department of Health and Human Services (MDHHS) mandates participation in state-required performance improvement activities. These activities may also include tasks assigned by the Integrated Planning and Leadership Team (IPLT) and the Quality Improvement Steering Committee (QISC).

Oversight of the quality improvement infrastructure is achieved through collaboration with a diverse group of stakeholders, including members, advocates, service providers, DWIHN's Chief Medical Officer, and other relevant parties. This collaborative effort ensures a comprehensive quality assurance approach. Planned and systematic activities are implemented to guarantee that the quality standards for community mental health services are consistently met by DWIHN and its contracted service providers, ultimately aiming to enhance the well-being of individuals in the community.

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

- Measurement of Performance: The PIP should utilize objective quality indicators to systematically measure performance. These indicators may encompass various aspects of healthcare delivery, including member outcomes, service accessibility, and member safety metrics. Collecting and analyzing this data enables stakeholders to understand current performance levels and identify areas that require improvement.
- Implementation of Interventions: The project must include the design and implementation of targeted interventions aimed at improving both access to care and the quality of services provided. This may involve strategies such as enhancing staff training, streamlining processes, deploying new technologies, or extending hours of operation to better accommodate members' needs.
- Evaluation of Effectiveness: Ongoing evaluation of the effectiveness of the interventions is essential. This evaluation should rely on the state-established performance measures, enabling project leaders to assess how well the interventions are meeting their intended goals. Techniques for evaluation may include comparing pre- and post-intervention data, gathering feedback from members, and conducting follow-up surveys to gauge satisfaction and outcomes.
- Planning and Maintenance: It is crucial not only to plan interventions but also to establish activities aimed at maintaining or enhancing improvements over time. This may involve continuous monitoring, regular reviews of performance data, and adapting strategies as needed based on feedback and assessment results. Sustainable improvements require commitment to ongoing evaluation and adjustment.
- Various tools and methodologies can be utilized throughout the continuous quality improvement (QI) process. Some of these tools include:
    - Dashboards. Using data dashboards to visually present key performance indicators and outcomes in an easily digestible format for stakeholders.
    - Problem Solving Methodology. Structured approaches for identifying and addressing specific issues within care processes.
    - Process Mapping. Visual representation of workflow processes to identify bottlenecks and opportunities for streamlining operations.
    - Cause and Effect Diagrams. Visual tools that help identify the root causes of problems with care delivery.
    - Brainstorming Sessions. Collaborative meetings to generate ideas for potential solutions.
    - Control Charts. Graphical tools for monitoring process behavior over time to identify trends and variations.
    - Check Sheets. Simple data collection forms for tracking occurrences or outcomes.
    - Bar Charts and Scatter Diagrams. Visual tools for representing data trends and distributions.
    - Matrix Analysis. A technique for evaluating multiple factors simultaneously.
    - Ishikawa Fishbone Diagram. A structured method to identify potential causes of a problem, promoting deeper analysis.

Cultural and Linguistic Needs

DWIHN is dedicated to serving a diverse membership, including individuals from various cultural and linguistic backgrounds. Our goal is to improve outcomes by enhancing cultural competency, language accessibility, and physical accessibility. We aim to identify existing racial and ethnic disparities within our provider network across all populations. To achieve these goals, the organization has established several key objectives in its work plan:

- Foster innovation in service delivery
- Ensure affordability for all members
- Maintain professional competence among staff
- Promote continuous learning opportunities
- Encourage teamwork
- Support collaboration throughout the organization

It is well-established that racial and ethnic disparities exist in behavioral healthcare. Thorough data analyses indicate that these disparities significantly contribute to lower HEDIS (Healthcare Effectiveness Data and Information Set) scores, which reflect the effectiveness of care. To enhance the overall quality of care for its members, DWIHN actively seeks to identify and understand the racial and ethnic compositions within its membership. This initiative aims to uncover potential healthcare disparities. DWIHN achieves this goal through systematic monitoring and evaluation of services, along with a proactive approach to identifying and implementing opportunities for improvement. The organization incorporates several essential principles into its Quality Improvement Plan (QIP):

- The Importance of Culture: Recognizing that cultural factors play a crucial role in the effectiveness of healthcare delivery.
- Assessment of Cross-Cultural Relations: Engaging in ongoing assessments of how cultural differences affect interactions between service providers and members.
- Expansion of Cultural Knowledge: Committing to the continuous education of staff about diverse cultural practices and perspectives to enhance service delivery.
- Adaptation of Services: Customizing services to meet the specific and unique needs of each member, ensuring that care is relevant and appropriate.

DWIHN and its Provider Network are dedicated to achieving linguistic and cultural competence, ensuring that all individuals receiving behavioral health services have meaningful access to and engagement in their care. This commitment reflects a profound respect for the community's cultural values, beliefs, and practices. DWIHN recognizes that the interplay of language and culture significantly impacts the delivery of support and services. Professional competence within the organization includes awareness of the rich cultural diversity in the service area, encompassing factors such as race, culture, religious beliefs, and regional influences. Furthermore, social determinants such as gender, gender identity, sexual orientation, marital status, education level, employment status, and economic conditions are recognized as vital for understanding members' individual needs. By addressing these diverse dimensions, DWIHN aims to deliver more equitable and effective behavioral health services to all individuals in its care.

Credentialing and Re-Credentialing

DWIHN has established comprehensive procedures for credentialing and re-credentialing to assess and verify the qualifications of physicians and other licensed healthcare professionals who work as employees or contracted providers within the network. These procedures are integrated into the overall work plan to monitor and ensure a competent workforce through the credentialing process. This guarantees that all healthcare professionals associated with DWIHN are fully qualified to deliver high-quality services to the community.

In addition to licensing professionals, the Quality Assurance and Performance Improvement Plan (QAPIP) includes specific written policies to ensure that non-licensed care providers and support staff are properly qualified for their respective roles. Maintaining a well-trained workforce is essential for upholding the integrity of the services offered.

DWIHN's credentialing procedures align with the guidelines established by the Michigan Department of Health and Human Services (MDHHS). Compliance includes all aspects of credentialing, including initial credentialing, recredentialing, recertification, and the reappointment of healthcare practitioners. DWIHN applies strict assessment criteria to evaluate the qualifications of both employed and contracted physicians, as well as licensed behavioral healthcare practitioners, in accordance with the Credentialing and Re-Credentialing Policy.

DWIHN ensures that all organizational providers with direct contracts within the network, as well as practitioners linked to the Community Mental Health Services Program (CMHSP), meet the necessary professional and ethical standards. The Credentialing and Re-Credentialing Policy and the Organization Credentialing Policy govern these practitioners, ensuring consistency and accountability. Additionally, DWIHN conducts quarterly and annual audits of the Credentialing Verification Organization (CVO). These audits rigorously assess the CVO's system controls and scrutinize adherence to established policies. As part of this quality assurance process, DWIHN samples 5% of the "clean" files for the Virtual Review Committee and thoroughly examines 100% of the "unclean" files, addressing any discrepancies or issues comprehensively. Importantly, practitioners have the right to correct any erroneous information that may appear in their credentialing applications. This provision is clearly stated in the Credentialing and Re-Credentialing Policy, empowering practitioners to maintain the accuracy and fairness of their professional records. By implementing these detailed policies and procedures, DWIHN is committed to cultivating a qualified and capable workforce dedicated to enhancing the health and well-being of the communities it serves.

Critical Incidents (CI), Sentinel Events (SEs), Unexpected Deaths (UDs), and Risk Events (RE)

The QAPIP description outlines the procedures for reviewing and addressing Sentinel Events (SEs) and other Critical Incidents (CIs) that may pose a risk of harm to individuals. The goal is to comply with MDHHS reporting requirements and ensure the safety of clinical care for members, which is monitored through the work plan.

This description explains how DWIHN will investigate Unusual Deaths (UDs), which include deaths resulting from suicide, homicide, undiagnosed conditions, accidental causes, or those suspected of involving possible abuse or neglect—specifically concerning members who were receiving specialty support and services at the time of their deaths.

The process involves analyzing Reportable Events (REs) that indicate potential risks of harm. These events primarily include actions taken by individuals receiving services that result in self-harm, actions that cause harm to others, and instances involving two or more unscheduled medical hospital admissions within a 12-month period that are unrelated to planned surgeries or the natural progression of chronic illnesses, such as terminal conditions.

The DWIHN Reporting Policy for Consumer Critical Events, Sentinel Events, and Death outlines comprehensive guidelines for reporting and thoroughly reviewing potential Sentinel Events and Critical Incidents involving individuals. DWIHN actively participates in statewide initiatives and collaborations to prevent, detect, and resolve critical incidents while ensuring compliance with state and federal mandates, particularly those related to home and community-based waiver programs. The QAPIP establishes a structured framework for systematically reviewing and following up on sentinel events and other critical incidents that may pose risks to the safety and well-being of individuals. DWIHN is committed to regularly analyzing and reviewing incidents, utilizing a variety of data sources and stakeholder feedback to identify necessary corrective actions and preventive measures. This ongoing analysis is crucial for identifying patterns, mitigating risks, and improving overall service delivery.

DWIHN has implemented a robust, systematic procedure for analyzing critical events that may pose risks to individuals receiving care. This procedure includes detailed documentation, investigation protocols, and multidisciplinary team reviews to ensure that all relevant factors are thoroughly considered. The insights gained from these analyses are crucial in determining effective interventions and strategies to address identified challenges and prevent future occurrences. The types of critical incidents addressed include, but are not limited to, serious injuries, unexpected deaths, incidents of abuse or neglect, medication errors, and other significant events that could adversely affect individuals' well-being.

By carefully identifying, reporting, and analyzing these events, DWIHN strives to promote a culture of safety, accountability, and continuous improvement in its services. The identified events include, but are not limited to:

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

DWIHN is responsible for promptly assessing critical incidents to determine if they qualify as sentinel events. This assessment must be completed within 3 business days of the incident being reported. If an incident is identified as a sentinel event, DWIHN has an additional two business days to initiate a comprehensive root cause analysis. This analysis aims to identify the underlying factors that contributed to the incident and to implement strategies for improvement. To ensure a thorough and credible evaluation of sentinel events, DWIHN requires that all individuals involved in the review process have the appropriate credentials and expertise. This requirement is especially important for incidents involving member deaths or other serious medical conditions, where the review must include insights from qualified professionals, such as physicians or nurses. Their involvement is essential to accurately assess the scope of care and understand the implications of the incident. DWIHN has identified seven specific incident types that must be reported through the Critical Incident Reporting System. These categories are designed to capture a wide range of sentinel events, ensuring that all significant occurrences are documented and addressed in a timely and appropriate manner. The identified reportable categories include:

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

DWIHN conducts comprehensive analyses quarterly to assess critical incidents, sentinel events, and risk events. This process aims to identify necessary remediation actions and implement preventive measures to avoid future occurrences. The Sentinel Event Committee/Peer Review Committee (SEC/PRC) plays a crucial role in this process by reporting its findings on sentinel events and ensuring in-depth evaluation and analysis. This committee is responsible for thoroughly documenting follow-up actions taken and outlining efforts to improve systems, in accordance with MDHHS guidelines.

The SEC/PRC systematically reviews and analyzes sentinel event reports submitted by providers within the Crisis Response Services and Substance Use Disorder (CRSP/SUD) framework. Additionally, they compile and present a detailed periodic summary, along with informed recommendations for action and disposition, to the Governing Body at least once a year. The SEC/PRC has the authority to require follow-up actions from providers as needed. These follow-up actions may include developing a Corrective Action Plan to address specific deficiencies, creating an Improvement Plan to enhance overall service delivery, or conducting a Root Cause Analysis (RCA) to identify the underlying causes of incidents. In cases of unexpected deaths involving Medicaid members who were receiving specialty support and services at the time of their passing, a thorough and meticulous review will be conducted. "Unexpected deaths" are defined as those resulting from various causes, including suicide, homicide, undiagnosed medical conditions, accidental incidents, or circumstances that raise suspicions of potential abuse or neglect.

Each review will include several key components: gathering data on the death's context, engaging with relevant stakeholders, investigating the care received prior to the incident, and assessing any potential systemic failures that may have contributed to the situation. This thorough examination is crucial for understanding the circumstances surrounding these tragic events and for developing strategies to prevent similar occurrences in the future. The review will encompass the following elements:

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

Upon receiving immediate notification of an event, MDHHS prompts DWIHN to take swift action. DWIHN submits detailed information through its Critical Incident Reporting System. Each event type has specific reporting requirements to ensure thorough documentation. The Sentinel Event Committee (SEC) and the Performance Review Committee (PRC) play a crucial role in analyzing all critical incidents, sentinel events, and risk events. Their work is essential for implementing effective measures to address issues and prevent similar occurrences in the future, highlighting our commitment to providing safe, high-quality care.

Every Clinically Responsible Service Provider (CRSP) is required to enter Critical Events, Critical Incidents, Sentinel Events, and Risk Events into the Critical/Sentinel Event Module of the Mental Health-Welfare Information Network (MH-WIN) within 24 hours of becoming aware of the event for members who are actively receiving services from their organization. Residential Treatment Providers must promptly report events involving members to the CRSP and provide relevant hospital documentation or police reports when applicable.

DWIHN has enhanced its reporting process to include data for each CRSP. This includes identifying trends and patterns reported by the SEC and PRC, along with corresponding recommendations. The SEC and PRC comprise the Chief Medical Officer, clinicians, and administrative staff within DWIHN. The expanded reporting now includes:

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

DWIHN requires all contracted Clinically Responsible Service Providers (CRSP) to form a Behavior Treatment Plan Review Committee (BTPRC). This committee is responsible for the thorough evaluation and oversight of Behavior Treatment Plans (BTP). Providers may choose to work together with network providers and Mental Health CRSPs to create and operate unified BTPRC. DWIHN expects all providers involved in the BTPRC to ensure a timely review of proposed Behavior Treatment Plans. This process is crucial for quickly addressing these plans, especially during emergencies, enabling prompt and effective responses to behavioral health needs.

The DWIHN-contracted Mental Health CRSP is responsible for overseeing compliance and implementation of policies and procedures related to Behavior Treatment. This oversight includes ensuring that all treatment interventions adhere to established guidelines and are delivered in a manner that respects the rights and needs of the individuals being served. The Quality Assurance and Performance Improvement Program (QAPIP) is tasked with conducting comprehensive quarterly reviews. These reviews analyze data collected from the Behavior Treatment Review Committee concerning the use of intrusive or restrictive techniques authorized for program members.

The analysis includes instances in which physical management techniques were employed, as well as situations that necessitated law enforcement intervention via 911 calls during behavioral crises. It is vital that only techniques explicitly outlined in the Technical Requirements for Behavior Treatment Plans—and approved during the person-centered planning process by the member or their legal guardian—are implemented. The data gathered during these reviews will include metrics such as the total number of interventions applied and the duration of each intervention for individual members. This information is essential for assessing the effectiveness of treatment strategies and ensuring alignment with best practices in behavioral health care.

Member Experience with Services

DWIHN conducts a Member Experience Survey to evaluate and improve the quality of care provided to its members. This survey employs a quantitative methodology that uses structured questionnaires to assess member experiences with our services. It is crucial to detail the internal processes DWIHN uses to conduct these quantitative assessments, as well as the specific survey instruments it employs. This includes activities such as focus groups, member advisory boards, and targeted interviews.

The primary goal of this assessment is to gather feedback from members about their experiences with the care they receive. DWIHN aims to accurately capture service recipients' perspectives while evaluating the availability and effectiveness of the support provided.

Key focus areas include assessing the quality, accessibility, and availability of care, ensuring that the unique needs of each member are addressed promptly and effectively. All DWIHN surveys are managed through DWIHN's Customer Service unit.

Long-Term Services and Supports (LTSS)

DWIHN has established processes to assess the quality and suitability of Long-Term Services and Supports (LTSS) for those who need them. This activity is integrated into the work plan, which evaluates member care across various settings. The assessment compares the services members receive to those outlined in their treatment or service plans within Home and Community-Based Settings.

DWIHN utilizes a comprehensive treatment or service plan mandated by MDHHS for members with identified special healthcare needs who require specific treatment courses or ongoing care monitoring. This plan is a dynamic document that necessitates regular updates and undergoes a systematic review and revision process during assessments of the member's functional needs. Reassessments occur at least once every twelve months, whenever there are significant changes in the member's circumstances, or at the member's request.

The treatment or service plan includes several essential elements:

- Development by a qualified individual in compliance with LTSS service coordination requirements, in collaboration with the healthcare providers involved in the member's care and with the active participation of the member.
- Creation by a professional specifically trained in person-centered planning, following the process defined in 42 CFR for LTSS treatment or service plans.
- Timely approval in accordance with the established requirements.
- Adherence to applicable quality assurance standards and utilization review protocols set forth by MDHHS, ensuring high-quality service delivery and favorable care outcomes for all members receiving LTSS.

Clinical Practice Guidelines

DWIHN prioritizes the adoption of Clinical Practice Guidelines (CPGs) that are relevant to our membership by evaluating several key factors. These factors include the incidence or prevalence of specific diagnoses or conditions within the population we serve, the variations observed in treatment methods or outcomes related to these diagnoses, and the availability of robust scientific and medical literature assessing the effectiveness of different treatment approaches. Once these guidelines are developed and finalized, they will be accessible on the DWIHN website, ensuring that all providers can easily find them. It is essential for providers to reference these practice guidelines to enhance the quality of care they deliver and support their ongoing treatment decisions and methodologies in behavioral health care.

A critical part of the guideline development process includes public review and comments. After conducting comprehensive clinical training sessions and updating relevant clinical protocols and practice guidelines on the DWIHN website, we enter the implementation phase through the proposed policies process. During this phase, DWIHN may distribute a draft version of the clinical practice guidelines to contracted providers who treat the specific conditions under review, inviting their feedback and suggestions for improvement. This collaborative input is invaluable, as it ensures the guidelines reflect real-world clinical practice and address providers' needs.

The Integrated Practice Leadership Team (IPLT) is responsible for ensuring that effective, evidence-based practices are in place by developing or adopting comprehensive clinical guidelines. All clinical practice guidelines must receive formal approval from DWIHN's IPLT before they are enacted. Under the strategic direction of the Chief Medical Officer, DWIHN staff continuously monitor, evaluate, and update all practice guidelines and clinical protocols. This process is guided by the latest research findings, compliance with state and federal regulations, and alignment with the most effective standards of care in the field. The review and updating of clinical practice guidelines occur at least every two years; however, adjustments may be made more frequently if significant changes in national guidelines or emerging best practices require immediate attention.

DWIHN expects all contracted practitioners to adhere rigorously to these guidelines within their clinical practices. Additionally, we actively encourage our providers to adopt and implement evidence-based practices. We recognize, however, that the guidelines may not address every individual circumstance or unique member need. To ensure compliance with clinical guidelines, DWIHN employs various monitoring mechanisms, including detailed reports, thorough treatment chart reviews, and various process indicators. Furthermore, DWIHN is committed to supporting its members in effectively managing their conditions by providing easy access to practice guidelines through its website and engaging in specific quality improvement initiatives aimed at enhancing overall care delivery.

Verification of Services

The QAPIP outlines how DWIHN verifies that services reimbursed by Medicaid are delivered to members by affiliated providers and, when applicable, subcontractors. The goal is to randomly review selected paid encounters and claims to eliminate fraud, waste, and abuse within the provider network. This verification activity is incorporated into the work plan to ensure accountability and maintain service delivery quality. Through this process, DWIHN analyzes trends in service delivery and health outcomes over time. This analysis helps assess whether improvements have been made and identify barriers affecting the quality of healthcare and services for members.

The process begins with the Individual Plan of Services (IPOS), a foundational document that specifies the services a member is entitled to receive. DWIHN employs a systematic approach to claims verification by conducting thorough reviews of claims submitted by a randomly selected group of contracted providers. These providers are chosen from a variety of funding sources, including MI-HEALTH LINK, Medicaid, Substance Use Disorder (SUD) services, Autism services, grants, and the General Fund.

The reviews conducted by DWIHN are thorough and consist of several key components: desk audits that evaluate documentation related to claims, compliance investigations to ensure adherence to regulations and standards, and on-site evaluations to directly observe operations and service delivery. Every six months, DWIHN generates a statistically valid random sample from a wide pool of "Paid Encounters/Claims." The size of this sample is carefully determined to meet the minimum sampling standards set by the Office of Inspector General (OIG), ensuring a rigorous and credible process. It is crucial that all program and clinical case records comply with DWIHN's established policies and procedures, as well as MDHHS requirements.

At the end of each year, DWIHN submits its Medicaid Claims Verification Report to the state. This annual report outlines the outcomes of the verification process, including any issues identified during the reviews and the subsequent follow-up actions taken. This comprehensive reporting mechanism reinforces the integrity of the service-provision framework and promotes continuous improvement across the network.

Behavioral Treatment Review

DWIHN has assigned the responsibility for the Behavioral Treatment (BT) review process to all contracted Mental Health (MH) Clinically Responsible Service Providers (CRSP). The objective is to meet the technical requirements set by MDHHS for the Behavior Treatment Plan Review Committee (BTPRC) by reviewing randomly selected cases. This process is tracked and monitored through the work plan.

This delegation ensures that providers comply with the requirements specified in their written contracts for the BTPRC. The process includes a quarterly review of data analyzed by the Behavior Treatment Review (BTR) Committee. This review focuses on cases where intrusive or restrictive techniques have been approved for use with beneficiaries, as well as situations that involve physical management or calls to law enforcement during an emergency behavioral crisis.

Currently, DWIHN manages a total of twenty (20) BTPRCs, which are held at various MH CRSPs to oversee the implementation and review of behavioral treatment strategies. The QAPIP conducts comprehensive quarterly reviews that analyze extensive data gathered from the BTPRCs. This analysis focuses on key aspects, including the approval and actual use of intrusive or restrictive behavioral techniques with members. It also examines situations in which physical management interventions have been employed or when emergency services, such as law enforcement, were contacted during behavioral crises. Furthermore, the analysis includes a detailed breakdown of the duration of these physical management interventions for each individual, enabling a nuanced understanding of their use.

The techniques permitted for use are governed by the Technical Requirements for Behavior Treatment Plans and must receive prior approval through person-centered planning conducted with the member or their legal guardian. Data collection encompasses not only the number of interventions performed but also the specific duration of each intervention for each individual. This meticulous data tracking enables a thorough evaluation of intervention efficacy and adherence to established protocols. In addition to reviewing data, the BTPRC also assesses the implementation of established procedures. It evaluates each committee's overall effectiveness in light of its specified responsibilities, identifying areas where corrective action may be needed.

The Committee plays a critical role in comparing system-wide key indicators, including rates of psychiatric hospitalization, progress toward behavior stabilization, and fluctuations in the application of behavior treatment plans. By systematically analyzing these indicators, the Committee can make informed decisions that enhance the quality and effectiveness of care provided to its members.

Committee Structure

To enhance overall quality within the DWIHN organization, several dedicated committees have been established to oversee and implement quality improvement initiatives. These committees play a crucial role in ensuring adherence to best practices and prioritize continuous improvement throughout the organization. Supporting these committees is a robust infrastructure that facilitates collaboration among key stakeholders, including department heads, process owners, and cross-functional teams. This collaborative approach ensures that diverse perspectives and expertise are integrated into the decision-making process, leading to more effective strategies for enhancing quality. Committees can meet in person or utilize virtual meeting platforms.

Program Compliance Committee (PCC)

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

Membership:

The PCC Committee of DWIHN comprises members from the Board of Directors. The Associate Vice President of Clinical Operations serves as the liaison for the committee. Meeting notices are posted in public locations and on DWIHN's website. All meetings are open to the public.

Function of the Committee:

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

- Annual evaluation of the effectiveness of the QAPIP and recommends approval of reports to the Board.
- System-wide trends and patterns of key indicators.
- Opportunities for improvement.
- Studies in areas identified from data review as having the potential for affecting the outcomes of care and related quality concerns.
- Policies and Procedures.
- System-wide attainment of goal(s) and objective(s).
- Developing and approving the QAPIP description and evaluation.
- Establishing measurable objectives based upon priorities identified using established criteria for improving the quality and safety of clinic services.
- Developing indicators of quality on a priority basis.
- Periodically assessing information based on the indicators, acting as evidenced through quality improvement initiatives to solve problems and pursue opportunities to improve quality.
- Establishing and supporting specific quality improvement initiatives.
- Reporting to the Full Board of Directors on quality improvement activities on a regular basis.
- Review of program operations.
- Recommend Board Actions to the Full Board of Directors.

Quality Improvement Steering Committee (QISC)

The Quality Improvement Steering Committee (QISC) at DWIHN serves as a vital advisory group dedicated to fostering system-wide representation in various aspects of DWIHN's continuous quality improvement program. This committee is responsible for ensuring that all stakeholders are involved in the planning, implementation, support, and evaluation processes, thereby facilitating a collaborative approach to quality enhancement. The QISC is responsible for providing ongoing operational leadership for the continuous quality improvement initiatives across DWIHN. To maintain effective oversight and to promote ongoing dialogue, the committee meets at least once a month, ensuring a minimum of seven (7) meetings each year. These gatherings allow committee members to assess current quality improvement efforts, share insights, and strategize on practice improvement projects. Additionally, the QISC plays a critical role in leading various practice improvement initiatives to enhance service delivery and operational efficiency. It serves as a communication hub, effectively coordinating quality improvement activities and ensuring seamless information flow throughout the program. Through these efforts, the QISC strives to uphold high-quality standards and improve outcomes for the individuals and communities served by DWIHN.

Membership:

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

Function of the Committee:

- Establish and annually review committee operational guidelines, such as confidentiality, meeting frequency, management of information requests, number of members required for a quorum, membership, etc.
- Establish committee goals and timelines for progress and achievement.
- Participate in the development and review of quarterly/annual reports to the Program Compliance Committee and the Full Board of Directors regarding the Quality Improvement System.
- Conduct an annual review of the effectiveness of the QAPIP. Establish a circular communication process to ensure that all stakeholders, including the Board of Directors, DWIHN staff, members, providers, and other involved parties, participate in the Quality Improvement Process.
- Provide recommendations and feedback on process improvement, program implementation, program results, and program continuation or termination.
- Examine quantitative and qualitative aggregate data at predetermined and critical decision-making points and recommend courses of action.
- Review reports from regulatory DWIHN reviews.
- Review of DWIHN improvement plans and make recommendations based on these reviews.
- Monitor progress and completion of plans of correction in response to recommended remedial actions identified for the DWIHN or by regulatory organizations.
- Review quality Improvement operating procedures and propose changes in procedures as needed.
- Oversee a process for establishing, continuing, or terminating subcommittees, standing committees, improvement teams, task groups and work groups.
- Identify training needs and opportunities for staff development in the quality Improvement process.
- Identify future trends and make recommendations for next steps.
- Develop standardized forms required for the work of the Steering Committee.
- Initiate and participate in recognition and acknowledgement of successes in quality Improvement for the DWIHN and the community mental health system.
- Leadership in practice improvement projects.

Improving Practices Leadership Team (IPLT)

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

Membership:

The IPLT committee is chaired by the Associate Vice President of Clinical Operations and Chief Medical Officer, which includes Improving Practice Leadership Specialists in the following areas:

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

Function of the Committee:

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

- Identify and mobilize program leaders or change agents within the organization to implement the activities required to achieve the desired outcomes.
- Develop an ongoing process to maximize opportunities and overcome obstacles.
- Monitor outcomes and adjust processes based on learning from experience.
- Align relevant persons, organizations, and systems to participate in the transformation process.
- Support Membership of a Member/Certified Peer Support to represent the PIHP/CMHSP on the Recovery Council of Michigan.
- Assess parties' experience with change.
- Establish effective communication systems.
- Ensure effective leadership capabilities.
- Enable structures and process capabilities.
- Improve cultural capacity.
- Demonstrate their progress in system transformation by implementing evidence-based, promising, and new and emerging practices.

Sentinel Events Peer Review Committee (SEPRC)

The Critical/Sentinel Event process is a comprehensive framework designed to ensure the reporting and analysis of all actual or alleged incidents that may pose significant risks or result in substantial harm to the physical or mental health, safety, or overall well-being of individuals receiving services within the DWIHN service delivery area. These incidents include, but are not limited to, member deaths, arrests, hospitalizations due to injuries, and medication errors. Each of these events is crucial for understanding and improving the quality of care and safety within the system.

The Safety Event Committee/Peer Review Committee (SEC/PRC) has the authority to make the final determination on whether an incident is classified as a Critical or Sentinel Event. Their judgment is crucial in determining the severity of an incident and identifying the necessary steps for response and prevention. In certain situations, particularly when specific questions or concerns arise regarding an incident, the SEC/PRC may invite additional stakeholders or experts to participate. This collaborative approach aims to foster a comprehensive understanding of the incident and develop effective improvement strategies. It is important to note that all peer review clinical activities conducted within this process are privileged and confidential. These activities strictly adhere to applicable state and federal laws and regulations governing peer review processes, ensuring that discussions remain protected and focused on enhancing the quality of care provided to members.

All unexpected deaths of Members who were receiving specialty support and services at the time of their deaths must be reviewed.

- Individual death cases should include standard information, such as coroner's reports and death certificates.
- Medical personnel should be involved in the mortality review process.
- It is important to document the steps taken during the mortality reviews, as well as the findings and recommendations made.
- Utilize mortality information to improve the quality of care.
- Aggregate mortality data over time to identify potential trends.

The term "unexpected deaths" includes cases of suicide, homicide, undiagnosed conditions, accidents, or those suspected of being caused by abuse or neglect. If needed, additional individuals will be invited to address the DRC's questions or concerns.

SEC/PRC Membership includes but is not limited to:

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

Function of the Committee:
The mission and goal of the SEC/PRC are to ensure that Contracted Providers and Clinically Responsible Service Providers (CRSPs) thoroughly review incidents and develop action plans to remediate or reduce the risk of similar incidents. Additionally, the SEC/PRC ensures that a comprehensive review of any Member's death is conducted by the Member's respective Service Provider, CRSP, and the Recipient Rights and Clinical Practice Improvement Units. All reviews are conducted in accordance with DWIHN's Death Reporting Policy, as well as applicable state and federal laws and regulations governing death review activities.

The SEC/PRC employs a three-tiered system for peer review activities:

1. First Tier: Critical and Sentinel Events are reviewed by the Quality Performance Improvement Team (QPIT) to assess standard-of-care and scope-of-service issues. If additional documentation is needed or concerns arise regarding the completeness of the information, these are communicated to the CRSP, and appropriate notifications are sent to DWIHN Department leaders.
2. Second Tier: The SEC/PRC Committee reviews the Critical and Sentinel Events. Findings from this review may include requests for additional information, corrective action plans, or referrals to Recipient Rights, Compliance, or Contract for action. Consistent shortcomings or failure to address identified issues may result in recommendations for performance sanctions in accordance with DWIHN policies, procedures, and contracts.
3. Third Tier: Data collection is reviewed by the QPIT for potential policy updates and implementation, as well as patterns, trends, compliance, education, and improvements. The results are then presented to the DWIHN Program Compliance Committee, a Board of Directors committee.

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

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

Membership:

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

Function of the Committee:

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

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

Credentialing Committee

The primary goal of the committee is to establish a comprehensive and clear framework for the functions and responsibilities of DWIHN's Credentialing Verification Organization (CVO) and the various service providers involved in delivering care. This framework will detail the specific roles of each entity in the credentialing process, ensuring quality and regulatory compliance. The committee is responsible for implementing robust credentialing and re-credentialing processes that adhere to best practices and applicable regulations. These processes are designed to verify the qualifications, experience, and competency of healthcare providers, ensuring that only those who meet the required standards are eligible to participate in service delivery. Operating under the guidelines established by the PIHP agreement with MDHHS, the Credentialing Committee plays a critical role in maintaining a skilled and capable workforce within DWIHN. This workforce is crucial for delivering services effectively, ensuring that clients receive high-quality care, which is funded by Medicaid and Medicare. Additionally, the committee's guidelines aligned with the Code of Federal Regulations, specifically 42 CFR 438.214, Provider Selection. By adhering to these regulations, the committee ensures that the selection and ongoing evaluation of providers and practitioners meet the required quality and performance criteria. Through these efforts, the committee aims to foster a safe and effective healthcare environment for all individuals served by DWIHN.

Function of the Committee:
The Committee conducts thorough reviews of completed files that have gone through a detailed process called primary source verification. This rigorous verification involves examining several key components, including:

- Current and valid state licenses
- Current and valid DEA or CDS certifications
- Board certification (if applicable)
- Education and training
- Work history
- Malpractice history
- Current malpractice insurance
- Medicare and Medicaid sanctions
- Medicare Opt-Out status
- Clinical privileges (if applicable)
- National Provider Identifier (NPI) number
- Criminal background checks

This entire verification process is carried out by a Credentialing Verification Organization (CVO) accredited by the National Committee for Quality Assurance (NCQA). The Committee plays a crucial role in approving files that meet all specified requirements and denying those that do not, thereby maintaining high standards for the provider network. Additionally, the Committee provides ongoing oversight of the CVO, monitoring exclusion and preclusion databases monthly to ensure compliance with all regulatory requirements. Each Committee member is required to sign an attestation affirming their commitment to confidentiality and adherence to procedures that prevent discrimination against practitioners and providers from diverse backgrounds. In accordance with the credentialing and re-credentialing processes outlined by the Michigan Department of Health and Human Services (MDHHS), the Detroit Wayne Integrated Health Network (DWIHN) has developed structured, written policies and procedures. These are designed to ensure that the credentialing and re-credentialing of its provider network are conducted appropriately and transparently.

Furthermore, the Quality Improvement department continuously evaluates the qualifications of the provider network staff to ensure compliance with all relevant federal, state, and local regulations. To maintain the highest standards of care, performance monitoring is conducted at least annually through a well-established process. This process verifies that care and support providers possess the necessary qualifications and are adequately equipped to perform their duties effectively and safely, ultimately contributing to the overall quality of care provided to clients.

Membership:

- Chief Medical Officer or their designated physician.
- Behavioral Health Providers for both children and adults, as well as Substance Use Disorder Providers for treatment and prevention for children and adults.
- DWIHN Staff.

Risk Management

The purpose of the committee is to conduct a thorough review of incidents involving Members and the provider system. All discussions and findings will be kept strictly confidential to protect sensitive information. This committee, known as the Risk Management Committee, meets on an as-needed basis to address specific incidents and assess potential risks within the provider system. The committee's reviews aim to identify patterns, recommend improvements, and enhance the overall safety and quality of care for all Members involved.

Membership:

The Risk Management Committee is chaired by the Vice President of Compliance.

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

Function of the Committee:

- Continuously enhances member safety while minimizing and preventing errors, events, and system breakdowns that could harm patients, staff, volunteers, visitors, and others. This is achieved through proactive risk management and patient safety initiatives.
- Reduce the adverse effects of errors, events, and system breakdowns when they do occur.
- Minimize organizational losses by proactively identifying, analyzing, preventing, and controlling potential clinical, business, and operational risks.

Compliance Committee

The Compliance Committee is an organization-wide governing body responsible for overseeing and ensuring adherence to relevant regulatory, legal, and operational compliance standards. The committee will meet at least once each fiscal quarter to review compliance issues, assess organizational processes, evaluate adherence to policies and regulations, and discuss emerging risks. In addition to the regularly scheduled quarterly meetings, the Vice President of Compliance has the authority to convene additional sessions as needed. This flexibility allows the committee to promptly address urgent compliance concerns, emerging regulatory issues, or matters that require immediate executive review. All committee members are expected to actively participate, share insights, and support the ongoing improvement of the organization's compliance infrastructure.

Membership:

The committee will be made up of the following individuals or their designated representatives:

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

Function of the Committee:

- Support the Vice President of Compliance by conducting risk assessments and defining the scope, necessity, and structure of compliance reviews throughout the organization.
- Provide guidance on the organization's compliance training needs and assist in planning, coordinating, and delivering appropriate training programs.
- Help develop, review, and refine organizational policies that reinforce and implement the Compliance Plan.
- Support the implementation of the Compliance Plan to ensure it aligns with regulatory standards, organizational expectations, and best practices.
- Participate in evaluating the overall effectiveness of the Compliance Plan, identify opportunities for improvement, and recommend corrective actions as necessary.
- Referring matters to the Program Compliance Committee (PCC) and/or the Board of Directors that involve:
    - Violations requiring notification to federal, state, or local agencies.
    - Violations with financial impact on the Network or those requiring repayment of funds to federal or state agencies.
    - Any additional compliance matters warranting Board review or oversight, as determined by the Compliance Committee.

Recipient Rights Advisory Council (RRAC)

The RRAC is established under the Michigan Mental Health Code (MCL 330.1757). This committee is dedicated to enhancing mental health services and promoting resilience within the community. The RRAC is required to hold at least two meetings per year, or more if needed. Typically, an RRAC meeting is held every other month, on the first Friday of the assigned month, from 1:00 PM to 3:00 PM. During these meetings, ORR staff discuss the Semi-Annual and Annual reports (when required), as well as various topics related to the mental health code, ORR policies, and statistical data from the Training & Education, Monitoring, Investigative, and Intake departments. The RRAC also discusses initiatives to support individuals and families. The meetings are held in compliance with the Open Meetings Act, ensuring transparency and accountability. As a result, the public is welcome and encouraged to attend, participate, and share their insights. By engaging in the community, the RRAC aims to foster a collaborative environment that promotes mental health awareness and advocacy.

Membership:

The membership is designed to reflect the diverse perspectives of the CMHSP's geographical area. At least one-third of the members must be primary members or family members, with at least half of that one-third being primary members.

Function of the committee:

Protect the Office of Recipient Rights (ORR) from pressures that could interfere with the impartial, even-handed, and thorough performance of its functions.

- Provide advisory support to the Executive Director and the Director of the Office of Recipient Rights (ORR).
- Review the funding process for the ORR.
- Recommend candidates for the Director of ORR position to the Executive Director.
- Consult with the Executive Director regarding any proposed dismissal of the Director of ORR.
- Participate in education and training regarding ORR policies and procedures.
- Review the semi-annual report submitted to the Michigan Department of Health and Human Services (MDHHS).
- Review of the annual report submitted to MDHHS.
- Contribute to the "Goals for ORR" and "Recommendations for ORR" sections of the Annual Report.
- Serve as the Recipient Rights Appeals Committee (RRAC).

Access Committee (AC)

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

These standards are outlined in various governing documents, including the Michigan Department of Health and Human Services (MDHHS) Access Standards policy, the External Quality Review (EQR) Checklist and Standards, as well as specific contractual provisions, such as 42 CFR §438.206(c)(1) (i-vi) Contract Schedule A–1(E)(7)(a), 42 CFR 438.68, and 42 CFR 438.207. The Committee must develop and implement strategies to continuously monitor compliance with these standards, which are essential for ensuring timely access to care for individuals in need and assuring adequate capacity and services. To carry out its mission effectively, the Access Committee will engage in detailed discussions that focus on data analysis, operational challenges, and potential solutions. This collaborative process will involve reviewing quantitative data on service usage, appointment wait times, and other relevant metrics to identify trends and areas for improvement. Based on this analysis, the Committee will establish actionable steps to enhance availability and facilitate access to care for all individuals served by DWIHN.

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

Membership includes, but is not limited to:

The Access Committee is chaired by the Director of Managed Operations, but it is not limited to the following:

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

Function of the committee:

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

Research Advisory Committee (RAC)

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

Function of the committee:

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

Membership:

- The Chief Clinical Officer of DWIHN will appoint members to the RAC based on recommendations from the Committee Co-Chairs and/or other Committee members. One of the Co-Chairs will be the Chief Medical Officer of DWIHN.
- The RAC will consist of members with diverse skills, expertise, and experiences, representing DWIHN, its Direct Contractors, service recipients, and various stakeholders, including those from research and funding communities.

Constituent's Voice

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

Function of the Constituent's Voice:

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

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

Quality Improvement Teams, Ad Hoc Committees, and Workgroups

DWIHN may identify various areas for improvement that do not align with the current standing committee structure. To effectively address these opportunities, temporary teams will be formed. These teams may take the form of ad hoc groups, work groups, or quality circles, each focused on specific tasks or objectives as needed. The formation of these temporary teams will be guided by the organization's requirements and can be initiated by the Quality Improvement Steering Committee, the Quality Improvement Department, or the Standing Committee. The decision on who appoints these teams will depend on the organization's specific needs and the nature of the improvement required. Furthermore, all activities and findings from the various committees, ad hoc teams, DWIHN units, and workgroups will be documented in reports. These reports will include critical outcome measures to assess the effectiveness of the initiatives undertaken. Once compiled, the reports will be submitted to the Quality Improvement Steering Committee (QISC) for evaluation, discussion, and guidance in the ongoing effort to enhance quality within DWIHN.

Utilization Management (UM)

DWIHN is required by regulatory standards to maintain a written description of its Utilization Management Program (UM Program), available upon request. This document ensures consistent assessments of service utilization and outlines DWIHN's methods for identifying overutilization, including service utilization reports, performance measures, adherence to clinical practice guidelines (CPGs), and financial reports.

Adequacy of Quality Improvement Resources

The Quality Improvement (QI) Unit is led by an experienced Director of Quality Improvement, who plays a pivotal role in guiding the unit's initiatives and strategies. Supporting the Director is a dedicated team comprising two full-time Quality Administrators, each responsible for distinct aspects of quality management and improvement processes. The QI Director collaborates closely with the DWIHN Senior Leadership Team to ensure that quality improvement efforts align with the organization's goals and priorities. This collaboration also extends to the Quality Improvement Steering Committee (QISC), which oversees quality-related initiatives and monitors progress toward specific quality improvement goals and objectives. In addition to working with leadership, the QI Unit partners with DWIHN's Information Technology (IT) Unit, recognizing the essential role that technology and data play in quality assurance and performance improvement. The IT Unit is crucial to the Quality Assurance and Performance Improvement Plan (QAPIP), undertaking various essential functions, including both internal and external data analysis. This analysis is crucial for evaluating organizational performance and pinpointing areas for improvement.

The IT Unit supports business modeling and strategic planning by facilitating quality initiatives and optimizing overall business operations. Their responsibilities include developing and maintaining robust databases that securely store vital information, offering expert consultations to various departments, and providing technical assistance to enhance the efficiency of QI activities. When managing QAPIP projects, the IT Unit engages in complex data analyses. This involves performing statistical evaluations of outcome data to determine the significance of changes over time, mining large datasets to extract valuable insights, and analyzing factors that contribute to performance outliers—situations where outcomes deviate significantly from expected performance benchmarks. Additionally, the IT Unit conducts correlation analyses to explore and understand relationships between different variables that may impact quality.

Based on the results generated through these analyses, the IT Unit produces detailed reports, summaries, and tailored recommendations. They also create visual representations of the data to facilitate understanding and communication of key findings, all aimed at strengthening Quality Improvement activities. Finally, the following chart provides an overview of the internal staff members on the Quality Improvement Steering Committee (QISC), detailing their titles and the percentage of time they commit to quality improvement activities. This information highlights the team's structure and dedication to ongoing quality enhancement efforts within the organization.

Title	Department	Percent of time per week devoted to QI
Chief Medical Officer	Administration	100%
Director of Quality Improvement	Quality Improvement	100%
Quality Improvement Administrator	Quality Improvement	100%
Director of Utilization Management	Utilization Management	50%
Clinical Officer	Clinical Practice Improvement	65%
Director of Customer Service	Customer Service	15%
Director of Integrated Health Care	Integrated Health Care	65%
Director of Managed Care Operations	Managed Care Operations	10%
Strategic Planning Manager	Compliance	10%
Information Technology	Information Technology	75%
Practitioner Participation	Provider Network	100%

Quality Improvement Evaluation

The Quality Improvement evaluation is a comprehensive assessment conducted annually at the end of each fiscal year. This evaluation process is conducted by DWIHN and submitted to MDHHS. Once submitted, the evaluation is kept on file along with the QAPIP description. These important documents are reviewed by both the Health Services Advisory Group (HSAG) and MDHHS as part of the broader certification process to ensure compliance with established health service standards. The evaluation provides a detailed summary of the goals and objectives outlined in DWIHN's Quality Improvement Work Plan. This Work Plan is a strategic document that specifies the quality improvement activities DWIHN plans to implement in the upcoming year.

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

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

Each year, the Quality Improvement Work Plan undergoes a comprehensive review and approval process. This process is carried out by two key groups: the Program Compliance Committee (PCC) and the Full Board of Directors. The PCC carefully assesses the plan to ensure it meets established standards and organizational goals. The Full Board of Directors then grants final approval, confirming that all necessary resources and support are allocated for effective implementation. This annual review process ensures that the Quality Improvement Work Plan stays relevant and effective in enhancing our programs and services.

Appendix 1

SENTINEL EVENT COMMITTEE/ PEER REVIEW COMMITTEE PROCESS

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

PROCESS – PAGE 2

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