Quality Assurance Performance Improvement Plan

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Introduction

The Quality Management Division and Quality Improvement Steering Committee of the Detroit Wayne Mental Health DWMHA (DWMHA) are pleased to present their Annual Quality Improvement Report for FY 14-15. This report, submitted to the President/Chief Executive Officer and the Program Compliance Committee (PCC) of the Board. In keeping with the stipulations in the Michigan Department of Health and Human Services (MDHHS) Managed Specialty and Supports Service Contract, the Board is responsible for oversight of the DWMHA’s Quality Improvement Program. As such, the Board has approved the Comprehensive Quality Improvement Plan for FY 14-15. This report provides an update on the goals and objectives in that plan. Acceptance of this report fulfills the Board’s responsibility to review at least annually, the results of the monitoring functions and actions taken including assessment of the effectiveness of the Quality Assurance Performance Improvement Plan (QAPIP).

On October 1, 2013, the Detroit Wayne Mental Health DWMHA (DWMHA) began as a separate entity under the leadership of President and CEO Tom Watkins, Wayne County Commissioner Tim Killeen, Board Chairman George Gaines, and Transition Consultant William Allen. The development and implementation of the Wayne County Enabling Resolution was to create the new Detroit Wayne Mental Health DWMHA. The first year was the beginning of many changes, including various cultural changes, internal re-structuring and a new DWMHA, Mission, Vision and Core Beliefs that express the commitment of DWMHA to be a consumer and community focused; data-driven and evidenced-based organization.

Mission/Vision/Values

The Mission, Vision and Values adopted in FY 13-14 are reflected below.

Mission
To lead and support a recovery-oriented system of care that provides and manages an array of supports, services, care and treatment which honors choice and advances that quality of community life for adults with mental illness; individuals with autism and developmental disabilities, persons with substance use disorders; children with serious emotional disturbance; their family and the community.

Vision
To be a leader in a community that is supportive and embraces individuals with disabilities in community life in a manner that reflects the values, roles and responsibilities of full and meaningful citizenship consistent with recovery dimensions and principles.

Values
To advance, reflect and embrace:
- Integration of Primary and Behavioral Health Care,
- Social justice and equity,
• Public accountability,
• Efficacy,
• Cultural proficiency and representation,
• Community benefit,
• Reciprocal community partnerships and collaboration,
• The efficient use of fiscal, human, technical and physical property resources,
• The principles of self-determination, a recovery orientation and perspective of the resiliency of individuals, families, and the community.
• The achievement of real life choices and desired outcomes through a person-centered process,
• Intended beneficiary systems ownership, influence and participation,
• Efforts and actions as bound by law, knowledge, ethnics, resources and obligations.

Mission, Visions and Values Proposed for FY 14-15 – see Appendix A

Purpose of the Report

The purpose of this report is to analyze our performance relative to the goals and objectives developed by the Board of Directors and to review our utilization management activity.

The goal of a Quality Assurance Performance Improvement Program (QAPIP) is to monitor, evaluate and continuously improve systems and processes. To accomplish this goal, we must regularly evaluate progress by comparing goals to actual performance using objective measures. The DWMHA infrastructure has seen many changes in light of becoming an organization separate from Wayne County. The changes offer an opportunity to inform and make data-driven decisions, to help reach conclusions and make changes in processes that continuously improve operations. The information gathered for this report will assist the DWMHA in identifying improvement opportunities.

Structure of the Report

This report provides a high-level summary of the attainment of goals and objectives that support continuous quality improvement and the implementation of the Quality Assurance Performance Improvement Plan (QAPIP). The DWMHA has produced a number of documents, white papers, division and program annual reports, which codifies various activities provided by the DWMHA or under its direction. These reports are available for review upon request. A comprehensive list is attached to the report entitled DWMHA Publications/Reports for FY14-15.

Population Served

DWMHA provided services to an unduplicated count of 74,022 during FY 14-15 which represented a decrease of approximately 527 individuals from FY 13-14. Of those
served 56,611 were the Medicaid population and 17,411 were the non-Medicaid population.

A diverse population of persons with severe mental illness, serious emotional disturbance, intellectual/developmental disabilities, substance abuse disorders and co-occurring disorders were served during FY 14-15. Of those served 34,183 (46%) are of African-American descent, 19,640 (26%) are Caucasian, 1,602 (2%) are Hispanic or Latino. Of clients served 1,540 (2%) individuals are either American Indian or Alaskan Native, Asian, Native Hawaiian or other Pacific Islander or some other race. No race was specified for 17,057 (24%) of the individuals served. Refer to Table 1 for more details.

Table 1

<table>
<thead>
<tr>
<th>Population Served by Ethnicity FY 14-15</th>
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<tbody>
<tr>
<td>N=74,022</td>
</tr>
<tr>
<td>Black or African American 1,540 (2%)</td>
</tr>
<tr>
<td>White 34,183 (46%)</td>
</tr>
<tr>
<td>Hispanic or Latino 1,602 (2%)</td>
</tr>
<tr>
<td>American Indian, Asian, Native Hawaiian, other 17,057 (24%)</td>
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<tr>
<td>Unreported</td>
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A diverse population also exists with regard to age. The largest group of individuals served is the 50-64 year old age group 19,240 (26%), followed by children, ages 0-17 year old is 15,184 (20%), the 26-39 age group 14,556 (20%), the 40-49 age group 13,286 (18%), the 18-25 age group 8,389 (11%), and finally the 65 and older age group 3,367 (5%). Refer to Table 2 for more details.
The total number of Developmentally Disabled Individuals served was 10,468 or 14%. The Mentally Ill (MI), mild population served was 892 (1%). This reflects those with a mild impairment. Adults with Serious Mental Disorders constituted the largest group with 36,244 (64%) followed by 15,184 (18%) children with Severe Emotional Disturbance (SED) being served, Substance Use Disorder with 11,234 being served and a subset number of consumers with a Co-occurring Disorder of 20,856. Refer to Table 3 for more details.

Table 3
Of the 74,022 consumers served during FY 14-15, 41,905 (57%) lived in Detroit, with 32,117 (43%) residing out-county. The number of females served 44,496 (46%) was less than the 50,199 (53%) males served. Of those served 327 (<1%) did not specify their sex and/or it is unknown.

Funding sources during the fiscal year included Medicare, Medicaid, Non-Medicaid, Block Grants and PA2. The Medicaid count includes MI Child, HAB Waiver and Healthy Michigan recipients.

**DWMHA TQM Program**

The DWMHA’s Quality Assessment Performance Improvement Plan (QAPIP) supports the values of a managed care system in which access to services, quality, efficiency and positive outcomes, including client satisfaction and consumerism are foremost. Consistent with DWMHA’s mission, the plan embraces the philosophy and methodology of continuous quality improvement to identify opportunities to increase the effectiveness and efficiency of care and services to its consumers.

The objectives of the QAPIP include opportunities to:

- Provide an objective and systematic approach to the ongoing monitoring and continuous improvement of processes based on the collection, review and analysis of data relative to indicators of importance to DWMHA functions,
- Ensure accountability,
- Assure an objective, systematic and fair method for monitoring performance of network providers against contract obligations and service outcomes,
- Support a system in which consumers and advocates have input into the evaluation of the system of care.

**Quality Improvement Structure**

The DWMHA has an organizational structure which allows for clear and appropriate administration and evaluation of the QAPIP. The DWMHA’s Quality Improvement Steering Committee (QISC) is the decision making body of the DWMHA’s Quality Improvement Program and has responsibility for:

- Providing oversight to the DWMHA’s QAPIP
- Providing recommendations and feedback on process improvement, program planning, implementation and program evaluation
- Examining quantitative and qualitative aggregate data and make recommendations for courses of action
- Monitoring, planning and implementation of specific plans in response to recommendations identified for the DWMHA by regulatory organizations
- Ensuring systemic communication and implementation of mechanisms or procedures for use in adopting and communicating process and outcome improvement

During the past year many changes continue to occur at DWMHA, including recommendations for making additional enhancements to the quality structure. The Quality structure was reviewed to ensure that it conforms to the processes and operations within the new DWMHA structure. The changes will include the work of the DWMHA Strategic Planning Committee, the new proposed Mission, Vision, and Values, the Pillars for Improvement, proposed Strategic Plan and the realignment of the Improving Practices Leadership Team (IPLT).

Additionally, DWMHA has formed the Strategic Planning Committee of the Board. The Committee should finalized a Strategic Plan which includes strategic, horizon, and performance improvement goals and objectives. To date, the Committee has proposed changes in the Mission, Vision and Values of DWMHA. As well, they have identified pillars and improvement themes and focus areas. This work was informed by the Board of Directors, stakeholder focused groups, staff input, input form the Best Practice Taskforce, and the Quality Taskforce. The recommendations of the Strategic Planning Committee will guide our QAPIP PI activity for the next few years.

See Appendix B for details.
Annual Service Summary and Program Highlights

During FY 14-15 many new programs and initiatives occurred. Highlights of some of the programs follow:

Rebidding of MCPN System

The Purchasing Division, on behalf of the Detroit Wayne Mental Health DWMHA (DWMHA), solicited responses for Managers of Comprehensive Provider Network (MCPN) for each of the two populations (i.e., I/DD and MI-SED). The contract will be for a term of eighteen (18) months effective January 1, 2015, with a one-year option to renew. The term was carefully established taking into consideration the volatility of pricing, availability of market indices to tie prices to, potential for a changing pool of available Bidders, departmental needs, and other similar factors. The contracts awarded for FY 14-15 are: SMI MCPNs: Carelink and Gateway and I/DD MCPNs: Consumerlink, Community Living Services and Integrated Care Alliance.

Integration/Implementation of Substance Use Disorder Plan

The Substance Use Disorder Plan is moving into the next phase of full integration. The integration plan is progressing as planned, however, the transition of the data from the previous data platform to the platform in MH-WIN is incomplete. The transitional data did not include the data on admissions prior to October 1, 2015. The remaining data elements collected was able to identify prevention and treatment needs, gaps and resources.

Best Practice Taskforce

The Best Practice Taskforce was developed to provide a recommendation to DWMHA on the best foundational structure needed to position the organization for future success. It was composed of two board members and key stakeholders (providers, DWMHA staff, higher education and community representatives). They researched best practices through consultation with the National Council on Behavioral Health, and successful programs in Missouri and Philadelphia. The recommendation from the Taskforce as the best-fitting platform for delivering public sector behavioral healthcare services in Wayne County at this time is the Backbone+ASO+Spokes. A full report can be found in Appendix C.
MiHealthLink Demonstration Project

On May 1, 2015, the DWMHA began accepting and receiving consumers with Medicare and Medicaid into the MiHealthLink Demonstration Project. Since May 1, 2015, approximately 19,682 consumers have actively enrolled in the Project with approximately 39 comprehensive providers providing services to our consumers receiving both Medicare and Medicaid.

Quality Care Task Force

The Quality Taskforce was developed in response to an adverse incident at one of our adult foster care homes. A staff person was videotaped using corporal punishment to address a challenging behavior of a persons served. An opportunity for improvement was identified, by conducting a root-cause analysis and addressing the root-cause we could avoid future incidents. The taskforce was composed of DWMHA staff and stakeholders (AFC providers, workers, advocates, persons served and persons from higher education.) The taskforce collected data, conducted surveys, and focused groups. A number of recommendations came out of the taskforce. The most salient were to focused on implementation of planned actions in response to the Home and Community Based Wavier-Final Rule, and to enhanced the competence and skills of the direct care professionals. A full report can be found in Appendix D.

Credentialing/Impaneling

The DWMHA Provider Network Unit has begun impaneling and credentialing of preferred providers that meet the criteria necessary to provide behavioral health services which meet appropriate Medicaid and Medicare standards. The providers are required to complete a Facility/Organization application, Office of Inspector General (OIG) and Systems for Award Management (SAM.gov) process in order to be eligible for contracting with DWMHA or with the Managers of Comprehensive Network (MCPN).

See Appendix E for full report.

Adult Mental Illness Learning Collaborative (AMILC)

The Standards of Care committee was reorganized and is now the Adult Mental Illness Learning Collaborative. The committee is still comprised of representatives from the various service providers under the DWMHA Provider Network. Under the reorganization, the AMILC is reviewing Practice Guidelines and Standards of Care for improvement, communication and implementation throughout the DWMHA provider system.
Autism Spectrum Disorder (ASD) Benefit Waiver FY14-15

The Autism Spectrum Disorder (ASD) Benefit was implemented April 1, 2014 following Center for Medicare/Medicaid Services (CMS) approval of the Michigan Department of Health and Human Services (MDHHS) State Plan Amendment ((i) SPA). DWMHA received 451 referrals for the Autism Spectrum Disorder (ASD) Benefit during the FY 14-15. This is a 58% increase since the previous year and represents 50% of the total DWMHA ASD Benefit Referrals (897 referrals). The DWMHA ASD Benefit has a 76% MDHHS Approval rate for cases meeting diagnostic and need-based criteria. At the end of the FY 14-15, DWMHA had 393 cases open in the ASD Benefit. Three hundred and seventy-two (372) open cases are in the current benefit target population (18 months-5 years of age) and 21 open cases are being served under the early expansion. The ASD Benefit continues to grow at a rate of 13 cases per month and has not plateaued in enrollments at this time. Eighty-three (85%) percent are receiving services at the Early Intensive Behavioral Intervention (EIBI) Higher Level of Care and 17% are receiving services at the Applied Behavior Intervention (ABI) Lower Level of Care. A full report can be found in Appendix F.

Clinical Practice Improvement and Grantsmanship

The practice improvement efforts for FY 15 were intentionally focused on areas of high need among DWMHA’s service consumer populations and across DWMHA’s provider system. The Block Grant funding continues to support the delivery of Evidence-Based Mental Health First Aid Sustainability Project, Trauma-Informing System of Care Project, Supported Employment Project, Permanent Supportive Housing Project, and Integrated Health Information Technology Project.

Integrated Treatment for Co-occurring Disorders (COD)

The Dual Diagnosis Capability reviewers conducted 39 Dual Diagnosis Capability in Mental Health Treatment or Dual Diagnosis Capability in Addictions Treatment. The reviews involved providers across the DWMHA provider network. The reviews were able to provide a data analysis for identifying those domain and subdomain areas that require more support through training and technical consultation/assistance.

Evidence-Based Supported Employment (EBSE) Project

There were 11 provider partners involved in the EBSE Readiness Assessments and/or EBSE Fidelity Reviews. The assessments and/or reviews were to provide follow-up with each of the provider programs, along with associated consultation and technical assistance to support their pursuit of approval by the Michigan Department of Health and Human Services (MDHHS) using a designated billing code.
Permanent Supportive Housing (PSH) Project

There were 8 provider partners involved in the Permanent Supportive Housing Project. During FY 15, 225 individuals with serious mental illness (including those with co-occurring addictive disorders) were successfully transitioned into Permanent Supportive Housing arrangements based upon choice. There were 150 consumers which constituted first-time referrals, and 292 consumers that were able to express increased awareness of PSH options.

Virtual Center of Excellence (VCE)

The Virtual Center of Excellence (VCE), completed its ninth year of providing training to the workforce of Detroit Wayne Mental Health DWMHA (DWMHA). The VCE awarded 456,575 credits for live and online training during FY 15 and added nearly 28 hours of new online courses and training videos to the VCE website. The new additions to VCE’s course catalog include the following:

- Developing Cultural Competence in Systems of Care
- Gender Identity & Expression in Children & Youth
- Prescription Drug Abuse
- Workplace Violence
- Crisis Pre-Intervention Through Verbal De-escalation
- A four-hour course on developing Person-Centered Plans
- A new “Part 1” Recipient Rights training for new hires into the Detroit Wayne CMH system
- The Medicare Fraud, Waste, Abuse & Compliance Training was added to the VCE website. Developed for the Centers for Medicare & Medicaid Services website, www.cms.gov, this course is required for all employees providing Medicare services for provider organizations actively participating in the “MI Health Link/Dual Eligible” project.

189,415 participants were provided training through 223 live and online trainings. Together they received more than 450,000 hours (a 50% increase over the previous year) of various continuing education credits.

Just over 8,200 people attended 141 live events. In Figure 1, the credits associated with these live events accounted for:
- Social Work, Licensed Professional Counselor (NBCC), Substance Use Professionals (MCBAP), Continuing Medical Education (CME), Child Mental Health Professionals (CMHP), Qualified Mental Health Professionals (QMHP), and Qualified Intellectual Disability Professionals (QIDP)
In 2015, Consumerlink provided IPOS training for all Skill Building and Employment services contract provider staff. At the completion of the training, each of their provider contracts were amended to permit the providers to provide Treatment Planning (H0032) services. The provider wide training will permit a more timely and detailed IPOS.
Field Placement Program for Workforce Development and Retention

- Affiliation Agreements were initiated with 4 area academic institutions (Wayne Community College District, Wayne State University, Eastern Michigan University, and University of Michigan).
- 12 Wayne County Community College District students were placed with DWMHA to provide Healthy Michigan enrollment assistance and basic need resources to members of our community.
- A Field Placement Manual was developed for students placed at DWMHA.
- Collaboration with universities statewide was accomplished to advocate for policy change to allow student behavioral health professionals to deliver Medicaid billable services with appropriate supervision.
- Collaboration occurred with Detroit Wayne County Health DWMHA and MSU’s Teaching Health Center to support 5 psychiatric residents within DWMHA system of care.
- Placements for 21 MSW scholars were identified, reviewed and supported, including training for delivering services in Integrated Healthcare settings.
- 2 student intern orientation sessions were prepared and facilitated, to provide information regarding DWMHA system of care
- Direct Care Worker Training Taskforce was supported with participation from student interns.
- A training grant for workforce development was developed in partnership with the University of Michigan.

Health Professional Shortage Area Initiative

- Submitted applications and received NHSC site certification for 5 agencies (a total of 10 sites).
- Provided student loan repayment program information to 3 providers.
- Submitted applications and received approval of 4 service areas: Northwest Detroit, Dearborn, Inkster and Romulus.
The Integrated Health Care Initiative

August 15, 2015 was the implementation date of the standard Bio-Psycho-Social Assessment in the EMR’s of MCPNs and Providers in the DWMHA network. With the Dual-Eligible Project we recognized the BPS as the "Level-2" intake assessment to be completed with a referral from the Integrated Care Organizations (ICOs). Our first step was to develop the BPS in MHWIN so that we had at least one shared system for the Providers to access the document. In the past several months, PCE has been busy delivering the new assessment in EMRs for their clients.

The implementation of the "Behavioral Health-TEDs" (BH-TEDs) record is a project that is being driven by the Michigan Department of Health and Human Services (DHHS). The BPS document collects some of the BH-TEDs data and is also one of the triggering events for the submission of the BH-TEDs record from the Providers and MCPNs. For these reasons the implementation of the BH-TEDs project was linked to the delivery of the BPS Assessment. In addition, a “standard” form presents a consistent representation across DWMHA in Care Coordination with Physical Healthcare.

Level of Integrated Healthcare Delivery- DWMHA Providers

The DWMHA continues to monitor and measure the level of integration throughout the provider network. DWMHA classified each behavioral health provider using the
SAMSHA-HRSA Center for Integrated Health Solutions “Standard Framework for Levels of Integrated Healthcare”. DWMHA has approximately twenty (20) comprehensive behavioral health provider organizations. In addition, the DWMHA staff provided educational sessions and technical assistance that has resulted in a thirteen percent (13%) increase, from 2013 to 2014, of provider organizations at a level four or greater. Sixty-five (65%) percent, thirteen (13) of DWMHA provider’s comprehensive behavioral health provider organizations are at a level four or greater.

**Data Sharing Care Coordination Project**

The Data Sharing Care Coordination Project is to identify consumers of DWMHA and who are also members of Medicaid Health Plans, and share utilization and cost data of these common individuals; to develop a process of sharing information on common individuals, in effort to better manage their health care utilization, reduction of unnecessary cost; and to identify systemic opportunities which facilitate an integrated approach to improve the health outcomes of consumers. DWMHA has established successful data sharing relationships with **sixty-three (63%)** of all the Medicaid Health Plans in Wayne County and **one hundred (100%)** of all the Medicare Integrated Care Organizations in Wayne County.

**MI Care Connect**

MI Care Connect is a health information exchange that will manage the behavioral health consent electronically, allow for the display of appropriate Care Connect 360 data, and appropriate assessment and care plan data for the purposes of highly effective care coordination to improve the health outcomes of DWMHA consumers.

In FY15, significant headway has occurred on the implementation of Mi-Care Connect. The data download from MDHHS’ Care Connect-360 into the DWMHA utilization data in Mi-Care Connect (MCC) provides a combined data set. The data is used by the Care Management Technologies (CMT). It is then processed through the Population Health Management application called ProAct. The resulting alerts and profiles were then merged into Mi-Care Connect to better support Care Coordination on the Mi-Care Connect application. A broad representation of DWMHA staff were trained in July 2015 on the use of the ProAct application. In August 2015, the MCC Steering Team recruited six of DWMHA largest Providers to be "Early Adopters" with MCC. They were trained and have been using MCC since September -2015. Over the past four months, the Early Adopter Group has worked with DWMHA and PCE to stabilize MCC and to build additional functionality. The application was quickly adapted by the Program staff at the Providers for Care Coordination and IPOS development.

**Office of Peer-Participant Advocacy (OPA)**

OPA now serves as a collective voice to advance the consumer movement through service delivery, treatment engagement, governance and research. The previous
Consumer Enhancement Program has been expanded under the OPA. The OPA has also assumed responsibility for some activities that were conducted by the former DWMHA university partners, including consumer and provider satisfaction surveys. One aim of OPA is to develop a non-traditional mental health workforce involving primary consumers with lived experiences. One such workforce project is the Participant Satisfaction Report FY 14-15. See Appendix G for full report.

The Constituents' Voice (CV) was formed in January 2015 as the new advisory group to the Detroit Wayne Mental Health Authority (DWMHA) President/CEO on the design, delivery, evaluation, and implementation of policies, procedures and service systems decisions with particular regard to community inclusion. Prior to establishing the CV, two such groups existed. The two groups were merged and the CV was formed. The CV has 33 seats, two-thirds of which are filled with people having lived experience for each adult service categories in the system. Members are appointed to a three year term.

**Substance Use Disorder Integration**

On October 1, 2014, the Substance Use Disorder (SUD) integration was completed. All of the SUD programs and providers were enrolled under the DWMHA provider system umbrella. The work with PCE on the establishment of an integrated consumer record for each of the consumers in the SUD program was completed in March 2015.

In March 2015, all of the SUD providers were trained on the MH-WIN data system. The MH-WIN data system began collecting the data and consumer information starting April 1, 2015. Effective April 1, 2015, the completion of the integrated BioPsychosocial Assessment for all SUD adolescents and adults was implemented in MH-WIN. In addition, the automated payment system for all SUD providers went live on May 1, 2015. The automated payment system includes billing, claims adjudication and payments for the provider system.

In August 2015, the DWMHA held its first 2-Day Faith Based Prevention Conference focusing on co-occurring disorders. 334 attendees that was representative across providers and their prevention programs attended the 2-Day conference.

**Vivitrol Pilot**

SEMCA in partnership with Alkermes (maker of Vivitrol), developed a pilot with Hegira Oakdale Recovery Program (residential). The pilot program was used to determine the effectiveness of Vivitrol on Opioid and Alcohol Dependent clients. Vivitrol is a once per month injectable opiate antagonist medication. It is designed to block the euphoric effect of opioids. In addition, it has also been known to reduce the cravings for alcohol. During FY 15, the pilot program was implemented at the SUD providers, Nardin Park and Hegira Programs, Inc.
Screening, Brief Intervention and Referral to Treatment (SBIRT)

Screening, Brief Intervention to Treatment (SBIRT) is an Evidence-Based Practice (EBP) designed to address personal health care needs in a primary care setting where persons may experience less stigma in sharing personal information. This EBP was used with the targeted population for persons receiving health care in Garden City Hospital Emergency Department and the Western Wayne Federally Qualified Health Center (FQHC). There were 5,407 consumers screened and 300 or 5.55% of those screened were referred for treatment.

Cross-System Children and Youth/Connections

Connections utilizes the system of care philosophy, which emphasizes youth and family involvement, cross-system collaboration, and cultural and linguistically competency, to provide community-based services to children with Serious Emotional Disturbance (SED). Connections operates on many levels, working to improve the way systems function, improve the way services are delivered, and improve outcomes for children and families. See Appendix H for full report.

Services Received by Children in FY14-15

Screening Kids in Primary Care Plus (SKIPP)

SKIPP is a demonstration project of Pediatric Integrated Health Care in Wayne County. The initial grant was developed by Michigan Department Health and Human Services (MDHHS) and funded by the Flinn Foundation. The project ended on April 19, 2014 and was refunded for 1 Behavioral Health Consultant (BHC) to provide services in 2 of the original 4 locations from June, 2014 to September 30, 2015. During FY 14-15, the BHC has had 1052 initial or follow-up patient contacts.

Juvenile Justice

Integrated Community Based Service (ICBS) Initiative. ICBS is a collaborative partnership between Community Mental Health (CMH) and Juvenile Justice to ensure Juvenile Justice youth receive all services available to them, conducive to meeting their developmental needs. During FY 14-15, 504 youth were identified as SED through this program and lined to mental health services.
Referrals from the Assured Family Services (formerly the Juvenile Assessment Center)

All youth entering the Juvenile Justice system are screened and assessed for Serious Emotional Disturbance by the Assured Family Services. During FY 14-15, 714 youth were referred for CMH services. The Assured Family Services has seen a decrease in the number of youth referred from the previous fiscal year.

SED Waiver

DWMHA in collaboration with the Michigan Department of Health and Human Services (DHHS) began an initiative to provide Wraparound Services to children in foster care, who are at risk of psychiatric hospitalization. During FY 14-15, 39 youth were served in this program.

Baby Court

In 2005, Wayne County Baby Court began with the goal of helping the court meet the developmental and emotional needs of infants in foster care. During FY 14-15, approximately 34 parents and their 42 infants were served. Of these, 8 cases remain open. Parents who have been through the Baby Court are more sensitive and responsive to their infants, and display more positive affect toward their children during interactions.

Lesbian, Gay, Bisexual, Transgender, Transsexual, Queer, Questioning, and 2-Spirit (LGBTQ2S) Youth

Over the past several years, Connections has worked with the Ruth Ellis Center to provide services to this vulnerable population. The Ruth Ellis center is working with Family Alliance for Change to connect families to a Parent Support Partner who specializes in working with families who have LGBTQ2S children. During FY 14-15, the Ruth Ellis Center provided over 700 unique contacts, served youth through street outreach, outpatient community mental health services, youth leadership programming, and residential foster care.

Native American Children, Youth, and Families

When We Work Together, Then We Are Wise project is a SAMHSA SOC Expansion Implementation Grant. This grant is a partnership between Connections: Wayne County System of Care, American Indian Health and Family Services (AIHFS) and The Guidance Center (TGC). During FY 14-15, Wraparound services have been implemented at the AIHFS with efforts for the AIHFS to begin accreditation efforts to
continue to build capacity. The Cultural and Linguistic Competency (CLC) Assessment Survey was completed and implementation will begin in the first quarter of FY 15-16.

Cornerstone Project Replication

The Cornerstone model is an evidence-supported practice, which provides a bridge for transition-age youth to adulthood. The ultimate goal of Cornerstone aims to help young people improve overall functioning and quality of life while maintaining a consistent relationship between service providers and youth during their transition years.

In FY 14-15, 6 new Cornerstone sites were engaged in this process. Youth Peer Support Specialists were approved as a Medicaid-reimbursable service. Transition Services were provided to 61 youth and young adults. Approximately 70.73% of the youth and young adults that improved or achieved their treatment plan goals. Overall, 93.94% of the youth and young adults expressed satisfaction with the Cornerstone services.

Grants and Funding

Systems of Care Block Grant

Connections received a $1.04 million block grant to expand the SOC for the 9th year in a row. Funds are used for specialty positions, programs designed to focus on system change, special projects, evaluation, and development of the workforce.

Early Childhood Comprehensive Systems Grant (ECCS)

DWMHA partnered with Great Start Collaborative-Wayne on a project to participate in a learning community focused on developing Continuous Quality Improvement (CQI) plans and activities that address trauma and toxic stress in early childhood. Through this project, several trainings were conducted to help early childcare workers and caregivers learn how to distinguish the signs of trauma and toxic stress from normative development.

Safe Schools and Healthy Students

SAMSHA awarded the state of Michigan $8.1 million dollars over the course of four years to promote safe schools and healthy students. FY 14-15, the Education Achievement DWMHA (EAA) in Detroit was selected as a site for this grant.
Connections has been working in collaboration with the Safe Schools/Healthy Students partners on various projects and initiatives, such as helping to build partnerships, linking, and connecting the EAA to resources, expanding planning committee representation, and more. The partnership continues to be strengthened as we work together to ensure children, youth, and families’ mental health needs are met.

**Progress on Goals and Objectives**

Subsequent pages will provide a summary of goal achievement based on the goals approved for FY 14-15 and recommendation for continuous improvement activity.

In support of the Quality Management goal to monitor, evaluate, and continuously improve systems and processes, collaboratively staff worked closely with DWMHA staff to operationalize sections of the Application for Participation and to align it to the Application for Renewal and Recommitment (ARR), and identify measurable outcomes. The ARR committee was in consensus that the areas were aligned and that measurement could be based on the AFP for the Quality Plan.

Each of the goals will be discussed in this report.

- a. Meet/Exceed Michigan Department of Health and Human Services Standards
- b. Meet/Exceed External Quality Review Standards
- c. Meet/Exceed Michigan Mission Based Performance Indicators
- d. Create a Culture of Audit Readiness
- e. Improve Data Quality
- f. Performance Improvement Goals and Objectives identified by the Needs Assessment for FY 14-15
**SCORES**

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<th>Met</th>
<th>Indicates that the performance indicator was fully compliant with our requirements, expectations or specifications, ≥ 95% compliant.</th>
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<td>Indicates that the performance indicator was substantially compliant with our requirements, expectations or specifications and had only minor deviations that did not fully comply, 85%-94%.</td>
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<tr>
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The Goals and Objectives for FY 14-15

**Goal I: Meet/Exceed Michigan Department of Health and Human Services (MDHHS) Performance Requirements - Met**

The Detroit Wayne Mental Health DWMHA (DWMHA) has developed standardized monitoring tools to be utilized as part of the continuous quality improvement process. The process is designed to provide an organized, documented practice for assuring that eligible Detroit / Wayne County residents are receiving medically necessary and appropriate services for mental health issues, substance use disorders and intellectual/developmental disabilities. In addition, this process ensures that services conform to accepted standards of care, while achieving the consumers’ desired outcomes.

The monitoring practice involves ongoing efforts to improve services through continuous and consistent evaluation and change, resulting in refined processes and programs, leading to improved outcomes.

The DWMHA has over fifty-five clinical service providers offering a comprehensive array of services. The delivery of these services is monitored through a number of forums including self-monitoring by service providers, on-site and desk reviews by MCPN's and DWMHA staff.
A total of 4,858 case records were reviewed for FY 14-15 (See chart 4 for details.)

Chart 4

**CASE RECORD REVIEW COMPLETED BY: MCPN, PROVIDER & DWMHA FY 14 VS. FY 15**

Critical, Sentinel Events and Deaths

During FY 14-15 the DWMHA Sentinel Event Committee received, reviewed and processed 2,182 critical events for all consumers including Adult-MI, Children w/SED, I/DD Adult/Children (not on HSW), I/DD Adult/Children on HSW, Children on Children’s Waiver, MiHealthLink members and consumers receiving services in SA outpatient and residential programs.

During FY 14-15, the DWMHA’s Critical Event/Sentinel Event Committee reviewed 847 of the reported critical events that met the reportable criteria for Michigan Department of Health and Human Services (MDHHS) web-based reporting.

A review of the most recent national statistics of the leading cause of death among all populations in the United States and in Michigan showed that the leading causes of death both the State and in the U.S. continues to be diseases of the heart followed by accidents, cancer, pneumonia and aspiration. The data reviewed for DWMHA reportable deaths suggests that the leading causes of death for consumers in Wayne County is the same.
Consumer Satisfaction

DWMHA actively seeks input from persons served and several satisfaction surveys were conducted to assess how we are doing on critical success factors and dimensions both at the DWMHA and the provider level. The November, 2014 “Mental Health Statistics Improvement Program” (MHSIP) results provided promising news for the Detroit Wayne Mental Health DWMHA (DWMHA) provider network. This annual survey measures consumer perceptions in the areas of service related to access, quality and appropriateness of treatment, person centered planning, personal outcomes and overall satisfaction.

The two target populations for the 2014 review included adult participants in the Assertive Community Treatment (ACT) Program and families with children receiving Home-Based Services. Outcomes from both groups reflect comparable measures in several categories.

Respondents in the ACT Program rated their level of approval as “Satisfied” in the areas of General Satisfaction, Access Appropriateness, Quality Treatment Planning, Participation in Connectedness, and Social Connectness.

Families of children participating in Home-Based Services indicated satisfaction in the areas of Access, Participation in Treatment, Cultural Sensitivity, and Appropriateness.

Both groups indicated overall satisfaction with services that are being provided. In all categories, consumers in both groups consistently rated services as satisfactory. The “Outcome”, “Social Connectedness” and Social” subscales, while still in the satisfactory range, received the lowest ratings in both groups. This provides an opportunity for improvement especially in light of the DWMHA goal to increase community inclusion of persons served.

The survey suggests that DWMHA is on the right course with providing quality, consumer-driven care and have an opportunity for growth that is consistent with DWMHA mission and core beliefs.

DWMHA Central Access Center

During FY14 – 15, there were 2,492 callers that participated in the Wellplace Satisfaction Survey. Over 95% reported satisfaction with access to services. The areas that received the highest satisfaction rating dignity and respect (98%); calls answered in a warm and welcoming manner (95%) followed by staff explaining things in a way that was easily understood (93%).

A 10% sample of one quarter (representing 88 surveys) was validated by DWMHA’s Customer Services Unit to ensure the reliability and validity of the caller satisfaction survey. In the sample, 94% reported overall satisfaction with Pioneer Services.
The Access Center was also Mystery shopped by PIHPs/CMHSPs across the state. 89% reported that the staff was knowledgeable in addressing needs for services, which is slightly down from the previous years.

**Grievance System**

The Grievance System is an important element in identifying how providers perform in various areas. It is a system that allows consumers to voice their concerns and issues to administration. The grievance process can also serve as a source to identify legitimate problems and opportunities for improvement in the quality of care provided to consumers receiving services within Detroit Wayne Mental Health System. See Appendix I for details.

Based on a review of the grievances throughout the year several recommendations have emerged including the following:

- Closer monitoring by MCPN’s of all providers as it relates to Customer Service.
- Greater accountability by the MCPN’s to ensure that their providers are in full compliance with grievance time frames.
- Several educational opportunities present themselves by way of having the DWMHA’s Grievance Coordinator continue to provide technical assistance to MCPN’s and the Wayne County Juvenile Detention Facility (WCJDF) on an individual basis at their locations to ensure that more staff be included in trainings and system modifications.
- Repetitive grievance issues are followed up on with the provider and/or MCPN’s and WCJDF to offer training, assure ample network accessibility, and provide feedback to the DWMHA.
- New Grievance Coordinator/s at provider locations receive training on the grievance processes and procedures to avoid delayed processing.

**Appeals**

In Fiscal Year 14-15, there were a total of (177) services that were appealed. Fifty-one were Outpatient Individual Therapy Services, (19) Case Management, (36) Psychiatric Services, (24) Medication Clinic, (15) Home Based, (12) Nursing Services, (11) Group Therapy, (3) Intensive Day, (3) Parenting with Partners and (3) Early Childhood Services. See Appendix J for details.

In FY 14-15 the DWMHA initiated a system improvement process by bringing the process in house. The change will standardize the monitoring, tracking and trending beginning the first quarter of FY 15-16. A total of five educational forums were conducted with MCPN’s and contracted providers to address the importance of reporting concise and consistent data to the DWMHA. At which point, there were some concerns expresses by the Provider Networks regarding duplication of efforts.
Goal 2: Meet/Exceed External Quality Review Standards - Met

Validation Overview

Validation of three mandatory external quality review (EQR) activities are required by the Balanced Budget Act of 1997 (BBA). State Medicaid agencies must ensure that performance measures reported by their Pre-paid Inpatient Hospital Plans (PIHP) are validated. The MDHHS agent designated to perform the validation of the EQR is Health Services Advisory Group, Inc. (HSAG). The findings from the review is provided to MDHHS and the PIHP for compliance and areas that require improvement, if needed. HSAG and MDHHS both report that DWMHA has continuously and progressively improved. In FY 14-15, the DWMHA received two on-site EQR reviews and one off-site EQR review.

Compliance Monitoring

The findings for the FY 14-15 Compliance Monitoring Review were determined from an on-site review of the Detroit Wayne Mental Health Authority (DWMHA) system. The review for FY 14-15 findings resulted in an overall score of 99%.

Based on the results of findings from the review of documentation and on-site interviews, HSAG assigned each individual element reviewed for Standards I–VII, IX-XI, XIII-XIV a score of Met. Standard VIII and XII included one section a score of Partially Met and requires improvement. Standard XV was a new standard that focused on Ownership, Control and Criminal Conviction. The DWMHA score on for this standard was 84%, requiring improvement. While the score for Standard XV may appear to be a high degree of concern, the DWMHA scored the second highest on this Standard among all of the PIHPs. See Appendix K for details.

Performance Measurement Information System Capability (ISCAT)

The DWMHA continued to be rated as “Fully Compliant” on all Performance Measures Validation (PMV) scores in FY 14-15. In the review of the feedback from HSAG, DWMHA took action to address the recommendations from the audit. The PIHP continued its effort to improve the rates which had fallen below MDHHS’ expected thresholds and is now above the State’s 95 percent threshold for all QI data elements. The PIHP also implemented processes for its providers in an effort to improve quality and timeliness of data submitted by them. See Appendix L for details.

Performance Improvement Project (PIP)

The DWMHA is required to conduct two PIP’s annually. One of the PIPs is selected for each of the PIHPs by MDHHS which is required to be validated for the External Quality Review (EQR) component of the DWMHA contract with MDHHS. That PIP is on the
Health and Wellness of consumers. The second PIP is the choice of the PIHP. For the second PIP, the DWMHA selected Fall Risk Precautions.

Performance Improvement Project I (PIP)

The PIP selected by MDHHS and validated by HSAG is to improve the proportion of Medicaid Eligible Adults in an Outpatient Mental Health Treatment Setting with a Serious Mental Illness and who have at least one Chronic Health Condition. The goal of the PIP is to have consumers participate in lifestyle changes via completion of a Peer-Led Wellness Self-Management Workshop and the completion of a Health Risk Assessment form that is to be provided to their respective primary care physician. The inclusion of a peer-led intervention will aid an increase in peer service utilization and peer focused activity.

The PIP was validated in FY 13-14 and FY 14-15. The PIP has demonstrated the compliance of DWMHA to engage consumers in the PIP. The PIP activity involves evidence-based wellness programs and the completion of the MDHHS Primary Care Physician Referral Worksheet. See Appendix M for details.

Performance Improvement Project II (PIP)

The second PIP for FY 14-15 is “Falls Risk Precaution”. The decision to select this PIP was based on a review of the critical incidents received on the number of consumers that were seen in the emergency room and/or hospitalized as a result of a fall. In addition, both the MDHHS and the ICOs will be collecting and analyzing data based on fall precautions. The PIP is in the implementation stage whereby the staff from each of the I/DD MCPNs and AFC homes received several informational sessions on the purpose of the PIP. The PIP will involve training to the supports coordinators, AFC home staff and consumers on the precautions for use in the assessment for falls. See Appendix N for details.

Goal 3: Michigan Mission Based Performance Indicators (MMBPI) – Met

The Michigan Mission-Based Performance Indicator System was first implemented in fiscal year 1997 and is contractually required of the 10 PIHPs. Since 1997, the system has undergone changes based on feedback from consumers, families, advocates and mental health professionals. These indicators include measures on timeliness of service in emergent and non-emergent situations, service following discharge from an inpatient facility, services provided to Habilitation Waiver consumers and percentage of readmissions to an inpatient facilities. The code book with the detailed reporting instructions is available on the MDHHS web site.

DWMHA has met or exceeded the performance standards for all performance Indicators reported to MDHHS except for recidivism. Although most of the system collectively
meets standards, individual MCPNs may not always meet them, and there were quarters where the indicators were not consistently met. When this happens, a root cause analysis and a plan of correction are implemented. This is an opportunity for improvement across the DWMHA system. See Appendix O for full report.

Goal 4: Create a Redesign Culture of Audit Readiness to a Culture of Audit Ready – Significantly Met

Annual Site Reviews and Claims Verification

The DWMHA is committed to ensuring that consumers are receiving services based on medical necessity and included in the consumer’s individual plan of services (IPOS). The IPOS is the conduit in which the Claims Verification process begins. The verification of the services and billable codes occur using the consumer’s IPOS and documentation in the case record to support the claim/s. The DWMHA’s standardized electronic claims review process requires both the providers and the MCPNs to self-monitor their systems for claim errors. In addition, the Residential Provider Claims are included in the self-monitoring claims verification process conducted by the MCPNs.

For FY 14-15, the DWMHA Quality Management Unit conducted a review of 258 providers and conducted a claims verification of 13,371 claims, with an overall compliance score of 98%. In order to maintain the high compliance, the DWMHA and the MCPNs are committed to conducting on-site validation reviews, reviewing and monitoring the data submitted into MH-WIN database and with on-going training to the MCPNs and provider staff to ensure compliance with quality standards. In those instances when the compliance scores are lower than expected, the DWMHA will require corrective action plans to ensure compliance.

Goal 5: Improve Data Quality – MET

A change that occurred during FY 14-15 major change was in the Data management. Stated issues included the Peter Chang Enterprise (PCE) technical design flaw that led to among other issues a concern with the integrity of all data submitted by the DWMHA. Data quality was needed to ensure data completeness and integrity, which is critical to the accuracy of required State reports. Timeliness of data collection was also a targeted outcome. The data warehouse tool would provide a core resource to future reports and analytics to drive business decisions.

The past year brought about an increased awareness in the organization that data quality is not only an IS issue, but is an organizational issue.

The establishment of several multi-departmental workgroups with the core group being the Cost Utilization Steering Committee. This workgroup, composed of several senior executives, reports to the Executive Leadership Team (ELT). Among other functions,
the group is responsible for promoting the use of data in making critical decisions in Finance, Clinical and Operations areas. There are four workgroups reporting to this Committee:

- **Data Analytics and Presentation Tools (DAPT)** - This group defines and reviews Key Performance Indicators, Report Cards, Data Cubes, Dashboards, and other reports and spreadsheets for use throughout the organization. This assures that data and definitions and measures are consistent across the various units within the DWMHA so that everyone is working from the same set of information.
- **Cost Integrity Group (CIG)** - This group performs Cost, Utilization, and Program Analysis. It also provides review and support of Models of Practice and Outcomes. It also supports Provider Contract managers in performing collaborative reviews with the Providers and MCPNs regarding Cost, Data, and Program Integrity.
- **The Procedure Code Workgroup** (mentioned above) will continue its work adding, removing, and refining code definitions based on MDHHS changes and DWMHA business needs.

Those three groups are active in identifying and rectifying data quality issues. The following group depends on quality data from the first three to perform its function.

- **Healthcare Finances** - This group is involved with setting payment rates, MCPN / Provider Funding, Provider Financial Management, Fund Source Management, State Financial Reporting, and budgeting.

In addition to the establishment of these key groups, IT has also done the following:
- Created the first data warehouse
- Created policies regarding data timeliness and completion requirements
- Created new edits on encounters received by the DWMHA
- Created a comprehensive list of data quality issues
- Started receiving Inpatient Authorizations to improve IBNR analysis
- Created several data cubes and dashboards to improve understanding of data issues and shortfalls

**Priority Needs, Planned Actions and Action Taken FY 14-15**

The DWMHA Strategic Planning Committee, the Quality Care Task-force and Certified Peer Support Specialists workgroup conducted seven successful focus group meetings throughout Wayne County. More than 400 stakeholders participated in PEST (Political, Economic, Social, and Technology) and SWOT (Strength, Weaknesses, Opportunities, Threats) analysis activities where insightful community/consumer perceptions were obtained. The feedback from the focus groups allowed the DWMHA to hear the stakeholders suggested improvement priorities as well as opportunities for implementation tasks they feel align with the priority areas.
Additional analysis included review of the DWMHA Performance Indicator results, Satisfaction surveys and other mission critical indicators as well as a review of literature including but not limited to the Substance Abuse and Mental Health Service Administration (SAMHSA) Strategic Plan, Michigan Department of Community Health (MDCH) 2015 Strategic Priorities, Michigan Mental Health and Wellness Commission Report, Affordable Care Act (ACA) and more. See Appendix P for full report.

PRIORITY ISSUE #1. INCREASE COMMUNITY INCLUSION AND INTEGRATION
SCORE: **SIGNIFICANTLY MET**

PRIORITY ISSUE #2. ENHANCE CRISIS MANAGEMENT & RESPONSE
SCORE: **PARTIALLY MET**

PRIORITY ISSUE #3. EXPAND CAPACITY FOR IMPROVING PRACTICES
SCORE: **SIGNIFICANTLY MET**

PRIORITY ISSUE #4. ENHANCE RECOVERY ORIENTED SYSTEM OF CARE
SCORE: **MET**

PRIORITY ISSUE #5. ACHIEVE OPERATIONAL EXCELLENCE
SCORE: **PARTIALLY MET**

PRIORITY ISSUE #6. IMPLEMENT INTEGRATED CARE
SCORE: **MET**

PRIORITY ISSUE #7. IMPROVE HEALTH AND SAFETY
SCORE: **MET**

DWMHA Compliance Program

In FY 14-15, the DWMHA has begun to strengthen its conflict of interest enforcement pursuant to state law in all operations, which includes, but not limited to:

- All DWMHA staff (part/full-time) are required to disclose all conflicts when hired and update on an annual basis.
- The DWMHA Board is required by state and federal law to disclose any and all financial and personnel conflicts and abstain from voting on matters involving these conflicts. Furthermore, conflict of interest principles also include the preclusion of promoting or urging, on behalf of individuals or entities, which may
pose an appearance of a conflict. The Board has adopted policies that should curtail these issues but they need to be enforced and implemented.

- Due to the strict enforcement of conflict of interest principles and the Open Meetings Act (OMA), all Board members should receive extensive training on the various conflict of interest and OMA rules and regulations to ensure compliance.

The number of compliance investigations rose from 8 in FY 14 to 25 in FY 15. During FY 14-15, there were 25 compliance investigations of which 7 did not warrant a full investigation since a precursory review determined that the allegations did not rise to the level of fraud, waste and abuse. The investigation regarding Gateway/Team Mental Health resulted in notification to the Office of Inspector General (OIG). As a result of the investigations, the DWMHA will be recouping $567,405.77 in overpayments for FY 2015. The increase in the number of investigations and the recoupment of overpayments is a key indicator that the program is operating since individuals are reporting more fraud, waste and abuse to the DWMHA. In addition, Compliance was involved in the review and issuance of 15 conflict of interest waiver requests and 3 personnel related investigations and hearings. See Appendix Q for details.

Utilization Management

The Annual Utilization Management (UM) Program Executive Summary is included for FY 14-15. The complete Utilization Management Annual Program Evaluation is attached.

It is the responsibility of the Authority (DWMHA) to ensure that the UM Program meets applicable federal and state laws and contractual requirements. The DWMHA is required to have a written Utilization Management Program Description which includes procedures to evaluate medical necessity criteria, and the processes used to review and approve the provision of mental health and substance abuse services. The DWMHA is also required to have an Annual Utilization Management Program Evaluation report in order to:

- Critically evaluate Utilization Management Program goals;
- Identify opportunities to improve the quality of Utilization Management processes;
- Manage the clinical review process and operational efficiency.

DWMHA UM Program Goals FY 14-15

1. Advance the implementation of the DWMHA’s standardized UM Program Description by the MCPNs and the Access Center. - MET
2. Monitor service utilization, including over and under-utilization of behavioral health services. - MET
3. Monitor clinical review procedures, practices and plans of correction to ensure system wide compliance with the DWMHA, State, Federal regulations and requirements and provider satisfaction. - MET
4. Monitor consumer satisfaction with their treatment experience and outcomes. – PARTIALLY MET
5. Advance consumer involvement in design, delivery and evaluation of mental health system. – MET
6. Promote collaboration and provide guidance to the system by identifying patterns of behavioral health service utilization by funding source. – PARTIALLY MET
7. Advance the implementation of the Dual Eligible Project for individuals with Medicare and Medicaid (MME) to ensure timely access and utilization of identified behavioral health services. – PARTIALLY MET
8. Promote integrated mental health, substance use disorders and physical health care service by collaborating with health care professionals on the appropriate level of care and cost-effective use and maintenance of optimally achievable quality of behavioral health care resources. – MET
9. Evaluate clinical utilization review procedures, practices and provide consultation / technical assistance to community stakeholders that promote participation and use of specialty behavioral health waiver programs: Autism Benefit Waiver, Habilitation Supports Waiver, Children’s Waiver Program and SED (Serious Emotional Disturbances) Waiver. - MET

The DWMHA has retained the UM activities for the Autism Benefit Waiver, the MiHealthLink program and SUD services. The delegation of certain UM activities to the MCPNs and the Access Center continues while requiring each of them to have a comprehensive written UM Plan that integrates the DWMHA’s UM Program Description. Each is accountable to the DWMHA and must provide an annual evaluation of their UM Plan to ensure compliance with the DWMHA, Federal and MDHHS expectations.

The DWMHA reviewed the MCPNs’ and the Access Center’s Annual UM Plan Evaluations for FY 14-15. All of them continue to incorporate the DWMHA’s UM Program requirements and minimum standards for evaluating the effectiveness of their UM programs, including over and underutilization, client and provider satisfaction, and protection of beneficiary rights in UM processes.

Additionally, the DWMHA’s UM Program Description was revised to include guidelines, medical necessity criteria and UM reporting requirements for Substance Use Disorders, Autism Spectrum Disorder (ASD) Benefit Waiver and the Demonstration Project for Persons with Medicaid and Medicare (MiHealthLink).

**Summary of Utilization Management Trends FY 2014-2015**

*Acute Inpatient Adult Hospitalization*
- There was a decrease in the number of adults hospitalized in community facilities in FY 14-15, which equated to a 6.5% reduction from 6,299 adults to 5,891 adults. As expected, there was a reduction in total days and amount of claims paid.

*Acute Inpatient Child Hospitalization*
There was a decrease in the number of children hospitalized for FY 2014-2015 from 1,090 to 903 which represents a 17% decrease in children hospitalized. Subsequently, the total days utilized and the total amount of claims were reduced.

**State Hospitalizations**
- State hospitalizations decreased from FY 2014-2015, from 203 consumers hospitalized in State facilities to 130. This in turn resulted in back log in the community hospitals with extended patient wait times for state hospital admission, especially among the I/DD population. To address this challenge, DWMHA assisted community providers in exploring, implementing, and utilizing alternatives to state hospital such as crisis residential services, mobile crisis units, and crisis stabilization facilities.

**Partial Hospitalization**
- There was a steady increase in persons served from FY 2014-2015. There were 668 unique consumers served in FY 2013-2014 versus 780 in FY 2014-2015

**Intensive Crisis Residential**
- The number of consumers receiving intensive crisis residential (ICR) has increased significantly for this FY with a 27% increase of consumers served. Like partial, ICRs are less costly than inpatient. Hegira and Safehaus Too (for children) were two new crisis residential facilities approved in FY 14-15.

**Autism Spectrum Disorder (ASD) Benefit Waiver FY2014-15**
During the FY 14-15, an ASD Benefit Clinical Practice Standards Manual was developed, implemented and disseminated system wide. The manual outlined requirements and established standards related to service delivery and data reliability.

In August 2014, the DWMHA also transitioned the management of the ASD benefit from the MCPN to DWMHA. By the end of FY14-15, a full-time ASD Specialist was hired and six ASD providers were directly contracted with DWMHA to provide Applied Behavior Analysis (ABA). The number of children served, receiving ABA and Early Intensive Behavioral Health interventions (EIBI) has improved dramatically as well as the average days of referral to start of services. See Appendix F for details.

**Intellectual-Developmental Disabilities (I/DD) MCPN Learning Collaborative**
DWMHA established the I/DD MCPN Learning Collaborative as a way to identify the differences in practices and rates paid; share information about good management and service delivery practices. The Learning Collaborative used FY12-13 utilization and cost data from DWMHA; beneficiary demographic data and provider-level rates paid supplied by the MCPNs; and state-level data from the Sub-Element Cost Report posted on the state’s website.

The Learning Collaborative discussions revealed that there are very different philosophies about the models of clinical (including supports) practice, varied costing assumptions, rates paid and diverse coding practices among the three I-DD MCPNs. Highlighted recommendations are found in the full report and many can be applied to the Adult MI population in relation to UM principles.
Children at Risk Study
Children (ages 0 – 17 year) with severe emotional disturbance, substance use disorders and developmental disabilities who had experienced three or more hospitalizations during FY2012-2013 were tracked by the MCPNs for a special study, coordinated by the DWMHA. Each time a high risk child was hospitalized, the MCPN and Service Provider identified risk factors and treatment barriers that could contribute to repeat hospitalizations, as well as clinical interventions needed by the child and family.

Only 14% of the high risk children experienced two to five hospitalizations during the study period. The assumption for this low rate of repeat hospitalizations among “high risk” children was the presence of the collaborative efforts among the families, MCPNs, Service Providers and Community Partners. Hospital diversionary efforts were effective and successful in achieving the goal of reducing hospital recidivism.

Adult Hospitalization Recidivism Study
DWMHA consistently fails to meet the standard for adults regarding the MDHHS Performance Indicator which requires a 15% or less inpatient rate of readmission within 30 days of discharge to an inpatient psychiatric unit. As a result, the UM department did a profile of recidivistic adults in order to identify factors prior to, during and post hospitalization that may be contributing to recidivism.

A follow-up study is continuing for FY 2014 -2015 to identify additional precursors or potential recommendations to improve recidivism rates.

MiHealth Link (Dual Eligible Program)
The implementation of the dual eligible program, began in May of 2015, requiring intensive restructuring of the UM department as the authorization functions for the higher levels of care will be managed by DWMHA staff. The UM Department hired three full time Clinical Review Specialist that will be responsible for managing the prior authorization process for the higher levels of care: acute psychiatric inpatient, partial hospitalization, sub-acute detox, crisis stabilization and crisis residential services. The staff will continue to develop systems and procedures to address the UM authorization processes for this program that will coordinate and integrate care among primary care and behavioral health.

- **Recommendations for FY 14-15/Opportunities for Improvement**
  - In conjunction with Clinical Services, under the direction of the DWMHA’s Chief Medical Officer, UM began to integrate clinical practice standards, define medical necessity criteria appropriate for intensive levels of care that require prior authorization and monitor the array of outpatient services utilized, including minimum and maximum number of key services, such as specialized residential, case management, supports coordination and develop authorization or monitoring processes that maximize treatment outcomes.
➢ Determine key UM performance indicators and standardize data and information for routine reporting, inclusive of waiver programs, substance use disorders, and integrated care.

➢ UM will continue collaboration with the IT, Finance, and Quality departments, to ensure that existing UM data is reliable, accurate and consistently reported. Hospitalization data will continue to be monitored for accuracy and network performance including length of stay, episodes of care, and readmissions.

➢ UM will ensure that the DWMHA’s Benefit Plan, which is based on covered services per funding source, supports service utilization and all services are authorized through the Individual Plan of Service, and based on medical necessity.

See Appendix R for full report.

Summary

DWMHA provided services to an unduplicated count of 95,022 during FY 14-15 which represented an increase of approximately 20,000 individuals from FY 13-14. Of those served 53,713 were the Medicaid population and 27,183 were the non-Medicaid population.

The DWMHA is trending in a positive direction towards attainment of our improvement goals and objectives. We have consistently improved our performance in the compliance areas. This is evident on all three of the External Quality Review components, Compliance Monitoring, Performance Improvement Projects, and Performance Measurement. Our performance resulting from the MDHHS site visits have consistently improved, as has our performance on the MMBPI’s. The biggest opportunity for improvement is in the area of continuous quality improvement as it relates to service goals and objectives. We are encouraging the DWMHA to fully embrace the Total Quality Management-Continuous Quality Improvement philosophy throughout our system.

Recommendations for Opportunities and Improvement

It is recommended that as soon as feasible the Board conducts a comprehensive strategic plan to guide the DWMHA’s development and restructuring, and to provide a strategic direction for change. In the meantime, it is recommended that the Board approve the following:

1. The FY 14-15 Annual QAPIP Evaluation Report
2. The proposed Mission, Vision and Values recommended by the Strategic Planning Committee - Appendix A
3. The proposed revised Quality Improvement Steering Committee Structure - Appendix B
4. The QAPIP Performance Improvement Goals and Objectives – Appendix B
5. The Utilization Management Program Evaluation Report - Appendix R
Appendix

See QAPIP Annual Report Appendix CD for full reports.
Appendix A – Proposed Mission, Vision and Values FY 14-15
Proposed for FY 14-15

Mission

We are a safety net organization that provides a full array of services and supports to empower persons within our behavioral health system.

Vision

To be recognized as a national leader striving to improve the behavioral and health status of the people in our community.

Value Statement

- We are a person centered, family and community focused organization
- We are outcome-driven, data and evidence-based organization
- We respect the dignity and diversity of individuals, staff and communities
- We are culturally sensitive and competent
- We are fiscally responsible and accountable with the highest standards of integrity

Board of Directors

Herbert C. Smitherman, Jr., MD, Chairperson
Marsha Bianconi
Constance Rowley

Dr. Cheryl Munday, Vice-Chairperson
Angelo Glenn
Dr. Iris Taylor

Timothy Killeen, Treasurer
Bernard Parker
Terence Thomas

Dr. Cynthia Taueg, Secretary
Frank Ross
Heather Underwood

Thomas Watkins, President/CEO
Appendix B - Proposed Quality Improvement Steering Committee FY 14-15

Appendix B2 – Clinical Practice Improvement & Grants FY 14-15 – See CD for Full Report
PRACTICE IMPROVEMENT PROCESSES

The primary Detroit Wayne Mental Health Authority (DWMHA) infrastructure through which practice improvement processes flow involves DWMHA’s Quality Improvement Steering Committee; the Improving Practices Leadership Team; and the following service population-specific groups that inform the considerations of IPLT and subsequently QISC:

- **Adult Mental Illness Learning Collaborative (AMILC);**
- **Intellectual & Developmental Disabilities Learning Collaborative;**
- **Cross-Systems Management Team, and its subsidiary groups;** and
- **Substance Abuse Advisory Council**

It is through this structure, which was re-organized and implemented during Fiscal Year 2015, that existing Practice Guidelines and Standards of Care will continue to be developed and/or improved upon, as well as communicated and implemented throughout DWMHA’s service provider networks.
Appendix C – Best Practice
Preface

The pages that follow represent 11 months of work by the following group of dedicated Task Force members, who researched and considered hundreds of pages of National, State and local input documents. Additional input was sought from 8 different community forums conducted over the span of two months, and an additional provider group forum, along with dozens of individual interviews of key stakeholders and thought leaders (facilitated by Public Sector Consultants/PSC). Consultation was also sought and received from demonstrated content experts recommended by the National Council on Behavioral Health – Missouri’s Medicaid Director (Joe Parks, MD), and the Commissioner of Philadelphia, PA’s Department of Behavioral Health and Intellectual Disability Services (Arthur Evans, PhD), in the process of compiling this report and its recommendations. The BHBP Task Force’s twice-monthly meetings also featured guest participation by PSC staff, Dr. Parks, and DWMHA Chief Information Officer, Bill Riley to optimally inform Task Force considerations. Thanks to each of the following members who participated and contributed!

- Terence A. Thomas, Esquire/JD; BHBP Task Force Chair, DWMHA Board Member
- Cheryl Munday, PhD; BHBP Task Force Co-chair, DWMHA Board Member
- Cynthia Arfken, PhD, Wayne State University, Dept. of Psychiatry and Behavioral Neurosciences
- Kari Walker, LMSW; President/CEO, The Guidance Center
- Joy Calloway, MHSA, MBA; President/CEO, New Center CMH
- Karen Schrock, MS; retired President/CEO, Adult Well-Being Services
- Brent Mikulski, MBA; President/CEO, Services To Enhance Potential
- William Hart, PhD; Executive Director, Lincoln Behavioral Services
- Carmen McIntyre, MD; Chief Medical Officer, DWMHA
- Corine Mann, LMSW, LMFT; Chief Strategic Officer/Quality Director, DWMHA
- Steve Wiland, LMSW, ICADC; Deputy Chief of Clinical Operations, DWMHA
- Joe Paliwoda, MBA, CADC; CEO, Personalized Nursing Lighthouse
- Tom Watkins, MSW, ABD EdD; President & CEO, DWMHA

The context for the report and recommendations that follow includes important basic, consensus assumptions that sustainable change is best accomplished incrementally, with as much stakeholder input and buy-in as reasonably possible, and that by virtue of the complex and ongoing changes in healthcare at this time, what follows is neither intended to be exhaustive, nor surgically precise, but rather to help guide our system’s next steps, with an expectation of ongoing efficacy monitoring, and data-driven adjustments leading to an even better future system of care supporting wellness and recovery for those we serve.
Background:

The Detroit Wayne Mental Health Authority (DWMHA, “Authority”) is Michigan’s largest such authority, with a $695 million-dollar annual budget, serving close to 75,000 individuals with mental health, intellectual and developmental disabilities (I/DD), and substance use disorder needs. In recognition of the rapid changes currently impacting healthcare, the DWMHA Board created the Behavioral Health Best Practices Task Force (BHBPTF, “Task Force”) to advise on system structure and administrative practices that would support more efficient operations, and better health outcomes for consumers. The BHBPTF charge was “to provide system design recommendations to the CEO and [Board of Directors] by July of 2015, that will move our Services System to a nationally recognized, locally good-fitting, best-practice model that maximizes behavioral health outcomes for those we serve, through optimally efficient use of available resources.” Initial meetings began in January 2015. In addition to DWMHA staff support, the Board secured the input of two national experts, Joe Parks, MD (Missouri Medicaid Director) and Arthur Evans, PhD (Philadelphia’s Department of Behavioral Health and Intellectual disAbility Services Commissioner), whose respective efforts have been identified as national models. The Authority Board also retained Public Sector Consultants (PSC) to assist in capturing, managing and organizing community stakeholder input.

Common Agenda and Themes

Content experts Joe Parks and Arthur Evans shared the pros and cons of their respective system redesign efforts to promote better health outcomes, to integrate physical and mental health care, and to provide care in a more cost-effective manner. It became clear to Task Force members that pursuing Behavioral Health Homes and Population Health initiatives is the best path toward achieving the Task Force’s charge. Consequently, the Task Force examined Michigan initiatives, including the current Medicaid State Plan Amendment Behavioral Health Homes pilot, as well as the Michigan Association of Community Mental Health Board’s (MACMHB) recent report with its following conclusions about the focus of healthcare:  

1. Better health outcomes for persons in care;
2. Value-based payments;

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1 Community Mental Health in Michigan, January 2015, full report available at www.macmhb.org
System improvement should result in better access to care and improved integration with physical healthcare providers. Consumers participating in the public forums facilitated by PSC articulated a strong desire for being able to exercise choice in the provision of their care, and additionally, participants in both sets of PSC-facilitated interviews emphasized the importance of a solid continuum of care to comprehensively meet the entire range of consumer needs.

The Affordable Care Act, passed in 2010, created the new option made available to state Medicaid programs in 2011, to provide health homes for enrollees with chronic conditions, including mental health and substance use conditions. CMS health home guidance lays out service requirements contained in the ACA and “well-established chronic care models,” including:

- Each patient must have a comprehensive care plan;
- Services must be quality-driven, cost effective, culturally appropriate, person- and family-centered, and evidence-based;
- Services must include prevention and health promotion, healthcare, mental health and substance use, and long-term care services, as well as linkages to community supports and resources;
- Service delivery must involve continuing care strategies, including care management, care coordination, and transitional care from the hospital to the community;
- Health home providers do not need to provide all the required services themselves, but must ensure the full array of services is available and coordinated; and
- Providers must be able to use health information technology (HIT) to facilitate the health home’s work and establish quality improvement efforts to ensure that the work is effective at the individual and population level.²

Michigan’s pilot behavioral health home efforts are prioritizing care for persons with co-morbid mental health and physical health conditions. Other States have also implemented health homes prioritizing specific case-management interventions for persons with combined high mental health and high physical health care needs. All other populations are still served but a primary purpose of the pilots has been to demonstrate the ability to improve health outcomes for persons with complicated physical and mental health care

needs. Harnessing data to alert providers to admissions and follow-through with health appointments is a hallmark of these programs. The goals are to achieve the following objectives:

a) Better Health – outcomes of, access to, and experience of care  
b) Cost effectiveness  
c) Integrated Care  
d) Use of Evidence-based practices

Additionally, the Excellence in Mental Health Act (part of the Protecting Access to Medicare Act of 2014) provides additional target requirements for public sector behavioral health systems to strive in the direction of accomplishing what has become known as the “Triple Aim” of healthcare:

1) improving the experience of care (quality & satisfaction),  
2) improving population health, and  
3) reducing the per capita cost of healthcare.³

With DWMHA’s Dr. McIntyre as one of the proposal authors, Michigan successfully pursued and was awarded a $1 million Planning Grant for 2016 for the purpose of further designing and practically demonstrating the utility and efficacy of various pilot Certified Community Behavioral Health Centers, including the development of sustainable prospective payment systems. The already published CCBHC criteria may be referenced in the CCBHC Certification Criteria Readiness Tool (2015),⁴ excerpts of which may be found in column V of the attached matrix.

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³Institute for Healthcare Improvement, IHI Triple Aim Initiative: Better Care for Individuals, Better Health for Populations, and Lower Per Capita Costs. (downloaded 2015),  
http://www.ihi.org/engage/initiatives/tripleaim/Pages/default.aspx

⁴National Council for Behavioral Health & MTM Services Consulting’s CCBHC Certification Criteria Readiness Tool (based upon SAMHSA’s Required CCBHC Criteria issued May, 2015).  
Data

The Task Force looked at Detroit Wayne Mental Health Authority data particularly as it related to costs associated with both mental health and physical health care. Bill Riley, Chief Information Officer of DWMHA, provided data to populate the following chart, which examined both behavioral health and physical health needs as represented by claims data from FY14.

**The Four-Quad Model to Review Severity of Consumer Base**

<table>
<thead>
<tr>
<th>Quad-III: High BH &amp; Low PH</th>
<th>Quad-IV: High BH &amp; High PH</th>
</tr>
</thead>
<tbody>
<tr>
<td>BH = Medicaid &amp; top 25% incurred costs or =&gt; 3 MH inpatient admits</td>
<td>BH = Medicaid &amp; top 25% incurred costs or =&gt; 3 MH inpatient admits</td>
</tr>
<tr>
<td>PH = Medicaid &amp; not meeting the “PH-High” criteria in Quad-IV</td>
<td>PH = Medicaid &amp; 3 or more PH inpatient admits OR =&gt; 5 ED Visits OR has an indication of =&gt; 2 of the following Co-Occurring: COPD, Asthma, Diabetes, Obesity, Hypertension, Heart Disease, or Cancer</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Count:</th>
<th>6,521</th>
<th>5,368</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults w/ MI:</td>
<td>1,796</td>
<td>2,579</td>
</tr>
<tr>
<td>SED:</td>
<td>1,856</td>
<td>579</td>
</tr>
<tr>
<td>I/DD:</td>
<td>2,869</td>
<td>2,210</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Quad-I: Low BH &amp; Low PH</th>
<th>Quad-II: Low BH &amp; High PH</th>
</tr>
</thead>
<tbody>
<tr>
<td>BH = Medicaid &amp; not meeting the “BH-High” criteria in Quad-IV</td>
<td>BH = Medicaid &amp; not meeting the “BH-High” criteria in Quad-IV</td>
</tr>
<tr>
<td>PH = Medicaid &amp; not meeting the “PH-High” criteria in Quad-IV</td>
<td>PH = Medicaid &amp; 3 or more PH inpatient admits OR =&gt; 5 ED Visits OR has an indication of =&gt; 2 of the following Co-Occurring: COPD, Asthma, Diabetes, Obesity, Hypertension, Heart Disease, or Cancer</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Total Count:</th>
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<th>15,534</th>
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<tr>
<td>Adults w/ MI:</td>
<td>11,653</td>
<td>13,173</td>
</tr>
<tr>
<td>SED:</td>
<td>5,803</td>
<td>1,205</td>
</tr>
<tr>
<td>I/DD:</td>
<td>2,648</td>
<td>1,156</td>
</tr>
</tbody>
</table>

IDD Total – 8,883  
MIA Total – 29,201  
SED Total – 9,443  

**Total Consumer Count Reviewed: 47,527**

Analysis

The analysis of claims data suggests that a small percentage of persons account for the majority of spending on mental health needs. Essentially 11,889 (or 25%) of the total client count of 47,527 reviewed accounted for 75% of the spending on mental health needs. A subset of this group in Quadrant IV, have combined high mental health and high physical health care needs. The persons in this quadrant have multiple health care needs and
represent a population that would likely benefit from the development of better coordination and integration with primary and specialty care providers.

Service Integration Recommendation

The signature practices associated with behavioral health homes (team-based, whole-person orientation with explicit focus on integration of behavioral health and primary care, use of Health Information Exchange data, continuity-of-care records, and action alerts, etc.) would be beneficial for clients served by the DWMHA providers. The population in Quadrant IV with high costs in both the mental health and physical health care systems is small in number at 11% of the total clients served 5,368/47,527. The potential for a pilot project with this demographic group holds great promise to promote better integration with physical health care providers, lower costs, increased access to care, and improved health outcomes.

Learning from Patient Centered Medical Homes in Primary Care

As DWMHA considers implementing Behavioral Health Homes, history can inform our actions. As early as the late 1980s, the State of Michigan's then "Crippled Children's" program (now named "Children's Special Health Care Services") recognized the need to coordinate care for children with complicated conditions. In fact, the program's mission was "Family-Centered, Community-Based, Coordinated Care". Each region of the state had a regional medical consultant who consulted with and facilitated coordinated care between the multiple specialists and families to deliver quality care. This approach continues today since most children in the program have multiple specialists treating them for multiple conditions. A key component is active engagement by the primary care physician or other specialist treating the child most often. In addition, the family served as the care coordination hub.

All payers have recognized the value of coordinated care and have taken some steps to move in that direction. Health Maintenance Organizations (HMOs) have existed for decades with the promise of being a health home. Often, however, the behavioral health issues were "carved out" to another system (CMH) for seriously mentally ill, or to a subspecialty panel for the moderately mentally ill. While there may have been a primary care health home, the lack of integration of behavioral health services resulted in fragmented delivery of care.

Blue Cross Blue Shield Association of America (BCBSA) has undertaken one of the largest Patient-Centered Medical Home initiatives to date. At a Capitol Hill Briefing on
June 4, 2012, the BCBSA spokesperson indicated that there were PCMH initiatives in 39 states, the District of Columbia and Puerto Rico.

"The PCMH is a model of healthcare based on an ongoing, personal relationship between a patient, a primary care physician and the patient's care team that aims to assure comprehensive, coordinated care across all aspects of the healthcare system. For example, the PCMH-based care team personally manages, facilitates and coordinates care with appropriate qualified professionals – such as hospitals, nursing homes, pharmacies and related community resources – as well as engages patients in promoting wellness and prevention and managing any chronic conditions they may have." (Blue Cross Blue Shield Press Release; June 4, 2012)

Various models of PCMHs were implemented, each with payment reforms based on the level of quality care delivered. Metrics included ER visit reductions, visits to specialists, improved management of chronic conditions, etc.

The Patient Centered Medical Home Initiatives were initially launched by Blue Cross Blue Shield of Michigan (BCBSM) in 2008. In 2009, Blue Cross Blue Shield of Michigan and its physician partners launched the nation's largest Patient Centered Medical Home designation program. This program was developed in partnership with doctors and physician organizations. An analysis estimated savings of $269 million in its first 4 years (BCBSM Patient-Centered Medical Home Website). BCBSM estimates that the program saved $512 million in the first six years.

These initiatives fall under the framework of The Value Partnerships PCMH, and follow four principles:

1) patient engagement in a team approach;
2) full 24-hour access to the primary care physician;
3) effective management of chronic health conditions; and
4) electronic patient registries and performance reporting tools.

In 2015, BCBSM designated more than 4,340 physicians in 1,551 practices as PCMHs based on their progress in implementing PCMH capabilities and qualities, and based on high performance on quality and use measures. **Currently, BCBSM's Patient Centered Medical Home program is the largest of its kind in the country.** There are positive fee adjustments to service providers for incorporating patient-centered characteristics and coordinating with PCMH practices.
What Has Been Learned?

- Patient/Family Engagement is Critical
- Goals and Objectives must be clear
- Financial Incentives must be in place
- Infrastructure is necessary to support technology enhancements
- Designation criteria must be jointly developed by the Authority and providers
- Preventive services must be addressed
- Chronic Care Management is a focus
- Cultural competence is required
- Creative engagement of primary care physicians will be necessary
- Various models are acceptable

In summary, there are many lessons already learned by primary care that do not have to be "re-learned" by Community Mental Health. The relationship development with primary care, consumers and providers will be key in the development of PCMHs. In the service of continuing to become educated about how best to implement forms of the Behavioral Health Home model, the seminal Wagner Chronic Care Model\(^5\) is worthy of review.

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\(^5\) MacColl Center for Health Care Innovation’s Improving Chronic Illness Care program (downloaded 2015)
http://www.improvingchroniccare.org/index.php?p=The_Chronic_CareModel&s=2
I. **HUB+SUB-HUB+SPOKES** is the label intended to describe the current system model that features DWMHA as the Regional Entity (HUB) receiving resources from, and ultimately responsible to the State of Michigan’s Department of Health and Human Services for the care of all those receiving services; currently subcontracting and delegating certain functions to our system’s 5 MCPNs (SUB- HUBs) who work with panels of providers that actually deliver the array of services to consumers (SPOKES). **Administrative duplication/cost and other inefficiencies is a primary risk of simply continuing with this model, with its current MCPN cost allocation of approximately $20 million.**

II. **BACKBONE+ASO+SPOKES** is the label intended to describe a model that would feature adjustments to the current system that would retain the Federal and State-mandated Regional Entity functions with the DWMHA (BACKBONE), and reduce/eliminate the administrative duplication by retaining contractual relationships with repurposed MCPNs to provide those Administrative Service Organization (ASO) functions for which they are better equipped. As strategies to accomplish those efficiencies are implemented, the forms of contractual and sub-contractual relationships with direct service provider organizations (SPOKES) will become clear. **This is the BHBP Task Force’s recommendation as the best-fitting platform for delivering public sector behavioral healthcare services in Wayne County at this time (please see additional recommendation details on pages 20-21 of this document).**

III. **HUB+SPOKES** is the label intended to describe a system in which DWMHA (HUB) would assume all of the administrative functions previously served by the MCPNs (which would then be eliminated), including direct relationships with all empaneled providers (SPOKES) of whatever type, size or service array. **Lack of current DWMHA capability to replicate all of the administrative functions that the MCPNs have provided, with a high level of effectiveness, is a primary risk of moving to this model.**

IV. **BEHAVIORAL HEALTH HOME MODEL** is the label intended to describe a system in which all providers seek to deliver a full array of integrated behavioral health and primary care services according to one or more of the program designs indicated in the matrix below as Coordinated/Facilitated Referral Model, Co-located/Partnership Model, or Fully Integrated/In-house Model. Despite Michigan’s efforts at piloting this model, there is not yet clear and compelling evidence (with service outcomes &/or sustainable funding models) to
support this as the sole system design for delivering public sector behavioral healthcare. **It is acknowledged that total conversion of our current system to only fully integrated Behavioral Health Homes at this time would lead to gaps in providing care and support for the varying levels of intensity and combination of needs represented across our target service populations. This model would not assure equitable access to services.**

V. **CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC** is the label intended to describe a system in which all providers seek to deliver a full array of integrated behavioral health and primary care services according to the Federal guidelines currently available as of May, 2015 from the Substance Abuse and Mental Health Services Administration (SAMHSA). 2016 represents a pilot demonstration year for States awarded the associated Planning Grant (including Michigan), to explore design and funding elements for future implementation. **It is acknowledged that total conversion of our current system to only Certified Community Behavioral Health Clinics is premature and could also lead to gaps in providing care and support for the varying levels of intensity and combination of needs represented across our service populations. This model also would not assure equitable access to services.**

The matrix that follows is not intended to be exhaustively complete, but rather to provide a crosswalk between the critical elements identified in the Task Force’s research and reflected in the significant input received from stakeholders, with the five models that emerged for consideration and recommendation.

Please note that in the matrix that follows **Red font** is intended to indicate elements in deficit, **Orange font** is intended to indicate that significant questions exist, and **Green font** is intended to indicate improved status. The comments in **Blue italicized font** are intended to indicate cross-cutting elements of concern that need to be better addressed independent of model chosen.
<table>
<thead>
<tr>
<th>CRITICAL ELEMENTS</th>
<th>I. Status Quo</th>
<th>II. DWMHA + repurposed MCPN(s) + Providers</th>
<th>III. DWMHA directly contracting with all Providers</th>
<th>IV. Behavioral Health Home models&lt;sup&gt;B&lt;/sup&gt;</th>
<th>V. Certified Community Behavioral Health Clinic model&lt;sup&gt;C&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DWMHA + MCPNs + Pioneer + Providers</td>
<td>Repurposed MCPNs &amp; Front-door/Access functioning as more effective ASOs than DWMHA currently would; Larger provider agencies/consortiums, fewer in number, with greater capacity for broader service would create efficiency savings, &amp; better align with BHH and CCBHC mandates; Would still allow for additional specialty providers capable of serving region-wide needs.</td>
<td>Larger provider agencies, fewer in number, with greater capacity to serve all populations would create $ savings &amp; efficiencies. Presumes DWMHA capability to assume all MCPN functions at an equal or better level of effectiveness.</td>
<td>Coordinated Facilitated Referral Model</td>
<td>Co-located Partnership Model</td>
</tr>
<tr>
<td>I. HUB + SUB-HUB + SPOKES”</td>
<td>II. “BACKBONE +ASO + SPOKES”</td>
<td>III. “HUB &amp; SPOKES”</td>
<td>IV.1. COOR’D</td>
<td>IV.2. CO-LOCAT ED</td>
<td>IV.3. INTE-GRATED</td>
</tr>
<tr>
<td>1. Availability and Accessibility of Services</td>
<td>A “% of new persons receiving a face-to-face assessment w/ a professional w/in 14 calendar days of a non-emergency request for service” – have met compliance for most of past several years; however, customer service expectations are moving in the direction of same-day services, which is far from the current status</td>
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<tr>
<td>Access to Care</td>
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<td></td>
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<tr>
<td>[Outreach &amp; Engagement]</td>
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<tr>
<td>[Transportation – also addressed below]</td>
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<tr>
<td>Cross-cutting element that needs to be better addressed with DWMHA having more direct impact/ control/ streamlining/ standardization/equity re: access to care</td>
<td></td>
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</tbody>
</table>

<sup>A</sup> Required by PAMA “Required 24/7 crisis management services, sliding scale payment options, no service rejection based on place of residence or ability to pay.”

<sup>B</sup> “Must include methods by which coordination and provision of access to:
- high-quality health care services, informed by evidence-based clinical practice guidelines;
- preventive and health promotion services (incl. MI & SA);
- mental health & sub abuse services;
- comprehensive care management, care coordination and transitional care;
- chronic disease management;
- individual and family supports;

Does not address equitable access to services for all service populations.

<sup>C</sup> “Accessible open hours, accessible locations, telemedicine, online treatment options.”

“Regular outreach & engagement activities”

Does not address equitable access to services for all service populations.
### Service Array / Scope of Services

| Fragmented and inconsistent re: comprehensiveness & quality | Larger provider agencies, fewer in number, with greater capacity to serve all populations would create $ savings & efficiencies. | Larger provider agencies, fewer in number, with greater capacity to serve all populations would create $ savings & efficiencies. | “Intentional emphasis on EVIDENCE-BASED CARE using the best available evidence to guide treatment decisions and delivery of care, including preventive and health promotion services, screening, assessment, treatment and relapse prevention. Evidence-based practices are explicitly informed by, and grounded in, relevant clinical research demonstrating treatment effectiveness. Because there is never sufficient evidence to guide all treatment decisions, external clinical evidence from systematic research must be combined with individual clinical expertise.” |

| Case Management – (as needed, conflict-free) | Larger provider agencies, fewer in number would allow for staffing cost efficiencies & re-investment to support more manageable caseload sizes | Larger provider agencies, fewer in number would allow for staffing cost efficiencies & re-investment to support more manageable caseload sizes | Not explicitly addressed or funded in the global Medical Home model, but would be addressed in Behavioral Health Home model applications that would need to provide the full array of MDHHS-covered services. |

| Peer-delivered Services | Primarily occur at provider agencies | Primarily occur at provider agencies | “Intentional emphasis on PERSON-CENTERED CARE via Self-management Support, and Shared decision-making, within a chronic care framework.” |

| Crisis Response/Service Continuum | Cost savings from improved admin efficiencies could be reinvested into a fuller array of needed crisis mobile/ | Cost savings from improved admin efficiencies could be reinvested into a fuller array of needed crisis mobile/ | Not explicitly addressed or funded in the global Medical Home model, but would be addressed in Behavioral Health Home model applications that would need to provide the full array of MDHHS-covered services. |

**Cross-cutting element that needs to be better addressed regardless of model**

- AMI provider caseload sizes reportedly 80-120 per staff person
- Only 9 ACT teams for entire County, low for population size

**Required by PAMA**
- “Screening, assessment & diagnosis, incl. risk assessment
- Person-centered planning, crisis planning
- OP mental health &/or sub abuse services
- OP primary care screening & monitoring of key health risks
- Counselor services
- Family supports
- Complete array of veterans services”

**Required by PAMA “Targeted Case Management”**
- “The CCBHC engages in outreach and engagement activities to assist consumers and families to access benefits, and formal or informal services to address behavioral health conditions and needs.”

**Required by PAMA “Peer support services”**
- “Full array crisis mental health services incl. 24-hour mobile crisis teams, emergency intervention & crisis stabilization services.”
<table>
<thead>
<tr>
<th>Crisis Residential Crisis Stabilization</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EMERGENT GAP - Cross-cutting element that needs to be better addressed regardless of model</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Psychiatric Rehabilitation Services</strong></td>
<td></td>
</tr>
<tr>
<td>Psychiatric Rehabilitation, Psychosocial Rehabilitation (Clubhouses) underutilized</td>
<td>Cost savings from improved admin efficiencies could be reinvested into a fuller array of needed psychiatric rehab services</td>
</tr>
<tr>
<td><strong>Evidence-Based Services/Interventions</strong></td>
<td></td>
</tr>
<tr>
<td>Use of EBPs</td>
<td></td>
</tr>
<tr>
<td>FY14 penetration</td>
<td></td>
</tr>
<tr>
<td>- ACT=1.92% (10th/10 MI REs)</td>
<td></td>
</tr>
<tr>
<td>- SE=1.58% (7th/10)</td>
<td>Cost savings from improved admin efficiencies could be reinvested into fuller implementation of valid instruments for establishing diagnoses and tracking consumers’ treatment response. These measures may or may not overlap with the screening instruments, depending on the measures’</td>
</tr>
</tbody>
</table>

A “% of children readmitted to an inpt psych unit w/in 30 days of discharge”=14.5%, but exceeding 15% standard for 2 of 4 quarters. Detroit-Wayne presently out of compliance with MDHHS/ Medicaid expectation to provide Crisis Residential & Crisis Stabilization services appropriate for Wayne County’s geographical area.

stabilization and crisis residential services.

Fewer provider agencies with more complete arrays of service would simplify connecting to care.  

Fewer provider agencies with more complete arrays of service would simplify connecting to care.

Required by PAMA “Psychiatric rehabilitation services”

"Behavioral health homes will also need valid instruments for establishing diagnoses and tracking consumers’ treatment response. These measures may or may not overlap with the screening instruments, depending on the measures’
<table>
<thead>
<tr>
<th>Vocational Outcomes</th>
<th>Cross-cutting element that needs to be better addressed regardless of model</th>
</tr>
</thead>
<tbody>
<tr>
<td>AV% of adults with mental illness served who are in competitive employment = 7.19% (9th/10 MI REs)</td>
<td>Not explicitly addressed or funded in the global Medical Home model, but would be addressed in Behavioral Health Home model applications that would need to provide the full array of MDHHS-covered services.</td>
</tr>
<tr>
<td>AV% of I/DD adults served who are in competitive employment = 4.1% (10th/10)</td>
<td>Included in “clinical outcomes data” corresponding to improved level of functioning, as well as in evaluating service efficacy/therapeutic effects of treatment services on “consumer outcomes”/“treatment outcomes.”</td>
</tr>
<tr>
<td>AV% of Dual MI+/I/DD adults</td>
<td></td>
</tr>
</tbody>
</table>
| 3 | Coordination of Care | Coordination of Care | Improving admin efficiencies would improve service authorization, timeliness, monitoring, & problem resolution. | B “Intentional emphasis on POPULATION-BASED CARE with strategies for optimizing the health of an entire client population by actively and systematically assessing, tracking, and managing the group’s health conditions and treatment responses.” | C “Required care coordination across settings & providers, including the following partnerships or formal contracts:  
- FQHCs  
- Other OP PC clinics  
- Inpt Psych  
- Inpt/sub-acute Detox services  
- SUD residential  
- VA service array  
- Acute care Hospitals  
- Foster Care  
- Schools  
- Child Welfare  
- Criminal Justice  
- Indian Health Services” |
| 4 | Consumer Input & Participation | Consumer Input & Participation | Would need intentional implementation | Would need intentional implementation | B “Intentional emphasis on PERSON-CENTERED CARE via Self-management Support, and Shared decision-making, within a chronic care framework.” | C Peer support (peer support specialists, recovery coaches) and counselor services and family supports required as part of scope of services, may be included on Crisis Teams. |
| 5 | Integration of MH and SUD Care (=BH) | Integration of MH and SUD Care (=BH) | Cost savings from improved admin efficiencies could be reinvested into enhancing direct treatment services | Cost savings from improved admin efficiencies could be reinvested into enhancing direct treatment services | Addressed only for eligible service populations, so risk of underserving individuals with co-occurring mental health and substance use disorders not meeting behavioral health home eligibility criteria. | C “The Medical Director will ensure the medical component of care and the integration of behavioral health (including addictions) and primary care are facilitated.” |
| 6 | Integration of BH and PH Care | Funded Initiative, but MCPNs have not been involved in supporting COD practice improvement SA provider contracts already managed directly by DWMHA | Larger provider agencies would have greater capacity to ramp-up and sustain direct treatment services. | Services: Larger provider agencies would have greater capacity to ramp-up and sustain more effective direct treatment services for co-occurring disorders. | Larger provider agencies would have greater capacity to ramp-up and sustain more effective direct treatment services for co-occurring disorders. |
| - Quad I | Presently only serving primarily Quad III and IV in mostly coordinated fashion, while supporting development of locally good-fitting models of co-location and/or fuller integration. Dual Eligibles Demonstration Project Quads I and II currently underserved, with higher systems costs for lack of better prevention, &/or early intervention. | DWMHA would still need to lead change in this area. | MCPNs have not been leading change in this arena, so little to nothing lost if MCPN layer is discontinued. | B Target service populations limited to individuals who “have at least two chronic conditions, or one chronic condition and be at risk for another, or one serious and persistent mental health condition” that is, primarily Quads II, III & IV, so risk of Quad I individuals being underserved.  
“In practice, behavioral health agencies serving as health homes will need to conduct evidence-based screenings for common health conditions and risk factors such as glucose and lipid levels, blood pressure, weight, body mass index, HIV, Hepatitis C, and carbon monoxide levels. Behavioral health agencies partnering with health providers to deliver health home services will need to ensure that health providers are screening for mental health and substance use conditions using valid measures such as the PHQ-9 for depression and the AUDIT for substance use.” |
| - Quad II |  |  |  |  |
| - Quad III |  |  |  |  |
| - Quad IV |  |  |  |  |

| 7 | Financing Care/ Payment System(s) | Traditional Medicaid, Healthy Michigan, General Fund; Over- | Cost savings from improved admin efficiencies could be reinvested via | Cost savings from improved admin efficiencies could be reinvested via | B “Many State Medicaid programs have developed medical home models and States receive Medicaid reimbursement for medical homes through a variety of  
“Enhanced funding based on successful outcomes (value-based purchasing);” |
<p>|  | | Cost savings from improved admin efficiencies could be reinvested via |  |  |  |  |</p>
<table>
<thead>
<tr>
<th>Data Management (data-driven decision-making &amp; adjustment)</th>
<th>Ongoing use of CAFAS, PECFAS, DECA; ASAM PPCR; Ramp-up for using LOCUS &amp; SIS DWMHA/MCPN duplication and time delay in data capture, reporting, analysis is serious</th>
<th>DWMHA needs to have central data repository under its direct access and control.</th>
<th>With improved data management capability at DWMHA, little to no loss if MCPNs eliminated.</th>
<th>Intentional emphasis on DATA-DRIVEN CARE via strategies including collecting, organizing, sharing and applying objective, valid clinical data to guide treatment – validated assessment tools, client registries, real-time treatment outcome analysis and adjustment capability.</th>
</tr>
</thead>
</table>
| Quality of Care, and Other Reporting | | | | Embedded clinical guidelines are strongly recommended.”

**For Michigan, 2016 is the pilot initiative window within which to work out a Prospective Payment System that can be sustainable moving forward for the delivery of integrated BH (MI & SA) and PH services.**
<table>
<thead>
<tr>
<th>Technology / Information Support</th>
<th>Cross-cutting element that needs to be better addressed regardless of model, especially including substance use disorder service data</th>
</tr>
</thead>
<tbody>
<tr>
<td>9 Staffing</td>
<td>Systems issue</td>
</tr>
<tr>
<td>Workforce Development/Retention</td>
<td>Workforce aging, compensation issues need to be addressed, regardless of delivery system. DWMHA multi-disciplinary internship initiatives, HPSA, HRSA grants VCE arguably overpriced, online learning content outdated</td>
</tr>
<tr>
<td>Licensing &amp; Certification</td>
<td>Cost savings from improved admin efficiencies could be reinvested to better compensate front-line staff; MCPNs have not significantly supported staff training, so little to no drop-off if discontinued</td>
</tr>
<tr>
<td></td>
<td>Cost savings from improved admin efficiencies could be reinvested to better compensate front-line staff; MCPNs have not significantly supported staff training, so little to no drop-off if discontinued</td>
</tr>
<tr>
<td></td>
<td>B Training acknowledged as important, especially in support of staff being able to deliver evidence-based treatment and other interventions.</td>
</tr>
<tr>
<td></td>
<td>C “Medical Director must be psychiatrist;”</td>
</tr>
<tr>
<td></td>
<td>C “Workforce size &amp; composition goodness of fit”</td>
</tr>
<tr>
<td></td>
<td>C “Intensive/comprehensive training, inservicing plan”</td>
</tr>
<tr>
<td></td>
<td>C “Requires multi-disciplinary staff, culturally &amp; linguistically trained, with appropriate licensing/credentialing”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10 Organizational Authority, Governance &amp; Accreditation</th>
<th>Cross-cutting elements that need to be better addressed regardless of model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Board governance model does not always lead to timely resolution of issues, needs</td>
<td>System accreditation can occur more completely and simply with repurposed MCPNs System accreditation can occur more completely and simply without MCPNs</td>
</tr>
<tr>
<td></td>
<td>B Strongly advocates for delivery system redesign.</td>
</tr>
<tr>
<td></td>
<td>C “Requires nonprofit status or a part of local gov’t behavioral health authority”</td>
</tr>
</tbody>
</table>

**MI REs** = State of Michigan Public Sector Behavioral Health Regional Entities (formerly PIHPs)

**PAMA** = Protecting Access to Medicare Act of 2014

A FINGERTIP REPORT: B.1. SERVICE UTILIZATION SUMMARY for Adults with Mental Illness; B.2. SERVICE UTILIZATION SUMMARY for Children with Serious Emotional Disorders; MEDICAID PERFORMANCE INDICATORS; PIHP COST SUMMARY; Period: 1/1/2014 - 9/30/2014. [http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868_4902-188760--,00.html#open](http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868_4902-188760--,00.html#open)


BHBPTF RECOMMENDATIONS

In order to preserve and continue those assets and resources that are working effectively at the present time, comply with current Federal and State regulations and guidelines, yet also move in the direction that will best serve the future of public-sector behavioral health service recipients of the Detroit Wayne region, including those with Substance Use Disorder and Intellectual/Developmental Disability service needs, the following are recommended:

1) That DWMHA should serve as the region’s backbone organization, providing and addressing necessary over-arching functions in the areas of overall Finance (Medicaid/General Fund/Grants management, reimbursement rate-setting, case-rate setting, value-based purchasing strategies, etc.), System-wide Services Management (a full array of community-based services, including Front-Door Access, and required Crisis Services), Service Quality (accreditation standards, practice standards, Recipient’s Rights, etc.), Centralized Data Infrastructure (required gathering/analysis/reporting), and Workforce Training (comprehensiveness, consistent quality, accessibility);

2) That beyond the Authority’s Federal- and State-mandated direct functions, that current MCPNs be evaluated for demonstrated areas of superior delegated administrative function (such as service/claims authorization processes), and be so subsequently contracted as one or more Administrative Service Organizations working in fully coordinated, transparent and accountable collaboration with DWMHA.

3) That the regional system design include all of the following moving forward, with detailed monitoring and analysis of cost/benefit/outcome data to inform forward-looking adjustments of the system:
   a. One or more Certified Community Behavioral Health Clinic pilots (elucidated in Column V above);
   b. One or more Behavioral Health Home pilots (in any/all of the 3 designs indicated in Column IV above);
   c. A number of larger providers capable of delivering a full array of services to multiple service populations (Adult MI, Youth & Family, I/DD, Substance Use Disorders);
   d. Indicated specialty service providers with sufficient capacity to deliver specialized services at a level to meet the needs of particular population cohorts across the County.

4) That the Detroit-Wayne County Service Array include demonstration pilots of both Behavioral Health Homes and Certified Community Behavioral Health Clinics, and that all service providers strive toward greater integration with physical healthcare services (Coordinated, Co-located, or Fully Integrated), and that the Triple Aim indicators be evaluated as different health integration models are designed and implemented.
a. It is recommended that DWMHA continue to receive consultative input from national content experts (such as Philadelphia’s Arthur Evans, or Missouri’s Joe Parks) as well as from in-state pilot projects (such as Washtenaw County’s Behavioral Health Home effort) to further inform our system design and implementation efforts moving forward.

b. It is also recommended that DWMHA seek consultation from BCBSM to inform ongoing application efforts, as they have experiential expertise and cost analysis data associated with their implementation with 1.25 million patients in 78 counties in Michigan.

5) That the **BACKBONE+ASO+SPOKES** system design model as described above offers the best way forward from the current circumstances to a more efficient and effective design for our public sector behavioral health system of care.
Appendix D – Quality Care Task Force Annual QAPIP Report
Quality Care Task Force Annual QAPIP Report

Associated with its investigative findings and in anticipation of major changes influenced by the Medicaid Final Rule, the Quality Care Task Force has evolved into two significant subcommittees. The first subcommittee was established to develop core competencies for Direct Care Workers and to pilot a specialized training program as a precursor to a Direct Care Worker certificate program. The second subcommittee was designed to orient residential care providers to the Final Rule and to develop a representative group of providers who would advocate for quality residential care and are knowledgeable of the impact of the Final Rule upon residential services. This group will be essential to positively influence other residential providers toward compliance as the Michigan Department of Health and Human Services rolls out its statewide assessment and transition plan, as required by the Center for Medicare and Medicaid Services.

The Direct Care Worker group has developed a curriculum and training program identified as “Compassionate Care”. This eight-week training is targeted to improve care by facilitating greater insight into prevention or early crisis intervention techniques and support skills needed to improve relationships in group and independent settings. Phase 1 was successfully implemented with all participants reporting greater job satisfaction and notable improvements in the ability to prevent or derail crisis events. Phase II is currently in process, utilizing a train-the-trainer format. The results of this pilot program will be available to discuss the development of a certificate program with local community colleges. The anticipated outcome of a certificate program is the establishment of standards for direct care service and a more mobile workforce that can be deployed to residential settings and provide care based upon consumer needs.

The Residential Provider Task Force has been established, is advising the Authority on provider concerns and issues related to the Final Rule and is assisting with the development of effective methods to educate the provider system on the impact of the Final Rule. Task Force members are currently identifying workable business plans in compliance with the Rule that could be used in a demonstration project to work through issues associated with the statewide transition plan. Members of the task force have also been invited to participate in the Behavioral Health and Developmental Disabilities Administration, Developmental Disabilities Performance Improvement Team. Their involvement will facilitate coordination across policy initiatives related to the Health and Community Based Service rules and promote a successful transition process for consumers, providers and service agencies.
Appendix E – DWMHA Provider Network Credentialing/Impaneling FY 14-15 (see CD for Full Report)
Appendix F – DWMHA Autism Report FY 14-15
Detroit Wayne Mental Health Authority

Autism Benefit Annual Summary

Fiscal Year 2014/2015

DWMHA received 451 referrals for the Autism Spectrum Disorder (ASD) Benefit during the 2014/2015 Fiscal Year. This is a 58% increase since the previous year and represents 50% of the total DWMHA ASD Benefit Referrals (897 referrals). The DWMHA ASD Benefit has a 76% MDHHS Approval rate for cases meeting diagnostic and need-based criteria. At the end of the 14/15 Fiscal Year DWMHA had 393 cases open in the ASD Benefit. Three-hundred and seventy-two (372) open cases are in the current benefit target population (18months-5 years of age) and 21 open cases are being served under the early expansion. The ASD Benefit continues to grow at a rate of 13 cases per month and has not plateaued in enrollments at this time. Eighty-three (83%) percent are receiving services at the Early Intensive Behavioral Intervention (EIBI) Higher Level of Care and 17% are receiving services at the Applied Behavior Intervention (ABI) Lower Level of Care.

Table 1. ASD Benefit Referrals

<table>
<thead>
<tr>
<th>Status</th>
<th>Level Of Care</th>
<th>Pending</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABI</td>
<td>EIBI</td>
<td>ABA</td>
<td>Total</td>
</tr>
<tr>
<td>Open</td>
<td>50</td>
<td>239</td>
<td>372</td>
</tr>
<tr>
<td>Early</td>
<td>2</td>
<td>16</td>
<td>3</td>
</tr>
<tr>
<td>Grand Total</td>
<td>52</td>
<td>255</td>
<td>393</td>
</tr>
</tbody>
</table>

The 2014/2015 Fiscal Year was a year of transition and growth for the DWMHA ASD Benefit. In October 2014, DWMHA successfully transitioned the ASD Benefit Contract management to direct contracts with the authority. DWMHA has eliminated waitlists and made positive strides in reducing the number of days from referral to services. The average number of days from referral to diagnostic evaluation was reduced by 72 days (from 87 to 15). The average number of days from referral to MDHHS approval was reduced by 14 days (from 48 to 34). The average number of days from referral to Individualized Plan of Service (IPOS) was reduced by 110 days (from 169 to 59). The average number of days from referral to Applied Behavior Analysis (ABA) Services was reduced by 94 days (from 180 to 86).

DWMHA currently contracts with eight ASD benefit service providers. Centria Healthcare is an in-home and clinic-based provider and serves 61% of the open cases in the ASD Benefit. Special Education Behavioral Connections is an in-home and clinic-based provider and serves 12% of the open cases in the ASD Benefit. The Children’s Center (TCC) accounts for 10% of the open cases in the ASD Benefit and is a clinic-based provider. Starr Commonwealth dba PsychSystems served 7% of the open cases in the ASD Benefit and is both in-home and clinic-based. University Pediatricians Autism Center (UPAC) is clinic-based and serves 3% of the open cases. Three percent (3%) is also served through Starfish Family Services who provide both in-home and clinic-based services. Neighborhood Service Organization (NSO) and The Guidance Center (TGC) both provide clinic and in-home services and serve 2% of the children in the ASD Benefit.

The DWMHA ASD Benefit has made positive strides in developing a workforce to serve children and families in the benefit and increased staffing by 236%. At the end of FY13/14, the DWMHA network had 18 staff serving as Board Certified Behavior Analysts (BCBAs) or Qualified Master Level Behaviorists. DWMHA currently has 40 staff serving as Board Certified Behavior Analysts (BCBAs) or Qualified Master Level Behaviorists. At the end of FY13/14, the DWMHA network had 90 staff serving as Behavior Technicians or ABA Aides. DWMHA currently has 323 staff serving as Behavior Technicians or ABA Aides.

Table 2. Open Cases

<table>
<thead>
<tr>
<th>Status</th>
<th>Level Of Care</th>
<th>Pending</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABI</td>
<td>EIBI</td>
<td>ABA</td>
<td>Total</td>
</tr>
<tr>
<td>Open</td>
<td>50</td>
<td>239</td>
<td>372</td>
</tr>
<tr>
<td>Early</td>
<td>2</td>
<td>16</td>
<td>3</td>
</tr>
<tr>
<td>Grand Total</td>
<td>52</td>
<td>255</td>
<td>393</td>
</tr>
</tbody>
</table>

Table 3. Timeline Statistics

<table>
<thead>
<tr>
<th>Status</th>
<th>Ave. Days from Referral to Evaluation</th>
<th>Ave. Days from Referral to MDHHS Approval</th>
<th>Ave. Days from Referral to IPOS Completion</th>
<th>Ave. Days from Referral to ABA Direct Start</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY1213</td>
<td>87</td>
<td>48</td>
<td>169</td>
<td>180</td>
</tr>
<tr>
<td>FY1314</td>
<td>53</td>
<td>73</td>
<td>128</td>
<td>152</td>
</tr>
<tr>
<td>FY1415</td>
<td>15</td>
<td>34</td>
<td>59</td>
<td>86</td>
</tr>
<tr>
<td>Total</td>
<td>37</td>
<td>50</td>
<td>109</td>
<td>131</td>
</tr>
</tbody>
</table>

Table 4. ASD Benefit Staffing

<table>
<thead>
<tr>
<th>Status</th>
<th>FY1314</th>
<th>FY1415</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCBA / Behaviorist</td>
<td>18</td>
<td>40</td>
</tr>
<tr>
<td>Behavior Technician / ABA Aide</td>
<td>90</td>
<td>323</td>
</tr>
<tr>
<td>Total</td>
<td>108</td>
<td>363</td>
</tr>
</tbody>
</table>

Appendix I – DWMHA Grievances Annual Report FY 14-15
The grievance system is an important element in identifying how providers function in various areas. It promotes consumers' access to medically necessary, high quality, consumer-centered mental health services by responding to consumers' concerns in a sensitive and timely manner. This process supports recovery and assures that people are heard. It empowers individuals receiving services to become self-advocates and provides input for making the system better for everyone. It also serves as a source to identify opportunities for improvement in the quality and delivery of service within the system.

I: Grievances Reported:

A total of 191 grievances were processed during the Fiscal Year 2014/2015. The grievances originated at either the Service Provider level/MCPN/SUD or at the Authority. The chart below reflects the 28 Providers and number of grievances filed between October 1, 2014 and September 30, 2015.
Beginning May 1, 2015, the Authority entered into an agreement for oversight of behavioral services for five Integrated Care Organizations (ICO) who participate in the Dual Eligible Program. Under this program, which is referred to as MI Health Link, the Authority will be accountable for the delivery, management, and reporting of all covered behavioral health services and supports for their enrollees. Below reflects the beginning activity for MI Health Link grievances fiscal year 2014-2015.

The month of July did not produce any grievances. August had one (1) grievance from Fidelis. The month of September had two (2) grievances; one from AmeriHealth, the other from Molina. The three (3) grievances were investigated and resolved within 30 days.

**II: Grievance Categories:**

It should be noted that a grievance could have several different issues contained within a single grievance. Although there were 191 grievances reported there 218 issues identified within those grievances. The graph below provides a breakdown of grievances by categories followed by examples from each category.
Access to Service was the highest with 35 or 16% of grievances. Examples include, disappointed that case manager been to house only one time in a month; doctor appointment information is not always clear and/or convenient, inability to access additional psychiatric services, and appointment wait time.

Interpersonal Issues accounted for 30 or 14% of the grievances. Grievances related to enrollees overhearing a staff threatening another staff, enrollee feeling that staff’s tone of voice made her feel stressed and unwanted, and after an argument, staff stood in the doorway and yelled, “I'll pray for you!”

Delivery of Service represented 27 or 13% of the grievances. Grievance examples included allegedly not being fed by the Intensive Day Treatment (IDT) Peer Specialist, supported housing referral not completed, and excess and redundant paperwork, staff failed to assist enrollee when needed, enrollee did not like the way the nurses administers injections,

Customer Service had 26 or 12% of the grievances. Grievances included complaints concerning staff being rude and unprofessional, receptionist refusing to address a disruptive person in the lobby, and staff refusal to answer telephone calls and/or return calls when message is left.

Clinical Issues had 24 or 11% of the grievances. Grievances included dissatisfaction with medication, consumer not making improvement, delayed enrollees diagnosis, side effects from prescribed medication; and enrollee reported "I was overdosed".
Quality of Care represented 22 or 10% of grievances. Grievances for this category included not receiving prescribed nutrition, confrontation with staff, MCPNs leaving an enrollee without the ability to obtain medication, provider denied an enrollee the opportunity to speak with his therapist, and everyone that has been assigned has quit and no one has followed up with care.

Access to Staff had 15 or 7% of the grievances. The complaints included delayed assignment of Support Coordinator, request for a male therapist not honored, enrollee not assigned a new therapist, and enrollee not being able to get a doctor’s appointment.

Environmental and Program Issues each accounted for 13 or 6% of the grievances.

- **Environmental Issues** were AFC home not having a shower, bed bugs in AFC home, and power outage.

- **Program Issues** included Enrollee not enrolled into budget class, enrollee failed to receive his certificate and Enrollee wanted to change from CLS to ConsumerLink and to change to a female workers.

Financial Matters and the Other category each represented 5 or 2% of the grievances.

- **Financial Matters** included inability to pay monthly therapy fee, inability to afford prescription refill, enrollee did not receive vouchers as promised and agency refused to relinquish the guardianship to enrollee.

- **Other** included issues about an exchange of words with another club member, staff from their in-home program stay with them while inpatient.

III. How Grievances Came to Authority

Of the 191 grievances reported, the highest number 113 or 59% were received by telephone. 51 or 27% were received via written communication. Walk-ins totaled 22 or 11% of grievances received and 2 or 1% was received electronically and externally each. L or 1% was from internal source. The pie chart below represents this information.
IV: Grievance Outcomes:

Of the 191 grievances reported, the majority, 150 or 79% of the cases were resolved within the Customer Service Department of the MCPN/Service Provider/SUD/WCJDF. Should a grievance not be resolved within the required 60-day timeframe or if the grievant is not satisfied with the resolution of the grievance, he/she may request a Medicaid Fair Hearing or an Alternative Dispute Resolution.

There are also grievances that may involve a suspected Recipient Rights violation, as reflected in the graph with 26 or 14%, these cases are coordinated with the Office of Recipient Rights (ORR). Grievances that require ORR resolution associated with substance use treatment represent 2 or 1% as SUD ORR. Local Appeal are 5 or 3% of the grievances. Adequate Action Notice reflected 1 or .5% as did Medicaid Fair Hearing. The grievance outcome category indicating 6 or 3% for Other are cases where the member was referred to Department of Human Services, Detroit Public School system or the case was out of jurisdiction.
V: Average Number of Days Grievance Remained Opened:

Grievances are required to be resolved within 60 calendar days. During the 2014-2015 fiscal year, the average number of days a grievance remained open was 27 days. The graph below reflects the average number of days a grievance remained open for the providers that opened a grievance.

VI: Trends and Patterns

- This year there were 191 grievances filed in the comparison to the last fiscal year, 2013-2014 there were 294 grievances filed. The reduction in the in the number filed was attributed to the procedure change where the Service Providers began, March 1, 2015, to submit grievances directly into the Authority via MH-WIN.

- During the 3rd Quarter, beginning May 1, 2015, the Authority entered into an agreement to process grievances for five Integrated Care Organizations (ICO) who participate in the Dual Eligible Program, also referred to as MI Health Link. Under this program the Authority will be
accountable for the delivery, management, and reporting of all covered behavioral health services and supports for their enrollees.

VII: Recommendations:

- Provide on-site continuous grievance process trainings for Service Providers and SUD Providers.
- Provide hands-on trainings at Provider locations.
- Develop MI Health Link training sessions for Service Providers and SUD Providers.
Appendix J – DWMHA Appeals Annual Report FY 14-15
DWMHA Appeals Accomplishments

2014-2015

1) The appeals department was moved into the Customer Service Unit.
2) During 2014 and 2015 fiscal year the appeal process was brought in-house.
3) MH-WIN was updated to be able to complete Local Appeal and Local Dispute Resolution.
4) MH-WIN was further updated to accommodate Medicare.
5) Began working with the Dual Eligible – ICO’s on Appeals for Medicaid and Medicare.
6) All of the Appeal Forms (Medicaid, Medicare and Local Dispute were updated, distributed and updated in MH-WIN).
7) Appeals Policies were created for the Dual Eligible population.
8) Appeals for Medicaid Policy was also updated.
9) Presented three (3) appeal trainings for the new Service Providers.
   13) Assisted with Four (4) MCPN reviews.
   14) Provided formal technical assistance for the following providers: Development Centers, Starfish, Gateway, New Center, The Children’s Center, Psygenics, Centria, Neighborhood Services Organization, Hegira, Services to Enhance Potential, Goodwill and Lincoln Behavior.
FY 14/15 in the (3) three quarters of 2014/2015, there were a total of 158 Medicaid Local Appeals processed. Out of 158 Local Appeals; Access reported (15) fifteen. Community Living Services reported (31) thirty one, Consumer Link reported (23) Twenty Three, Carelink reported (43) forty three, ICA/Synergy reported (7) seven, Gateway reported (39) thirty nine and lastly Substance Use Disorder reported zero. There were (4) four Non-Medicaid Local Appeal processed from Access for the 1\textsuperscript{st}, 2\textsuperscript{nd} & 3\textsuperscript{rd} quarter. These numbers are reflected in the bar graph, see below.

![Bar Graph: 2014-2015 FY Report of Medicaid and Non-Medicaid Local Appeals]

<table>
<thead>
<tr>
<th>ACCESS</th>
<th>CLS</th>
<th>Consumer Link</th>
<th>Carelink</th>
<th>ICA/Synergy</th>
<th>Gateway</th>
<th>SUD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>15</td>
<td>31</td>
<td>23</td>
<td>43</td>
<td>7</td>
<td>39</td>
</tr>
<tr>
<td>Non-Medicaid</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Categories of Services for Medicaid/Non-Medicaid Local Appeals

For FY 14/15 a total of (158) one hundred fifty eight Medicaid/Non-Medicaid Local Appeals processed. The Local Appeals are broken down by service categories. Out of 158 Appeals there were (40) forty for Denial of all CMH Services, (31) thirty one for Outpatient Therapy, (17) seventeen for Case Management, (27) twenty seven for Psychiatric Services, (10) ten for Medication Clinic, (15) fifteen for Community Living Supports, (3) three for Home-Based, (2) two for Nursing Services, (3) three for Intensive Day, (3) three for Infant Mental Health, (7) seven for ABA Autism/Early Childhood Services. These numbers are reflected in percentages on the pie chart, please see below.
Medicaid Fair Hearings

For the FY 14/15 was a total of (90) ninety Administrative Fair Hearing requests that were received by the Authority. Out of 90 Fair Hearings (12) twelve were from Access, (32) thirty two were from CLS, (12) twelve were from Consumer Link, (17) seventeen were from Carelink, zero from ICA/Synergy and SUD, and lastly (17) seventeen were from Gateway. These numbers are reflected in the bar graph below.
Outcomes

State Level Decisions

<table>
<thead>
<tr>
<th></th>
<th>Affirm</th>
<th>Dismiss</th>
<th>Deny</th>
<th>Resolve</th>
</tr>
</thead>
<tbody>
<tr>
<td>MFH</td>
<td>35</td>
<td>13</td>
<td>0</td>
<td>34</td>
</tr>
</tbody>
</table>
SUMMARY

In fiscal year 2014/15 the Authority initiated a system improvement process for appeals. A total of five educational forums were conducted with MCPN’s and contracted providers to address the importance of reporting concise and consistent appeals data to the Authority. At which point, there were some concerns expressed by the Provider Networks regarding duplication of efforts. After assessing the systems process improvement needs, it was determined that all Appeals would be brought in house for the Authority’s monitoring, tracking and trending beginning the second quarter of fiscal year 2014/15. Since that time the numbers of appeals have significantly risen. It should be noted that now with the collaborative efforts of the customer service appeals division and clinical providers many appeals are being directly addressed with the appellants and provider clinical team resulting in resolution without the need for court intervention. By also bringing the appeals process in house, potential appellants, may feel more comfortable in addressing their concerns by eliminating the perception of potential retaliation. It should also be noted that the appeals have also increased since there have been changes in Michigan Medicaid Provider Manual, i.e. Applied Behavioral Analysis, Community Living Supports. The customer service appeals division has now assumed the responsibility of actively monitoring and auditing the appeals at the provider/MCPN sites. This audit process will include electronic and on-site monitoring.
Appendix K – DWMHA External Quality Review Compliance Monitoring Report FY 14-15
Behavioral Health and Developmental Disabilities Administration
Prepaid Inpatient Health Plans

2014–2015
EXTERNAL QUALITY REVIEW COMPLIANCE MONITORING REPORT
for
Region 7—Detroit Wayne Mental Health Authority

October 2015
Table 2-1 below presents the results of the 2014–2015 follow-up compliance review of **Detroit Wayne Mental Health Authority**.

<table>
<thead>
<tr>
<th>Standard</th>
<th>Total Elements</th>
<th>Total Applicable Elements</th>
<th>Number of Elements</th>
<th>Compliance Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>I QAPIP Plan and Structure</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>0</td>
</tr>
<tr>
<td>II Performance Measurement and Improvement</td>
<td>24</td>
<td>24</td>
<td>24</td>
<td>0</td>
</tr>
<tr>
<td>III Practice Guidelines</td>
<td>17</td>
<td>14</td>
<td>14</td>
<td>0</td>
</tr>
<tr>
<td>IV Staff Qualifications and Training</td>
<td>9</td>
<td>6</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>V Utilization Management</td>
<td>21</td>
<td>21</td>
<td>21</td>
<td>0</td>
</tr>
<tr>
<td>VI Customer Services</td>
<td>13</td>
<td>10</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>VII Enrollee Grievance Process</td>
<td>16</td>
<td>13</td>
<td>13</td>
<td>0</td>
</tr>
<tr>
<td>VIII Enrollee Rights and Protections</td>
<td>37</td>
<td>33</td>
<td>32</td>
<td>0</td>
</tr>
<tr>
<td>IX Subcontracts and Delegation</td>
<td>8</td>
<td>4</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>X Provider Network</td>
<td>13</td>
<td>13</td>
<td>13</td>
<td>0</td>
</tr>
<tr>
<td>XI Credentialing</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>XII Access and Availability</td>
<td>20</td>
<td>17</td>
<td>16</td>
<td>0</td>
</tr>
<tr>
<td>XIII Coordination of Care</td>
<td>7</td>
<td>4</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>XIV Appeals</td>
<td>18</td>
<td>15</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>XV Disclosure of Ownership, Control, and Criminal Convictions</td>
<td>8</td>
<td>8</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>237</td>
<td>208</td>
<td>202</td>
<td>3</td>
</tr>
</tbody>
</table>

**M=Met, SM=Substantially Met, PM=Partially Met, NM=Not Met, NA=Not Applicable**

**Total Elements:** The total number of elements in each standard.

**Total Applicable Elements:** The total number of elements within each standard minus any elements that received a score of NA.

**Compliance Score:** The overall percentages were obtained by adding the number of elements that received a score of Met to the weighted (multiplied by 0.75) number of elements that received a score of Substantially Met and the weighted (multiplied by 0.50) number that received a score of Partially Met, then dividing this total by the total number of applicable elements.

Appendix A of this report presents details of the review of the standards.
SUMMARY OF THE 2014–2015 COMPLIANCE MONITORING REVIEW

Standard VIII Enrollee Rights and Protections

Recommendations

The PIHP misinterpreted the contract requirement to provide each beneficiary with the estimated cost to the PIHP of each covered support and service. Detroit Wayne Mental Health Authority must develop a process to ensure that it provides all beneficiaries the estimated cost to the PIHP of each covered support and service received. This information must be provided to beneficiaries annually (e.g., at the time of person-centered planning).

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Results—Standard VIII</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detroit Wayne Mental Health Authority should ensure that at least 95 percent of the time adults with a developmental disability start needed, ongoing services within 14 days of a non-emergent assessment with a professional.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Met</th>
<th>Substantially Met</th>
<th>Partially Met</th>
<th>Not Met</th>
<th>Not Applicable</th>
<th>Total Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>32</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>4</td>
<td>33</td>
</tr>
<tr>
<td>X 1.0</td>
<td>X .75</td>
<td>X .50</td>
<td>X .00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32.00</td>
<td>0.00</td>
<td>0.50</td>
<td>0.00</td>
<td></td>
<td>32.50</td>
</tr>
<tr>
<td>Total Applicable</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>17</td>
</tr>
<tr>
<td>Total Score ÷ Total Applicable</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>98%</td>
</tr>
</tbody>
</table>

Standard XII ACCESS AND AVAILABILITY

Recommendations

Detroit Wayne Mental Health Authority should ensure that at least 95 percent of the time adults with a developmental disability start needed, ongoing services within 14 days of a non-emergent assessment with a professional.

<table>
<thead>
<tr>
<th>Results – Standard XII</th>
</tr>
</thead>
<tbody>
<tr>
<td>Met</td>
</tr>
<tr>
<td>16</td>
</tr>
<tr>
<td>X 1.0</td>
</tr>
<tr>
<td>16.00</td>
</tr>
<tr>
<td>Total Applicable</td>
</tr>
<tr>
<td>Total Score ÷ Total Applicable</td>
</tr>
</tbody>
</table>
STANDARD XV – Disclosure of Ownership, Control, and Criminal Convictions

Recommendations

**Detroit Wayne Mental Health Authority** did not have a disclosure of ownership form that included all fields necessary to capture the required information from all pertinent individuals. The PIHP did not pass on to contractors the requirement to have a policy and process to collect fully compliant disclosure statements inclusive of all necessary information from subcontractors’ providers and subcontractors and relied on its prohibition of conflict of interest relationships in the request for proposal (RFP).

**Detroit Wayne Mental Health Authority’s** contract required providers to “affirmatively warrant” that no individuals in the entity itself or the entity’s network were debarred, suspended, excluded or ineligible from participation in any federal program under the provision of Section 1128(a) and (b) of the Act.

**Detroit Wayne Mental Health Authority’s** RFP attestation requirement referenced a time period that neither the bidder nor any of its governing board members had been sanctioned within the prior five years. PIHP contracts under the “Debarment and Suspension” section referenced a three-year time period. Federal regulations stipulate that providers are required to disclose the identity of any person with an ownership or control interest in the provider or disclosing entity or who is an agent or managing employee of the provider or disclosing entity that has ever been convicted of any crime related to that person’s involvement in any program under the Medicaid, Medicare or Title XX program (Social Services, Block Grants), or Title XXI (State Children’s Health Insurance Program) since the inception of those programs.

**Detroit Wayne Mental Health Authority** should familiarize its board and MCPNs with the full requirements specified in 42 CFR 455.104-106 and should formalize a policy and process for obtaining full disclosure statements from all board of director members, providers, and contractors.

**Detroit Wayne Mental Health Authority** must revise its disclosure statement form to ensure that full disclosures are obtained and maintained for its entire network of contractors, subcontractors, and providers, as applicable.

**Detroit Wayne Mental Health Authority** must have a process to identify and to notify the MDHHS Behavioral Health and Developmental Disabilities Administration (BHDDA) Division of Program Development, Consultation, and Contracts when any disclosures are made by providers with regard to criminal offenses described under section 1128(a) and 1128(b)(1)(2), or (3) of the Social Security Act. Those offenses include criminal offense convictions for program-related crimes and patient abuse and felony convictions relating to healthcare fraud and controlled substances.

**Detroit Wayne Mental Health Authority** must monitor MCPNs processes to obtain and maintain compliant disclosure statements and criminal conviction attestations from all required individuals and entities and report to the PIHP when applicable, as required.
## Results – Standard XV

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
<th>Multiplier</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Met</td>
<td>4</td>
<td>1.0</td>
<td>4.00</td>
</tr>
<tr>
<td>Substantially Met</td>
<td>3</td>
<td>0.75</td>
<td>2.25</td>
</tr>
<tr>
<td>Partially Met</td>
<td>1</td>
<td>0.50</td>
<td>0.50</td>
</tr>
<tr>
<td>Not Met</td>
<td>0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Not Applicable</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Applicable</td>
<td>8</td>
<td></td>
<td>6.75</td>
</tr>
</tbody>
</table>

Total Score \(\div\) Total Applicable = 84%
Appendix L – DWMHA External Quality Review Performance Measurement Information System Capability (ISCAT) FY 14-15
Behavioral Health and Developmental Disabilities Administration
Prepaid Inpatient Health Plans

STATE FISCAL YEAR 2015
VALIDATION OF PERFORMANCE MEASURES
for
Region 7—Detroit Wayne Mental Health Authority

September 2015
Performance Indicator Specific Findings and Recommendations

Based on all validation activities HSAG determined results for each performance indicator. The CMS Performance Measure Validation Protocol identifies three possible validation finding designations for performance indicators, which are defined in Table 6. For more detailed information, please see Appendix B.

<table>
<thead>
<tr>
<th>Designation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report (R)</td>
<td>Indicator was compliant with the State’s specifications and the rate can be reported.</td>
</tr>
<tr>
<td>Not Reported (NR)</td>
<td>This designation is assigned to measures for which: (1) the PIHP rate was materially biased or (2) the PIHP was not required to report.</td>
</tr>
<tr>
<td>No Benefit (NB)</td>
<td>Indicator was not reported because the PIHP did not offer the benefit required by the indicator.</td>
</tr>
</tbody>
</table>

According to the protocol, the validation magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be not compliant based on the review findings. Consequently, an error for a single audit element may result in a designation of NR because the impact of the error biased the reported performance indicator by more than 5 percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate, and the indicator could be given a designation of R. Audit elements and their scoring designations (i.e., Met, Not Met, and Not Applicable [N/A]) can be found in Appendix A—Data Integration and Control Findings and Appendix B—Denominator and Numerator Elements.
Table 7 displays the indicator-specific review findings and designations for **Detroit Wayne Mental Health Authority**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Calculation process</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>The percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.</td>
<td>The calculation process was in accordance with MDHHS Codebook specifications.</td>
<td>R</td>
</tr>
<tr>
<td>The percentage of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.</td>
<td>The calculation process was in accordance with MDHHS Codebook specifications.</td>
<td>R</td>
</tr>
<tr>
<td>The percentage of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional.</td>
<td>The calculation process was in accordance with MDHHS Codebook specifications.</td>
<td>R</td>
</tr>
<tr>
<td>The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.</td>
<td>The calculation process was in accordance with MDHHS Codebook specifications.</td>
<td>R</td>
</tr>
<tr>
<td>The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.</td>
<td>The calculation process was in accordance with MDHHS Codebook specifications.</td>
<td>R</td>
</tr>
<tr>
<td>The percent of Medicaid recipients having received PIHP managed services.</td>
<td>MDHHS will calculate this indicator in compliance with MDHHS Codebook specifications.</td>
<td>R</td>
</tr>
<tr>
<td>The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.</td>
<td>MDHHS will calculate this indicator in compliance with MDHHS Codebook specifications.</td>
<td>R</td>
</tr>
<tr>
<td>The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.</td>
<td>MDHHS will calculate this indicator in compliance with MDHHS Codebook specifications.</td>
<td>R</td>
</tr>
<tr>
<td>Indicator</td>
<td>Description</td>
<td>Calculation Process</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.</td>
<td>MDHHS will calculate this indicator in compliance with MDHHS Codebook specifications.</td>
<td>R</td>
</tr>
<tr>
<td>The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.</td>
<td>The calculation process was in accordance with MDHHS Codebook specifications.</td>
<td>R</td>
</tr>
<tr>
<td>The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).</td>
<td>MDHHS will calculate this indicator in compliance with MDHHS Codebook specifications.</td>
<td>R</td>
</tr>
<tr>
<td>The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).</td>
<td>MDHHS will calculate this indicator in compliance with MDHHS Codebook specifications.</td>
<td>R</td>
</tr>
</tbody>
</table>
Appendix M – DWMHA External Quality Review Performance Improvement Project Validation Report – Health and Wellness FY 14-15
BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES ADMINISTRATION

PREPAID INPATIENT HEALTH PLANS

2014-2015 PIP VALIDATION REPORT

Improving Wellness Self-Management of SMI Consumers With Chronic Health Conditions

for

Region 7 – Detroit Wayne Mental Health Authority

September 2015

for

Validation Year 2
2. **FINDINGS**

for **Detroit Wayne Mental Health Authority**

**Validation Findings**

The PIP validation evaluated the technical methods of the PIP (i.e., the study design implementation and evaluation). Based on a technical review, HSAG determined the overall methodological validity of the PIP. Table 2–1 summarizes the PIP validated during the review period with an overall validation status of *Met*, *Partially Met*, or *Not Met*. In addition, Table 2–1 displays the percentage score of evaluation elements that received a *Met* score, as well as the percentage score of critical elements that received a *Met* score. Critical elements are those within the validation tool that HSAG has identified as essential for producing a valid and reliable PIP. All critical elements must receive a *Met* score for a PIP to receive an overall *Met* validation status.

HSAG reviewed one PIP for the 2014–2015 validation cycle. The PIP received an overall *Partially Met* validation status when submitted. **Detroit Wayne Mental Health Authority** received technical assistance from HSAG, corrected the deficiencies, resubmitted the PIP for a second review, and improved overall validation status to *Met*. Table 2–1 illustrates the validation scores.

**Table 2–1—2014–2015 Performance Improvement Project Validation Activity for Detroit Wayne Mental Health Authority**

<table>
<thead>
<tr>
<th>Activity for Detroit Wayne Mental Health Authority</th>
<th>Submission</th>
<th>Resubmission</th>
<th>Overall Validation Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving Wellness Self-Management of SMI Consumers With Chronic Health Conditions</td>
<td>71%</td>
<td>100%</td>
<td><em>Met</em></td>
</tr>
</tbody>
</table>

**Percentage Score of Evaluation Elements Met**—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

**Percentage Score of Critical Elements Met**—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

**Overall Validation Status**—Populated from the PIP Validation Tool and based on the percentage scores.

Table 2–2 displays the validation results for **Detroit Wayne Mental Health Authority** evaluated during 2014–2015. This table illustrates the PIHP’s overall application of the PIP process and success in implementing the study. Each activity is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 2–2 show the percentage of applicable evaluation elements that received each submission.
Appendix N – DWMHA Performance Improvement Project – Falls Risk Screening
FY 14-15
Falls Risk Assessment Performance Improvement Project (PIP)

November 2015

I. IDENTIFIED PROBLEM

The Detroit Wayne Mental Health Authority (DWMHA) Quality Care Task Force, whose charge was to investigate and make recommendations to significantly improve residential care, had recommendations that lead to the development of the Falls Risk Assessment Performance Improvement Project.

The Quality Care Task Force Report (2014) identified injuries, including falls as an “Ongoing Challenge”:

“A review of incidents highlights a number of categories that need closer analysis to determine causation and interventions to improve the health and safety of consumers within the provider system. The Categories/Sub- Categories most identified for review were Injuries Requiring Emergency Room Medical Treatment and Behavior, all Sub-Categories. The Injuries Requiring Emergency Room Medical Treatment category included injury as a result of falling from a chair or other object; unsteady gait resulting in a fall; tripping over objects, injury when attempting to enter/exit a vehicle; and falls occurring in the bedroom or bathroom. A better assessment is needed to determine the cause of injuries. Are there biophysical elements such as side effects of medication or physical illness that contribute to falls? Is the primarycare physician involved and working with the care team toward managing the comprehensive care of individual residents? Has the routine or environment been evaluated and adjusted to safety-proof the resident experience? (“Transforming a System of Residential Services” Compiled by Sandra Peppers, Director of Special Projects, November 2014 http://www.dwmha.com/Portals/0/Documents/B...20Report.pdf)

A Performance Improvement Work Group was formed on March 18, 2015 to review the data on the prevalence of falls in the intellectual/developmental disabled persons served population; identify the root causes; plan a prevention strategy; measure the impact; and analyze the outcome. To date the group includes Quality Improvement and Monitoring Staff; Certified Peer Support Specialists; a Nurse with community living supports provider; Pharmacologist, Director of Office of Peer Participation & Advocacy; and Customer Service Manager (where are the MCPNs and Providers?). The Work Group continues to recruit community members.
II. DESCRIPTION OF PROJECT

**Study Topic:** Improving Fall Precautions for I/DD Consumers in Specialized Residential Care and Semi-Independent Living Settings via Implementation of a Fall Risk Assessment & Training. Three questions will be identified for screening risk of falls on the DWMHA system wide Bio-psycho-social Assessment.

The Michigan Department of Community Health (MDCH) has required through contract, each Prepaid Inpatient Health Plan (PIHP) conduct two performance improvement projects to affect consumer health, outcomes of care, functional status, and/or satisfaction with care. The study topic and intervention was determined by Detroit Wayne Mental Health Authority (DWMHA) after reviewing the Incident Reports and Critical/Sentinel Event Report data in the DWMHA Mental Health Wellness Information Network (MHWIN).

An overview of Incident Report data on falls of consumers with Intellectual/Development Disability (I/DD), Mental Illness or Severe Emotional Disturbance (MI/SED) and Substance Use Disorders (SUD) living in residential facilities found:

<table>
<thead>
<tr>
<th>Falls Reported on Incident Reports received by the DWMHA Office of Recipient Rights</th>
<th>Falls W/O Injury</th>
<th>Falls with Injury</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>892</td>
<td>499</td>
<td>1,391</td>
</tr>
<tr>
<td>2012</td>
<td>648</td>
<td>572</td>
<td>1,220</td>
</tr>
<tr>
<td>2013</td>
<td>652</td>
<td>603</td>
<td>1,255</td>
</tr>
<tr>
<td>Jan thru May 2014</td>
<td>365</td>
<td>270</td>
<td>635</td>
</tr>
<tr>
<td>Grand Total</td>
<td>2557</td>
<td>1944</td>
<td>4,501</td>
</tr>
</tbody>
</table>

From this chart, of the grand total of 4501 consumers who fell over a 3-year period, 43% of were injured. A significant number were seen in Urgent Care Centers or the Emergency Department of Hospitals.

From this overview it appeared that I/DD consumers were the most vulnerable. A review of the DWMHA Critical/Sentinel Event Report data in MH-WIN found that injuries due to falls were a significant portion of the reported injuries requiring emergency room care or hospitalization for I/DD consumers. A one quarter (October - December 2012) spot check for FY 2012-13 found that 17 out of 33 (52%) reported Critical Events for I/DD consumers marked as "Injuries Requiring ER" were due to falls. A one quarter (October - December 2013) spot check for FY 2013-14 found that 14 out of 33 (42%) reported Critical Events for I/DD consumers marked as "Injuries Requiring ER" & "Injuries Requiring Hospitalization" were due to falls.
A review of the descriptions of these falls led us to conclude some of these falls may have been prevented.

We reviewed the fall prevention literature. A review of the national literature confirmed that the rate of falls (including fatal falls) increases with age, affirmed the benefit of Fall Prevention activities and offered implementation guidelines. The Comprehensive Fall Prevention for Community-Dwelling Older Adults: Planning for Success in Identifying and Referring Older Adults through Hospital-Based Programs- September, 2005 (http://www.michigan.gov/documents/fallpreventionmanual_167797_7.pdf) concluded that fall prevention is effective in reducing falls:

“Research has proven that fall prevention programs that include fall risk assessments and medical follow-up reduced the risk of falling by 18 percent, and reduced the average number of falls sustained by 43 percent.

Yale University Program on Aging further states the two-thirds of the deaths due to falls are preventable if health care professions, caregivers and older adults apply proven evidence-based services to reduce fall risks.” (Pages 12-13)

Comprehensive Fall Prevention for Community-Dwelling Older Adults also noted: “Of the evidence-based interventions studied, the following have been proven to be most effective in reducing falls:

1. Comprehensive clinical assessment
2. Exercise for balance and strength
3. Medication management
4. Vision correction
5. Reducing home hazards” (Page 12)

While these statements are related to older adults, the DWMHA I/DD population has some similarities in terms of frequency of falls, increased health factors contributing to fall risk, involvement of care givers, and loss of independence due to injury.

Noting the similarities between older adults and the DWMHA I/DD population, the converse could be true for the DWMHA I/DD population, fall prevention decreases the risk of premature death, disability, improves independence, and increases social interactions.

Our review of Critical Events suggest that the DWMHA I/DD population is at particularly high risk for predictable and preventable falls. Thus, an opportunity exists to improve the outcomes of I/DD persons served by reducing the incidents of falls.
We will intervene by implementing a comprehensive fall risk assessment and correlate person-centered fall precautions to aid in the reduction in the number of falls within the I/DD population living in Specialized Residential and Semi-Independent settings.

III. Detailed Description of Performance Measures To Be Used:

We will be looking at whether the targeted intervention results in a decrease in the percentage of I/DD consumers with reported injuries requiring emergency room care or hospitalization due to falls during the measurement period.

<table>
<thead>
<tr>
<th>Numerator</th>
<th>The number of I/DD consumers in Specialized Residential and Semi-Independent Living settings with reported injuries requiring emergency room or hospitalization due to falls in the Critical/Sentinel Events Module of the DWMHA Mental Health Wellness Information Network (MHWIN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>The total number of I/DD consumers in Specialized Residential and Semi-Independent Living settings with reported injuries requiring emergency room or hospitalization in the Critical/Sentinel Events Module of the DWMHA Mental Health Wellness Information Network (MHWIN)</td>
</tr>
</tbody>
</table>

The results will be reported as percentages. We will compare the percentages of injuries due to falls in the measurement periods to the percentage of injuries due to falls during the baseline period.

DWMHA is seeking accreditation by the National Committee for Quality Assurance. To meet the accreditation standards of two additional measures which will be added to this PIP:

<table>
<thead>
<tr>
<th>Measure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of patients aged 65 years and older with a history of falls who had a risk assessment for falls completed within 12 months</td>
</tr>
<tr>
<td>Percentage of patients aged 65 years and older with a history of falls who had a plan of care for falls documented within 12 months</td>
</tr>
</tbody>
</table>
IV. DESCRIPTION OF CONSUMER/STAKEHOLDER INVOLVEMENT IN THE DESIGN OF THE PERFORMANCE IMPROVEMENT PROJECT (PIP)

The Fall Risk Screening PIP Work Group was developed to include a well-rounded selection of membership with careful consideration for inclusion of its membership of both internal and external stakeholders. The Work Group is comprised of internal stakeholders from the DWMHA’s Customer Service, Improving Practices, Managed Care Operations, OPA, and Quality Management Units. External stakeholders participating include the Managers of Comprehensive Provider Networks (MCPNs); service provider representatives from IS Care and Wayne Center; and representation of peer/consumers (M. Hall and R. Spruce). The Work Group meets bi-monthly. Each of the stakeholders that are participating on this Work Group contributes valuable input to the challenging concerns around falls and injury to DWMHA consumers.

V. DESCRIPTION OF THE PIHP’s INITIAL PERFORMANCE LEVEL

The Work Group undertook a root cause analysis. A review of the types of falls reported in the narratives of Critical and Sentinel Events reported during the calendar year 2014 found the most frequent type of fall was related to gait issues (37%). However, there many events with “Unknown” causes (17%). See chart below for additional types of falls reported.
The typical location of these reported falls was in the consumers’ home (68%). Hence, any interventions planned will be in consumers’ homes. See the chart on the next page.

The Work Group took these findings and developed a Fall Risk Screening Tool based on CDC STEADI and Pennsylvania Health FRAT models of fall risk assessment. See the tool in Appendix Exhibit A. Currently the Work Group is completing the script and algorithm for follow up actions to accompany the tool.

There is a draft Implementation Plan. See the plan in Appendix Exhibit B. DWMHA Legal Department is creating the Consent to Participate.

Large Group Providers have been identified to participate in the project with the assistance of the MCPNs Quality Directors:

- Bowers Adult Foster Care
- Colling Homes
- Community Opportunity Centers
- Domus Vitae
- Enhanced Group and
- Manor Homes.
VI. DESCRIPTION OF THE SPECIFIC ACTIONS TAKEN TO IMPROVE PERFORMANCE

The Work Group is in the process of completion of the planning phase. The next step is to implement a limited test of the Fall Risk Screening Tool on a small number of I/DD individuals by a Supports Coordinator who is a member of the Work Group prior to executing the full Implementation Plan. The purpose of the test is to identify any unanticipated barriers.

VII. ANY AVAILABLE DATA ON THE OUTCOME OF THE PROJECT

No data is available at this time; the process is ongoing. However, upon implementation, data will be collected and shared with the DWMHA community at large.

VIII. DESCRIPTION OF CONSUMER/STAKEHOLDER INVOLVEMENT IN REVIEWING THE PIHP’s PERFORMANCE

The DWMHA has several groups in place with consumer representation that have been a part of this process. Two members are participating in the Work Group. Two presentations were made to the Constituents Voice and the Advocacy Groups. The Work Group will provide progress reports and outcomes of this PIP to the Quality Improvement Steering Committee and share outcomes on DWMHA.com.

IX. CONCLUSIONS

DWMHA is committed to the whole health of individuals it serves and has undertaken the improvement project to assess and reduce the risk of falls. No data is available at this time; the process is ongoing. At the conclusion of this project the entire population served by DWMHA will have a brief fall risk screening as part of the system wide Bio-Psycho-Social Assessment to improve the health of consumers.
ADDENDUM

EXHIBIT A: FALL RISK SCREENING TOOL

![FALL RISK SCREENING Tool Image](image)

**FALL RISK SCREENING**

<table>
<thead>
<tr>
<th>Consumer name:</th>
<th>MHWIN #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(print)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DOB:</th>
<th>□ Female □ Male</th>
<th>Date</th>
</tr>
</thead>
</table>

Specialized Residential or SIL Facility Name: ____________________________

---

**Please complete the screening tool with a review of current factors (except history of falls):**

<table>
<thead>
<tr>
<th>FALL RISK FACTOR IDENTIFIED</th>
<th>FACTOR PRESENT</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of Falls: Has history of one or more falls in past year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(excluding seizures)</td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>Number of Medications: Takes 4 or more medications per day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subtest Use/Intake: Current alcohol intake/substance use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision: Test difficulty reading book/newspaper,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>recognition of object across the room or recently started</td>
<td></td>
<td></td>
</tr>
<tr>
<td>wearing bifocals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing: Has difficulty hearing conversational speech</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walking Gait: Is unsteady on feet, shuffles or takes uneven</td>
<td></td>
<td></td>
</tr>
<tr>
<td>steps or housebound</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfers: Lack of control when moving between surfaces</td>
<td></td>
<td></td>
</tr>
<tr>
<td>requires physical or hands-on assistance from staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balance: Needs to hold furniture, requires cane or walker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>frame/requires physical or hands-on assistance from staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environmental Hazards: Slip/trip hazards, clutter or poor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>lighting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dizziness: Reports feeling dizzy when standing up or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>changing position</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**REFER FOR FALL RISK ASSESSMENT FROM THE APPROPRIATE PROVIDER**

Staff Signature | Credentials | PROVIDER AGENCY

---

**DRAFT**
EXHIBIT B: IMPLEMENTATION PLAN

DRAFT IMPLEMENTATION PLAN FOR THE FALLS RISK SCREENING PIP
(PERFORMANCE IMPROVEMENT PROCESS)

OCTOBER 21, 2015

Study Topic: Improving Fall Precautions for I/DD Consumers in Specialized Residential Care and Semi-Independent Living Settings via Implementation of a Fall Risk Screening Training.

Initial Phase: Testing the Falls Risk Screening Tool

Target Population: I/DD Adults residing in Specialized Residential Homes

Recommendation:

To implement a pilot through Specialized Residential Group Home Providers with greater than three Specialized Residential Homes to increase the number of participants to be screened. Suggested groups included: (it seems like the home providers have changed – please check)

- Covenant to Care
- Community Opportunity Centers
- Domus Vita Homes
- Enhanced Homes
- Imani Homes
- Independent Community Care
- K&K
- Quest Homes

Inclusion: Residents who sign the Consent to Participate Form or whose Guardians sign the Consent form. DWMHA Legal Department is creating the Consent to Participate Form.

Exclusion: Non-ambulatory residents and those residents with active seizure disorders will be excluded as their falls will not be impacted by the fall prevention strategies planned for the training phase which focus on gait issues. Residents with no seizures in the past 12 months will be included in the pilot.

The Work Group will need to involve the Supports Coordinators to gain the consent from Guardians.
Plan to Engage Home Providers: Consider involving DWMHA Managed Care Operations to invite the Group Home Providers to a meeting to engage them in this pilot. (I thought this was using the MCPN Quality Directors?)

Tool: DWMHA Fall Risk Screening Tool (See page 3).

Screeners: Case Managers and Supports Coordinators

Plan Training:

- Who? Case Managers/Supports Coordinators with ICA, CLN & CLS
- Where? At Service Provider sites.
- When? Following Team Meeting to increase participation.
- What? Falls Risk Screening Tool, Sheet of Examples from FRAT (pages 38 –44, and STEADI Algorithm
- Trainers: Suggestion to use Interns (need to explore this further)
- Offer a Certificate. Can this become a VCE Training?
- Need to develop a feedback/review survey.

Intended Outcomes:

1. To identify the typical Fall Risk Factors. The three most frequent factors identified will be the basis of three questions to be suggested additions to the system-wide Bio-psycho-social Assessment Form.
2. To identify ease or barriers to implementing the Fall Risk Screening.
3. To identify ease or barriers for training staff to implement the Fall Risk Screening.
4. To rollout system-wide for the Case Managers, Supports Coordinators or Direct Care Workers to utilize:
   a. When assessing an individual for Specialized Residential placement,
   b. During Pre-Planning/Treatment Planning of individuals,
   c. When an individual is identified in an Incident report as having a fall, and
   d. When an Individual discloses a fall to Supports Coordinator or Case Manager.
   e. Prompt from the Bio-Psycho-Social Assessment
5. The frequent Fall Risk Factors will be addressed in a training phase of this PIP.
6. Data to be collected and shared with the DWMHA community.
Appendix P – DWMHA Priority Needs, Planned Actions and Actions Taken FY 14-15
Priority Needs, Planned Actions and Action Taken FY15

CMHSP: **Detroit Wayne Mental Health Authority (DWMHA)**

Based on feedback received from stakeholder groups and data collected from this process, the CMHSP must identify at least 5 priority needs. Of these, the CMHSP must identify the areas where it intends to address and what action is being planned in that area. The table below provides a format for identifying the top issues.

**Priority Issue:** Please give a brief explanation of the issue, in order of priority, with 1 being highest.

**Reasons for Priority:** Identify what makes this a priority issue. For example: the issue was identified by multiple stakeholder groups; or the size of the issue; or consistency with other community efforts, etc.

**CMHSP Plan:** Give a brief overview of what steps the CMHSP intends to take to address the identified issue. Please include basic time frames and milestones.

**FY 14 Response:** The DWMHA Strategic Planning Committee, the Quality Care Task-force and Certified Peer Support Specialists workgroup conducted seven successful focus group meetings throughout Wayne County. More than 400 stakeholders participated in PEST (Political, Economic, Social, and Technology) and SWOT (Strength, Weaknesses, Opportunities, Threats) analysis activities where insightful community/consumer perceptions were obtained. The feedback from the focus groups allowed the DWMHA to hear the stakeholders suggested improvement priorities as well as opportunities for implementation tasks they feel align with the priority areas.

Additional analysis included review of the DWMHA Performance Indicator results, Satisfaction surveys and other mission critical indicators as well as a review of literature including but not limited to the Substance Abuse and Mental Health Service Administration (SAMHSA) Strategic Plan, Michigan Department of Community Health (MDCH) 2015 Strategic Priorities, Michigan Mental Health and Wellness Commission Report, Affordable Care Act (ACA) and more.

See the chart on page 10 for the Seven Priority Issues identified and Actions Planned in the FY14 submission.
FY 15 Response: An update regarding the actions carried out to address the Priority Issues are on the following pages.

We have assigned a score to the progress made to date on each Priority Issue using the following system:

<table>
<thead>
<tr>
<th>SCORES</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Met</td>
<td>Indicates that the performance indicator was fully compliant with our</td>
</tr>
<tr>
<td></td>
<td>requirements, expectations or specifications, ≥ 95% compliant.</td>
</tr>
<tr>
<td>Significantly Met</td>
<td>Indicates that the performance indicator was substantially compliant with</td>
</tr>
<tr>
<td></td>
<td>our requirements, expectations or specifications and had only minor</td>
</tr>
<tr>
<td></td>
<td>deviations that did not fully comply, 85%-94%.</td>
</tr>
<tr>
<td>Partially Met</td>
<td>Indicates that the performance indicator deviated from our requirements,</td>
</tr>
<tr>
<td></td>
<td>expectations or specifications, 70%-84% compliant.</td>
</tr>
<tr>
<td>Not Met</td>
<td>Indicates that the performance indicator deviated significantly from our</td>
</tr>
<tr>
<td></td>
<td>requirements, expectations or specifications such that the reported rate</td>
</tr>
<tr>
<td></td>
<td>was biased, &lt; 70% compliant.</td>
</tr>
<tr>
<td>N/A</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

PRIORITY ISSUE #1. INCREASE COMMUNITY INCLUSION AND INTEGRATION
SCORE: SIGNIFICANTLY MET

Action Step #1: The Behavioral Health Best Practices Task Force submitted its report to Administration on 12/15/2015 with recommendation for model of care which included the following recommendations:

“…That the regional system design include all of the following moving forward, with detailed monitoring and analysis of cost/benefit/outcome data to inform forward-looking adjustments of the system:

a. One or more Certified Community Behavioral Health Clinic pilots…;

b. One or more Behavioral Health Home pilots…;

c. A number of larger providers capable of delivering a full array of services to multiple service populations (Adult MI, Youth & Family, I/DD, Substance Use Disorders);
d. Indicated specialty service providers with sufficient capacity to deliver specialized services at a level to meet the needs of particular population cohorts across the County.

…That the Detroit-Wayne County Service Array include demonstration pilots of both Behavioral Health Homes and Certified Community Behavioral Health Clinics, and that all service providers strive toward greater integration with physical healthcare services (Coordinated, Co-located, or Fully Integrated), and that the Triple Aim indicators be evaluated as different health integration models are designed and implemented.

a. It is recommended that DWMHA continue to receive consultative input from national content experts (such as Philadelphia’s Arthur Evans, or Missouri’s Joe Parks) as well as from in-state pilot projects (such as Washtenaw County’s Behavioral Health Home effort) to further inform our system design and implementation efforts moving forward.

b. It is also recommended that DWMHA seek consultation from BCBSM to inform ongoing application efforts, as they have experiential expertise and cost analysis data associated with their implementation with 1.25 million patients in 78 counties in Michigan."

Action Step #2a-c: Associated with its investigative findings and in anticipation of major changes influenced by the Medicaid Final Rule, the Quality Care Task Force has evolved into two significant subcommittees. The first subcommittee was established to develop core competencies for Direct Care Workers and to pilot a specialized training program as a precursor to a Direct Care Worker certificate program. The second subcommittee was designed to orient residential care providers to the Final Rule and to develop a representative group of providers who would advocate for quality residential care and are knowledgeable of the impact of the Final Rule upon residential services. This group will be essential to positively influence other residential providers toward compliance as the Michigan Department of Health and Human Services rolls out its statewide assessment and transition plan, as required by the Center for Medicare and Medicaid Services.

The Direct Care Worker group has developed a curriculum and training program identified as “Compassionate Care”. This eight-week training is targeted to improve care by facilitating greater insight into prevention or early crisis intervention techniques and support skills needed to improve relationships in group and independent settings. Phase 1 was successfully implemented with all participants reporting greater job satisfaction and notable improvements in the ability to prevent or derail crisis events. Phase II is currently in process, utilizing a train-the-trainer format. The results of this pilot program will be available to discuss the development of a certificate program with local community colleges. The anticipated outcome of a certificate program is the establishment of standards for direct care service and a more mobile workforce that can be deployed to residential settings and provide care based upon consumer needs.
In terms of planning process, the Residential Provider Task Force has been established and the Task Force members are currently identifying workable business plans in compliance with the “Final Rule” that could be used in a demonstration project to work through issues associated with the statewide transition plan. Members of the task force have also been invited to participate in the Behavioral Health and Developmental Disabilities Administration, Developmental Disabilities Performance Improvement Team.

Development of the Residential Travelocity Brochure is pending.

**Action Step #3:** A Performance Improvement Work Group was formed on April 24, 2015 to review the data on the current implementation of self-determination; identify the drivers and restraints to implementation, identify a DWMHA model of Self-Determination, test this model/implementation strategy, measure the impact, and analyze the outcome as it pertains to a system wide roll out of this model. Despite the DWMHA Policy (“Self Determination and Consumer Directed Supports”), the DWMHA-MCPN Contract Access Standard/Self-Determination and the Self-Determination standard in the three-way contract for the MI Health Link Program, there is significant variance in implementation of Self-Determination system-wide. The Study Topic is: To create a system wide philosophy of Self-Determination and implementation plan for consistent application across the MCPN Networks. This study topic was determined by Detroit Wayne Mental Health Authority.

The Workgroup is comprised of internal stakeholders including DWMHA Chief Strategic Officer; DWMHA Director of Office of Peer Participation & Advocacy; DWMHA Quality Improvement and Performance Monitoring Staff; DWMHA Contract Managers; and DWMHA Customer Service Staff. The Workgroup is comprised of external stakeholders including: the MDHHS BH&DDA Self-Determination Development Coordinator; MCPN Executive and Quality Directors; and a consulting Psychopharmacologist. The Work Group continues to recruit community members. Each of the stakeholders participating in this Work Group contributes valuable input regarding the implementation of Self-Determination. The current plan is to implement a pilot to increase consumer demand for self-determination.

In addition to the actions above, DWMHA’s hosted a successful two-day conference - Constituents’ Voice Community Inclusion Conference & Conversation-May 28-29, 2015. The purpose of the conference was to create a conversation to advance community inclusion, a system-wide priority. The event targeted participants with lived and professional experience across various disabilities, as well as select interest groups representing DWMHA friends and partners. The conversational tone of the two days was designed to generate planning content for a community-based participatory approach that addresses the marginalization of people with disabilities.

**PRIORITY ISSUE #2. ENHANCE CRISIS MANAGEMENT & RESPONSE**

**SCORE: PARTIALLY MET**

**Action Step #1:** The Quality Improvement Administrator has revised the policy on the Behavior Treatment Plan process with accompanying procedures. This revised policy is being reviewed for approval. Once approved the process will be rolled out system-wide.

**Action Step #2:** In December 2015 DWMHA announced Phase I of the Crisis Response (or COPE-Community Outreach for Psychiatric Emergencies- Program): “In an effort to secure the best possible care for individuals in mental health crisis, the Detroit Wayne Mental Health Authority (DWMHA) recently awarded over $13.2 Million to offer Mobile Crisis Stabilization Services, Crisis Intervention, Pre-Admission Screening and related services to the residents of Wayne County. This initiative will reduce costly emergency room services and inappropriate incarceration – offering sound, values-driven management in Detroit/Wayne County today. Twenty-three mobile crisis outreach teams will be created to provide 24/7 psychiatric
evaluations, screening and clinical suicide risk assessment, pharmacological management and
determination of eligibility for inpatient hospitalization. The mobile crisis teams will work with law
enforcement, emergency personnel and hospitals to ensure the best possible treatment for persons in need
of emergency care, ensuring screening and triage within 15 minutes of initial contact with crisis team.”
(http://domemagazine.com/tomwatkins/tw122515) Hegira Programs have been awarded the funds for the
COPE Program and are currently planning implementation.

There was a bid out for additional 24-hour Crisis Line capacity and technology assisted support. ProtoCall
won the bid and will initiate service in April 2016.

**Action Step #3:** Phase II of the Crisis Response will move forward following the implementation of Phase I.

**PRIORITY ISSUE #3. EXPAND CAPACITY FOR IMPROVING PRACTICES
SCORE: SIGNIFICANTLY MET**

**Action Step #3-1a.** Thirty-nine (39) provider programs received Dual Diagnosis Capability in
Mental Health Treatment (DDCMHT) or Dual Diagnosis Capability in Addictions Treatment
(DDCAT) Reviews during FY15. Whereas this was a bit short of our initial, ambitious goal of 50,
these reviews yielded data that helped to inform five (5) workforce training events designed to
address substandard domain/subdomain areas, as well as the development of several additional
online learning modules.

**Action Step #3-2a.** Eight hundred seventy-five (875) workforce members from over 200 service
providing organizations and other community partners were reached with one or more of the eight
[8] trauma informed training events held in FY15. Trauma-Informed Care: Equipping Detroit
Wayne Providers: DWMHA’s First Annual Trauma Conference There has been increasing
recognition in recent years of the importance of developing and implementing treatment services
to effectively address post-traumatic stress disorder (PTSD) symptoms, while also successfully
managing the risk of triggering individuals into episodes of mental illness symptoms or substance
abuse relapse. The goal of this conference was to advance the development and implementation
of evidence based trauma-informed services to individuals served by the public behavioral health
system. 580 individuals attending the two-day conference

Additionally, DWMHA’s inaugural “Raising the Bar” conference drew 658 attenders over two days,
who were exposed to a wide range of plenary and breakout sessions, many of which were
designed to also deliver system-wide workforce training.

**Action Step #3-2b. Virtual Center for Excellence (VCE) continued to offer biweekly sessions of
Mental Health First Aid training to individuals working with adults and youth. From October 1,
2014-September 30, 2015,**

- 1025 Adult participants were trained,
- 37 Spanish participants were trained and
- 878 Youth participants were trained.
Ten thousand participants have been provided with Mental Health First Aid training since 2013, so we blew this one out of the water!

**Action Step #3-2c.** In fiscal year 2014-2015, the VCE trained nearly 189,415 duplicate participants through 223 live and online trainings. Together, they received more than 450,000 hours (a 50% increase over the previous year) of various continuing education credits. (A duplicate participant example is when one participant attends six trainings in one year; they are counted six times.)

Just over 8,200 people attended 141 live events. The credits associated with these live events accounted for:

- Social Work
- Licensed Professional Counselor (NBCC)
- Substance Use Professionals (MCBAP)
- Continuing Medical Education (CME)
- Child Mental Health Professionals (CMHP)
- Qualified Mental Health Professionals (QMHP)
- Qualified Intellectual Disability Professionals (QIDP)

These same credits also are available for most of VCE’s online trainings with the addition of Certified Rehabilitation Counselor (CRC/CCRC) credits.

Another 291,544 online training credits (a 200% increase over the previous year) were earned by the VCE users. These trainings included the MDHHS-required trainings as well as supplementary professional development courses. VCE also offers online training videos that qualify for CMHP, QMHP, QIDP credits and training hours, which are not counted in these figures.

**Action Step #3-3.** Attempts to increase the capacity of evidence-based practices have been varied. Capacity has increased in Infant Mental Health and *Trauma Focused* Cognitive-Behavioral Therapy (*TF-CBT*). Work continues to increase the capacity in other areas. See the chart on next page.
<table>
<thead>
<tr>
<th>EBP</th>
<th>Mar-15</th>
<th>Feb-16</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent Management Training-Oregon Model (PMTO)</td>
<td>21 staff</td>
<td>15 staff</td>
<td>3 agencies no longer providing PMTO; therefore, decrease in numbers</td>
</tr>
<tr>
<td>Wraparound</td>
<td>37.5 staff</td>
<td>36.5 staff</td>
<td></td>
</tr>
<tr>
<td>Infant Mental Health</td>
<td>49 staff</td>
<td>75 staff</td>
<td></td>
</tr>
<tr>
<td>Primary Service Provider (PSP)</td>
<td>16 staff</td>
<td>13 staff</td>
<td>This is due to staff turnover. Currently hiring 2 additional staff</td>
</tr>
<tr>
<td>Trauma Focused Cognitive-Behavioral Therapy (TF-CBT)</td>
<td>100 Staff</td>
<td>148 staff*</td>
<td>*Staff trained</td>
</tr>
</tbody>
</table>

**Action Step #3-4.** DWMHA received 451 referrals for the Autism Spectrum Disorder (ASD) Benefit during the 2014/2015 Fiscal Year. This is a 58% increase since the previous year and represents 50% of the total DWMHA ASD Benefit Referrals (897 referrals). The DWMHA ASD Benefit has a 76% MDHHS Approval rate for cases meeting diagnostic and need-based criteria. At the end of the 14/15 Fiscal Year DWMHA had 393 cases open in the ASD Benefit. Three-hundred and seventy-two (372) open cases are in the current benefit target population (18months-5 years of age) and 21 open cases are being served under the early expansion. The ASD Benefit continues to grow at a rate of 13 cases per month and has not plateaued in enrollments at this time. Eighty-three (85%) percent are receiving services at the Early Intensive Behavioral Intervention (EIBI) Higher Level of Care and 17% are receiving services at the Applied Behavior Intervention (ABI) Lower Level of Care. The 2014/2015 Fiscal Year was a year of transition and growth for the DWMHA ASD Benefit. In October 2014, DWMHA successfully transitioned the ASD Benefit Contract management to direct contracts with the authority. DWMHA has eliminated waitlists and made positive strides in reducing the number of days from referral to services. The average number of days from referral to diagnostic evaluation was reduced by 72 days (from 87 to 15). The average number of days from referral to MDHHS approval was reduced by 14 days (from 48 to 34). The average number of days from referral to Individualized Plan of Service (IPOS) was reduced by 110 days (from 169 to 59). The average number of days from referral to Applied Behavior Analysis (ABA) Services was reduced by 94 days (from 180 to 86).

DWMHA contracted with Relias Learning Systems for ASD Benefit Provider panel access to 100 courses related to ASD and the delivery of ABA, including the Registered Behavior Technician Coursework. We also delivered the October 2015 Grand Rounds on Comprehensive ASD
Diagnosis Evaluations and added additional video content to the VCE with this training. In addition, training content and links for ASD and ABA were added to the www.dwmha.com website and the www.vceonline.com website.

With the Medicaid Autism Benefit expanded from 6 years of age to 21 years of age on January 1, 2016, DWMHA will work to ensure that eligible consumer with ASD have timely access to evidence based ABA services and that provider capacity is increased to address demand.

**PRIORITY ISSUE #4. ENHANCE RECOVERY ORIENTED SYSTEM OF CARE**

**SCORE: MET**

**Action Step #1. See Priority Issue #2, Action Step #3.** Currently the Self-Determination Work Group is strategies how to increase demand for self-determination among consumers working collaboratively with the DWMHA Office for Peer-Participant Advocacy (OPA).

**Action Step #2a.** There has been numerous substance abuse reduction initiatives. Implemented the Michigan Prevention Data System (MPDS), October 2014. Data around prescription abuse and deaths in Wayne County lead to the following initiatives:

- Purchase Naloxone for our 1st responders FY 15-16
- Increase Prescription Drug Boxes in Detroit Wayne County area
- Increase Medication Assisted Treatments: Methadone, Vivitrol, Suboxone, Buprenorphine
- Expand Enhancing Community Health Outreach (ECHO) Project (Faith Based Organizations)
- Increase college campuses Generation X going door-to-door on prescription drugs, misuse and abuse
- Increase Community Prescription Drug Conference:
- Continue monthly prescription roundtable with Downriver parents (Parent 360),
- Continue monthly schools assemblies on Prescription Drugs: Central Collegiate Academy, Detroit and
- Continue Women Specialty Services Conferences weekly/monthly addressing Prescription and Drug Abuse.

**SUD Department planned and participated in the following conferences throughout the year:**

- Prescription Abuse Conference for Veterans (April)
- Annual Prescription Drug Workshops – April & October
- Michigan Prevention Association – April & November
- National Prevention Week Activities – May 18-23
- 16th Annual Michigan Substance Use and Co-occurring Disorder Conference, September 20th-22nd, Grand Rapids, MI
- Participated in Michigan Prevention Association advocacy and annual conferences, April and November.

**Action Step #2b.** By contract with SUD Providers with Peer Recovery Housing, the days were extended from 90 day to six (6) months.
**Action Step #2c.** The Youth Risk Behavior Survey was conducted. The SUD Department engages in many other youth prevention activities including developing a Youth Access to Tobacco Contest where Youth were able to win a chance to have their media messages posted on city buses and/or billboards during the period January 2015-FY 2016.

**Another action taken** based on recovery-oriented care was the Recovery Self-Assessment (Revised) survey. DWMHA successfully “selected a region-wide behavioral health recovery survey tool as a Continuous Quality Improvement project in partnership with a group of stakeholders” including providers and users of services, the majority of whom were people with lived experience. Members of the Community Planning Council Recovery Subcommittee (now terminated) selected the Recovery Self-Assessment (RSA-R) survey (O’Connell, Tondora, Kidd, Stayner, Hawkins, and Davidson (2007). Data Summary.

The results are based on survey feedback from Detroit Wayne Mental Health Authority administrators, providers, and service members. Overall, the findings for Detroit Wayne are positive. Some clear deficits exist, however. Service members, in general, had positive agreement with staff treatment. Staff seems treat members with respect, listen and connect them to services and resources needed. Data also suggests that staff convey a sense of hope which is an important driver in a recovery environment, as well as offer an array of services that meet the clinical needs. Service members, however, are not as involved in the design, delivery, implementation, and evaluation of the system.

Next Steps include:

- Present findings to the DWMHA Board and administration, and identify strategies for continuous improvement system-wide.
- Engage service members (e.g., advisory group, steering committees, council, clubhouse, etc.) at both a system and organizational level in developing improvement strategies.

Preliminary Recommendations for Continuous Improvement were:

- Expand oversight and monitoring of the networks efforts to improve participant involvement.
- Ensure increased use of peer services across populations served.

**PRIORITY ISSUE #5. ACHIEVE OPERATIONAL EXCELLENCE**

**SCORE: PARTIALLY MET**

**Action Step #1a.** With the advent of fee-for-service processes (i.e., Autism, SUD) and the MI Health Link Demonstration Project, along with the use of data by MDHHS to create financing methods (rates) and increased utilization management processes/analyses by DWMHA staff, the pricing/costing of encounters will require an increase in scrutiny to ensure consistency in the purchase of services/supports. To that end, DWMHA has created and implemented a Cost Utilization structure, which includes a Steering Committee and two critical workgroups - Costing Integrity Group (CIG) and Procedure Codes Work Group (PCWG).

**Action Step #1b.** The Costing Integrity Group (CIG) is currently working to identify the Corporate Key Performance Indicators.
**Action Step #1c.** The development of a MCPN Report Card is pending.

**Action Step #2a.** The MCPN contracts have been negotiated and signed. A Rebid a process is currently in the planning stage for the next MCPN contracts.

**Action Step #2b.** See Priority issue #6, Action Step #3.

**Action Step #2c.** See Priority #6, Action Step #1.

**Action Step 2d.** The DWMHA move to the new building is pending. The tentatively the DWMHA staff will move in March 2016.

**Action Step #2e.** The Behavioral Health Best Practices Task Force submitted its report to Administration on 12/15/2015 with recommendation for System Design utilizing a backbone and spoke model. That DWMHA should serve as the region’s backbone organization, providing and addressing necessary over-arching functions in the areas of overall Finance (Medicaid/General Fund/Grants management, reimbursement rate-setting, case-rate setting, value-based purchasing strategies, etc.), System-wide Services Management (a full array of community-based services, including Front-Door Access, and required Crisis Services), Service Quality (accreditation standards, practice standards, Recipient’s Rights, etc.), Centralized Data Infrastructure (required gathering/analysis/reporting), and Workforce Training (comprehensiveness, consistent quality, accessibility).

**Action Step #2f and 3.** Regarding financial stewardship, DWMHA is focused on reducing costs in the short term and the long term by embracing concepts such as best value purchasing and data driven management decisions. Initiatives include:

- The organization has transformed from a County Mental Health Agency to an independent governmental authority to reduce overhead and increase independence and control over its direction and resources.
- DWMHA purchased a nearby building in Detroit to allow it to shift from a County tenant to an owner of its own facility. This will provide savings currently and will provide greater savings once the building is paid off.
- Paid off all retiree legacy costs. Completed move to defined contribution model.
- DWMHA has greatly improved its data and cost and utilization analytic capabilities and enhanced its ability to make data informed decisions to achieve best value in providing supports and services.
- DWMHA has reduced administrative costs at MCPNs from 4.5% to 4% for the last nine months of FY15 and 3.6% for FY16.
- DWMHA is emphasizing enhanced rigor regarding coordination of benefits at the provider billing level to decrease net costs charged to MCPNs and to DWMHA.
- DWMHA has examined contractual relationships and payment structures in our network and implemented changes that will save several millions of dollars.
- The consolidation of SUD Coordinating Agencies at DWMHA has saved several million dollars due to enhanced efficiencies employed by DWMHA.
- Commencing in FY15 DWMHA became a part of MME “Duals” Demonstration Project (MI Health Link) which is providing integrated physical and mental health care to better serve people and as a result reduce total health care costs.
DWMHA is developing strategic plans that include improved crisis services that will help reduce crisis costs and divert more people in crisis from unnecessary hospital stays to more appropriate services in the community.

**Action Step #4.** As mentioned above, in October 2014, DWMHA successfully transitioned the ASD Benefit Contract management to direct contracts with the authority. DWMHA has eliminated waitlists and made positive strides in reducing the number of days from referral to services. The average number of days from referral to diagnostic evaluation was reduced by 72 days (from 87 to 15). The average number of days from referral to MDHHS approval was reduced by 14 days (from 48 to 34). The average number of days from referral to Individualized Plan of Service (IPOS) was reduced by 110 days (from 169 to 59). The average number of days from referral to Applied Behavior Analysis (ABA) Services was reduced by 94 days (from 180 to 86).

In addition, DWMHA made a decision in FY15 to begin readiness for seeking accreditation by the National Committee for Quality Assurance.

**PRIORITY ISSUE #6. IMPLEMENT INTEGRATED CARE SCORE: MET**

**Action Step #1.** The Dual Eligible (MI Health Link) program has been implemented in FY15. DWMHA is considered a PIHP leader in the MI Health Link Program in Michigan. DWMHA successfully met all delegated Medicare and NCQA standards of five (5) ICOs. DWMHA Integrated Healthcare staff continue to work with contracted and non-contracted providers to train on the MI Health Link program, provide technical assistance in completing the Level 2 Assessment, and continue to work with the ICOs to improve the processes for the MI Health Link program and improve the health outcomes for the enrollees. DWMHA has taken lead in implementing the Behavioral Health Consent form for the exchange of 42 CFR Part 2 data. The electronic exchange of health information for referrals between the ICOs and the PIHP is functioning well.

DWMHA has been active over the last year hosting public forums, meetings with consumers, family, providers, residential providers and many other stakeholders to educate the specifics of the MI Health Link program. As of January, 2016, DWMHA has received approximately 3,959 Level I referrals from five (5) ICOs. The total number of dual eligible people in Wayne County increased in December by nearly 0.5% to 60,650 people. Of the 60,650 people, 20,829 (34%) eligible people were enrolled in MI Health Link. The percentage of people who opted-out of the MI Health Link program remained constant at 46%. However, the percentage of people who were enrolled in MI Health Link dropped by 2.2% in December. The drop in MI Health Link enrollment appeared consistent across all ICOs.

Coordination of Care has been facilitated by the hiring a team of five professional dedicated to the MI Health Link participants.

**Action Step #2.** See Priority Issue #1, Action Step #1 above.
Action Step #3. The Substance Use Disorder Programs have been integrated into the DWMHA service delivery system. This was facilitated by:

- Established SUD Oversight Policy Board, April 2014.
- Established Standardized Treatment Rates, July 2014.
- Developed the SUD Access Training Manual for Pioneer/UM Dept.
- Developed Scopes of Services-Prevention, Treatment and Recovery Providers, August 2014.
- Established Provider Allocations for Contracts, August 2014.
- Utilized data to identify prevention and treatment needs, gaps and resources, August 2014.
- Developed SUD three year strategic plan, August 2014.
- Developed, implemented identified target outcomes based on community needs, August 2014.
- Initiated Prevention Provider Meetings, September 2014.
- Created Staffing Grants for Prevention Providers, September 2014.
- Created Provider Contracts, disseminated and emailed September 2014.
- Managed the funding sources: Block Grant, Medicaid, Healthy MI, MI Child, PA 2, October 2014.
- Initiated Treatment Provider Meetings, October 2014.
- Initiated Prevention Providers, In-house payments (with DWMHA), October 2014.
- Established a contract with Institute for Population Health (IPH) and Southeast Michigan Community Alliance (SEMCA) for screening and authorization of services, October 1, 2014.
- Implemented a continuum of care: Prevention, Early Intervention, Treatment, and Recovery with various innovative programs, October 2014.
- Implemented a Recovery Oriented System of Care (ROSC), October 2014.
- Implemented the Michigan Prevention Data System (MPDS), October 2014.
- Integrating SUD Policies and Procedures, on-going.
- Developed a letter for IPH & SEMCA to send out to our SUD clients informing them that their cases will be transferred to DWMHA along with a universal release of information form to retrieve their current and historical client information/data and to notify them that IPH & SEMCA are no longer their funders, September 2014.
- Terminated SEMCA’s contract and move 20 % of SUD clients into IPH’s Carenet System, December 2014.
- Initiated Transfer/Purchase of the coordinating agencies 1-800 #s, to transfer to DWMHA 1-800 #, October 2014.

PRIORITY ISSUE #7. IMPROVE HEALTH AND SAFETY
SCORE: MET

Action Step #1. See Priority Issue #4, Action Step #2a.

Action Step #2. A Performance Improvement Work Group was formed on March 18, 2015 to review the data on the prevalence of falls in the intellectual/developmental disabled persons served population; identify the root causes; plan a prevention strategy; measure the impact; and analyze the outcome. To date the group includes Quality Improvement and Monitoring Staff; Certified Peer Support Specialists; a Nurse with community living supports provider; Pharmacologist, Director of Office of Peer Participation & Advocacy; and Customer Service Manager (where are the MCPNs and Providers?). The Work Group continues to recruit community members. The Study Topic is: Improving Fall Precautions for I/DD Consumers in Specialized Residential Care and Semi-Independent Living Settings via Implementation of a Fall Risk Assessment & Training. Three questions will be identified for screening risk of falls on the DWMHA system wide Bio-psycho-social Assessment. The Work Group developed a Fall Risk Screening to be piloted in select group homes by Supports Coordinators. A Guide for Fall Risk Screening was developed and training of Supports Coordinators began on February 17, 2016.
Action Step #3. The Wellness Self-management Performance Improvement Project began in FY13 and continues. The Study Question is: Do the targeted interventions result in an increase in the participation percentage of adult SMI consumers with at least one Chronic Health Condition completing a Peer-Led Wellness Self-Management Workshop as reported to DWMHA Mental Health Wellness Information Network (MHWIN) during the measurement year?

To improve consumer engagement, DWMHA is following a closed group of enrollees who have at least one chronic health condition at four DWMHA SMI outpatient treatment programs for adults. DWMHA will intervene by pairing the consumer’s self-identified health condition(s) and motivation for change on the Healthy Michigan Plan Health Risk Assessment (DCH-1315) with a person-centered, face-to-face invitation to participate in to a Peer-Led Wellness Self-Management Program. This will occur within a session lead by a Case Manager or Peer Support Specialist utilizing motivational interviewing techniques. Enrollees will then be invited to participate in an Evidence-based or Promising Practice Peer-Led Wellness Self-Management Workshop. These sessions will be offered to the target population each quarter until the completion of a workshop can be confirmed.

Data is being collected by reviewing the encounter/claims data matching the targeted consumers with encounter code H0038 TT IH. DWMHA will measure the number of Study Population individuals that have completed an Evidence-based Wellness Self-Management Workshop at the four identified locations each quarter and compare to the target number of individuals needed to complete an Evidence-based Wellness Self-Management Workshop in order to accomplish the increase percentage of change from Baseline to Re-measurement at end of Year 1. The target is 2.6%. The Baseline number of participants was 52. Given the lag in processing claims the Year 1 data is being compiled.

Action Step #4. One of the major promotional activities at the Wellness Self-Management PIP sites have been the Weight Management groups. While these are not evidence-based and therefore are not measured as PIP activities. Yet they have created interest in the Wellness Self-Management Workshops. The Next Step Clubhouse had a Biggest Loser Contest which motivated consumers in their WHAM (Whole Health Action Management) Workshop. The PIP locations as well as other sites in the DWMHA Provider Network offer Weight Management Groups.

Action Step #5. DWMHA and its Provider Network assisted Healthy Michigan beneficiaries with re-enrollment in FY15.

In addition to these actions DWMHA also led the charge for the development of MI Care Connect. MI Care Connect is a health information exchange that will manage the behavioral health consent electronically, allow for the display of appropriate Care Connect 360 data, and appropriate assessment and care plan data for the purposes of highly effective care coordination to improve the health outcomes of DWMHA consumers. The data in MI Care Connect will enhance the integration of behavioral and physical health data throughout the tri-county region. In addition to the development of MI Care Connect, DWMHA is contracting with Care Management Technologies (CMT) to provide individual and aggregate data reporting and other data management tools to inform integrated clinical practice. As a result of these initiatives, DWMHA has already seen great improvements in the integration of our provider network, a milestone in effectively and responsibly caring for our consumers.

Below is the Chart of Priority Issues submitted in the FY14 Submission:

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<tr>
<th>Priority Issue</th>
<th>Reasons For Priority</th>
<th>CMHSP Plan</th>
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<tbody>
<tr>
<td>1. Increase Community Inclusion and Integration</td>
<td>A main theme addressed during the Stakeholder Focus Group meetings highlighted Community Inclusion and Integration as a</td>
<td>1) Develop an Authority philosophy and Practice Improvement Model between now and 7/31/2015.</td>
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<td>Priority Issue</td>
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| Priority Issue                | priority because they felt there is significant variation in the delivery of service in AFC homes.                                                                                                                  | 2) Implement The Quality Improvement Task Force recommendations:  
   a) Establish a 5 year plan with quantifiable targets to demonstrate movement of consumers from segregated housing programs to more inclusive and independent community residential settings. Year 1 a 1% decrease in AFC placements.  
   b) Create a “Residential Travelocity Brochure” and residential provider report card that offers an overall view of performance and tracks compliance with standards, policy and procedures, substantiated cases of abuse/neglect, recipient rights complaints, etc. Use the report card as a residential privileging tool.  
   c) Develop a set of core competencies for direct care workers. Pilot a certification program in Wayne County with the intent to support a statewide model in collaboration with MDCH.  
3) Develop and implement the Self-Determination PIP (now through 4/1/2016).                                                                                      |
| 2. Enhance Crisis Management  | Support input from stakeholder feedback as well as regulatory requirements (42 CFR 438.207) and maintain compliance with the QAPIP. DWMHA recognizes the need to maintain adequate provider network capacity which includes a robust crisis response capacity. | 1) Redesign the DWMHA Behavior Treatment process by 4/1/2016.  
2) Phase I: Add centralized mobile crisis team(s). Number to be determined during RFP process. RFP to be published May 2015. Implementation Oct 2015.  
3) Phase II: Add three crisis/CRU centers - one on East, West and downtown. Implementation will probably be by Oct 2016.                                                                 |
| & Response                    |                                                                                                                                                                                                                      |                                                                                                                                                                                                                                 |
|                               | The 2013 State of Michigan Health and Wellness Commission Report, Section VIII, Residential Care, item 3: Develop and adopt performance criteria for adult foster care homes.                                                                 |                                                                                                                                                                                                                                 |
|                               | MDCH FY 2013 Legislative Appropriations designed to develop a plan related to training requirements for direct-support staff. Supporting evidence can be found in the Estimated FTE Equivalent narrative.                                                                 | 1) Redesign the DWMHA Behavior Treatment process by 4/1/2016.  
2) Phase I: Add centralized mobile crisis team(s). Number to be determined during RFP process. RFP to be published May 2015. Implementation Oct 2015.  
3) Phase II: Add three crisis/CRU centers - one on East, West and downtown. Implementation will probably be by Oct 2016.                                                                 |
|                               | Implementation of the Home and Community Based Waiver Final Rule.                                                                                                                                                     | 1) Redesign the DWMHA Behavior Treatment process by 4/1/2016.  
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<td>This is also supported by the recognition of the increasing number of at-risk youth due to the increase in number of children in poverty, youth in out-of-home placement, and the current dropout rate.</td>
<td>The AFP 2013 highlighted this as one of the areas of focus for all PIHPs across the state.</td>
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### 3. Expand Capacity for Improving Practices

The Stakeholder Focus Groups ranked this as one of the top priority areas for DWMHA to ensure the establishment of valuable tools that meet the needs of persons served are established.

1) Conduct Practice Improvement Program Model reviews
   a) 50 Reviews between 4/1/2015 – 3/31/2016
2) Deliver Workforce Training system wide (4/1/2015- through 3/31/2016)
   a) Trauma informed (650 staff & 20 community partners/1st responders)
   b) MH First Aid (1,000 participants)
   c) Increase Workforce Stainability Training on-line courses
3) Increase Capacity of Evidence-Based Practices(PMTO, Wraparound, IMH, PSP, TF-CBT) by 10% (4/1/2015 - 3/31/2016)
4) Autism/ABA Services

### 4. Enhance Recovery Oriented System of Care

The Stakeholder Focus Groups ranked this as one of the top priority areas for DWMHA. Additionally, the Application For Participations (AFP) 2013 highlighted this as one of the areas of focus for all PIHPs across the state.

1) Develop and implement the Self-Determination PIP (4/1/2015 through 4/1/2016.
2) Reduce substance abuse, to protect the health, safety, and quality of all life for all residents of Wayne County by the following:
   a) Decrease prescription/OTC drug abuse by increased use of the Michigan Automatic Prescription System by facilitating a prescription abuse conference10/1/2016
   b) Enhance our recovery housing initiatives (increase the days by 6 months instead of 90 days, starting, April 22, 2015).
   c) Reduce impact of excessive alcohol with youth use by reviewing MiPhy Data and implementing the Youth Risk Behavior Survey. This will prevent and reduce gaps in services in our region.
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<tr>
<td>5. Achieve Operational Excellence</td>
<td>Based on the DWMHA vision to become the recognized leader for community based specialty services and supports and to best meet the needs of the people we serve, DWMHA will continue to transform itself into a Consumer and Community Focused, Data Informed and Evidence Based model of strategic and operational efficiency and effectiveness and thereby contribute to the reduction of the per capita cost of health care.</td>
<td>1. DWMHA is a Data Informed Organization Objectives:</td>
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<td>a) Implement the Authority’s Analytics Work Groups in the First Quarter of FY15</td>
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<td>b) Establish an initial set “Corporate Key Performance Indicators” by the end of the second quarter FY15 (April 1).</td>
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<td>c) Develop a Report card, by MCPN of the quality and completeness of transaction data from the Provider Network through the MCPNS by September 30, 2015</td>
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<td>2. Timely Completion of Major Projects at DWMHA Objectives:</td>
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<td></td>
<td>a) Negotiate and Implement new MCPN contracts by January 1, 2015</td>
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<td>b) Implement the CA-SUD Functions at the Authority in the second quarter of FY 15</td>
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<td>c) Implement the Dual Eligible – MME Pilot by May 2015</td>
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<td>d) Complete move to the new Building by September 30, 2015</td>
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<td>f) Recommend to MDCH administrative efficiencies by September 30, 2015</td>
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<td>3. DWMHA will demonstrate good stewardship of its financial resources and will manage those resources in the most effective and efficient manner. Objectives:</td>
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<td>a) Establish, execute and amend the Board approved FY15 Authority Budget and manage Authority financial resources, as impacted and informed by State of Michigan budget appropriations, Medicaid and HMP revenue rate adjustments at MDCH, and by prioritized and quantifiable changes in demand and need in the network and community, in accordance with duly established policies and procedures throughout FY15.</td>
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<td>i. Manage the MCPN, and other contracts, within approved budgets and enforce contract provisions as necessary.</td>
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<td>ii. Manage the Authority Administration Budget</td>
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<td>iii. Update the Board of Directors as to the status of the Budget on a quarterly basis</td>
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<td>iv. Establish a Financial Dashboard for the Board of Directors which may also be shared with general public</td>
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<td>b) Enhance management by fund source at DWMHA and throughout our network.</td>
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<td>i. Establish cost and utilization leadership and analytics workgroups in the first quarter of FY15.</td>
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<td>ii. Develop and enhance analytic and monitoring tools and processes to provide data informed management throughout FY15.</td>
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<td>c) Seek appropriate funding for DWMHA from MDCH.</td>
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<td>- Staff will advocate for appropriate funding and funding methodologies on various state committees Including Medicaid rate setting and General Fund allocation committees throughout FY15.</td>
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<td>d) Proactively manage risk.</td>
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<td>- Establish regular meetings of the newly founded Risk Management committee to identify, examine, manage and mitigate DWMHA exposure to various types of risk. Throughout FY15.</td>
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<td>4. DWMHA will continue to reduce the average number of days from referral to evaluation, from referral to IPOS, and from referral to ABA Direct Start.</td>
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| 6. Implement Integrated Care         | **Per the MDCH FY 2015 Key Strategic Priorities (BHDDA)** “Transform the Healthcare System” supports the mission to develop the Health Information Exchange to improve communication, customer experience and health outcomes. This comports with the Medicaid expansion authorized by the Affordable Care Act. Triple Aim of: 1. Improving the experience of care 2. Improving the health of populations, and 3. Reducing per capita costs of health care. | • Implement Dual Eligible program  
  o (5/1/2015 - 10/1/2015).  
• DWMHA Best Practice Task Force will make a recommendation for the Administrative infrastructure for integrated care by July 2015.  
• Ensure that DWMHA provider have processes to enable the delivery of substance use disorder and mental health services, and use evidenced-based practices to facilitate the integration of substance use/occurring disorders, mental health and primary care services by 4/1/2015. |
| 7. Improve Health and Safety         | The Stakeholder Focus Groups ranked this as one of the top priority areas for DWMHA as we reviewed and discussed the regulatory drivers for Behavioral Health that are coming from CMS as well as from MDHC such as the ACA, the 2013 AFP, and the MDCH FY 2015 Key Strategic Priorities (BHDDA) *Promote & Protect Health, Wellness & Safety.  
Review of DWMHA data Critical incidents death review data show that our consumers are dying before their time which supported Stakeholder Focus Groups into ranking this as 7th in priority for DWMHA. | • Reduce substance abuse, to protect the health, safety, and quality of all life for all residents of Wayne County:  
  o Decrease prescription/OTC drug abuse by increased use of the Michigan Automatic Prescription System by facilitating a prescription abuse conference: 10-01-2016.  
• Implement a *Falls Prevention PIP* for the DWMHA I/DD population who are in Residential Settings (3/1/2015 thru 6/30/2017). Based on the results of the PIP, we will take them to scale.  
• Implement *Peer Wellness Self-Management PIP* that aims to improve the lives of 4,036 individuals eligible to participate (We are in Q3 of year of the PIP which will go through 2017) Based on the results of the PIP take them to scale.  
• Increase # involved in weight management activities through all of our populations.  
• Assist the Health Michigan Beneficiaries in the re-enrollment process to maintain their health benefits (May 2015). |
Appendix Q – DWMHA Compliance Report FY 14-15
DWMHA COMPLIANCE

MEMORANDUM

TO: Dr. Cheryl Munday, Chair
Program and Compliance (P&C) Committee
CC: P&C Committee Members
FROM: Muddasar Tawakkul Esq., Director of Compliance
DATE: October 6, 2015
RE: FY 2015 Annual Report

FISCAL YEAR 2015

A. Developments in Compliance:

1. Attorney General Gates Memo- In October 2015, I had the pleasure of attending the first annual Health Care Compliance Associations “Healthcare Enforcement” conference that gathered heads of federal and state enforcement agencies (i.e. OIG, AG, and FBI) to discuss massive increase in healthcare fraud and the increase in enforcements. By far the most important issue discussed consistently was the recent Deputy U.S. Attorney General Gates memo issued in September 2015. In a nutshell, this memo states the AG’s office will no longer settle with hospitals and other corporate entities unless individuals are also held personally liable (civil and criminal).

The Gates Memo has a huge impact on how fraud, waste and abuse is investigated and prosecuted. Historically, the AG would settle with corporate entities without holding individual's liable. Now, every settlement will require individual liability. Lastly, individual
liability will not take into account the "ability to pay" and the prosecutors will try to obtain severe penalties. Thus, every PIHP and Provider Network should be motivated by the Gates memo to curtain fraud, waste and abuse in the system.

2. Conflict of Interest - The states Attorney General is aggressively pursuing criminal and civil violations for Medicaid fraud predicated on conflicts of interest relating to CMH and PIHP boards and staff. For instance, the case against the former Summit Pointe CEO (Battle Creek CMH) highlights the potential fraud due to conflict of interests. Throughout the CMH/PIHP system the state is pushing to enforce conflict of interest principles. Thus, it’s imperative for the Authority to strengthen its conflict of interest enforcement pursuant to state law in all operations, which includes, but not limited to:

1. All Authority staff (part/full-time) are required to disclose all conflicts when hired and update on an annual basis. Division of Compliance (Compliance) is conducting new employee training to ensure all conflicts are disclosed, in addition to, annual trainings.

2. The Board is required by state and federal law to disclose any and all financial and personnel conflicts and abstain from voting on matters involving these conflicts. Furthermore, conflict of interest principles also include the preclusion of promoting or urging, on behalf of individuals or entities, which may pose an appearance of a conflict. Board has adopted policies that should curtail these issues but they need to be enforced and implemented.

3. Open Meetings Act - (OMA) The state legislature has recently amended the OMA and is proposing additional changes to the law that indicate the “public’s right to access and transparency is more important than any operational or logistical concerns of local government. 1" These changes have strengthened language requiring all board “deliberations, actions and discussions” on pending matters take place in a proper forum. The failure to follow OMA can result in a board action being invalidated and fines being paid by the Authority or the imposition of criminal sanctions.

Due to the strict enforcement of conflict of interest principles and the OMA, all Board members should receive extensive training on the various conflict of interest and OMA rules and regulations to ensure compliance. This training should be in-depth and provide various examples and discussion on the various rules. Compliance is in the process preparing a training and proposing that this training take place in January or February of every year and be part of new Board member orientation.

B. Investigations:

Fiscal Year 2015 has been a very busy for the Division of Compliance (Compliance) regarding the number of investigations initiated or conducted. In FY 2015, Compliance
conducted twenty-five (25) new investigations, of which seven (7) did not warrant a full investigation since a precursory review determined that the allegations did not rise to the level of fraud, waste and abuse. In addition, Compliance continued and completed its investigation regarding Gateway/Team Mental Health, which began in FY 2014, and resulted in notification to the state OIG. As a result of these investigations, the Authority will be recouping $567,405.77 in overpayments for FY 2015.

Compared to FY 2014, Compliance only conducted eight (8) investigations in its “infancy” stage. As you will recall, prior to the creation of the Authority, the former Agency did not have a viable established compliance program. The increase in the number of investigations is a key indicator that program is operating since individuals are reporting more fraud, waste and abuse to the Authority.

1 Michigan Bar Journal September 2015/
The following is a general breakdown of the type and number of complaints received in FY 2015:

<table>
<thead>
<tr>
<th>Types of Reports</th>
<th>Number of Reports Received</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIPAA</td>
<td>3</td>
</tr>
<tr>
<td>Overpayments</td>
<td>12</td>
</tr>
<tr>
<td>Coordination of Benefits</td>
<td>1</td>
</tr>
<tr>
<td>Exclusions</td>
<td>3</td>
</tr>
<tr>
<td>Neglect and abuse</td>
<td>3</td>
</tr>
<tr>
<td>Other matters</td>
<td>3</td>
</tr>
</tbody>
</table>

In addition to conducting compliance investigations, Compliance also reviewed and issued fifteen (15) conflict of interest waiver requests in FY 2015. Lastly, Compliance was involved in three (3) personnel related investigations and hearings.

**C. Accomplishments/Goals:**

In addition to the duties of performing investigations, Compliance is responsible for the development of policies and assists in conducting training:

1. Revised the Compliance Plan, Standard of Conduct Policy, Investigation Policy, and a Conflict of Interest Policy to comport to the requirements of the “Dual Eligible’ Project.

2. As required by the “Dual Eligible” Project, developed the Authority’s Fraud, Waste and Abuse Policy and the training that is administered by the Virtual Center of Excellence (VCE).

3. Assisted in the revision of the Authority’s Provider Manual section on “compliance.” This revision was necessary to meet the new state standards and “Dual Eligible” Project.

4. Conducted numerous compliance, standard of conduct and conflict of interest training for all Authority staff, Board members, and the Substance Use Disorder Advisory Committee.

5. Participated in quarterly claim reviews conducted by Quality staff.
6. Provided training to staff and the Provider network, including SUD, on the rules for “Medicare/Medicaid Overpayment.”

7. Assisting the Board’s Policy Subcommittee draft its board policies.


9. Continually assisted departments with the development of policies and procedures to comport with various federal and state regulatory schemes.

10. Involved in a “compliance review” being conducted by each of the Integrated Care Organizations (ICO) as part of the “Dual Eligible” Project.

The aforementioned list is not exhaustive but demonstrate the most important milestones that were accomplished in FY 2015. Nevertheless, the Authority’s compliance program is continuing to develop and there are additional goals that need to be accomplished in FY 2016 to have a robust compliance program, which will include:

1. Update and Conduct the compliance training for all employees and board Members in January-February 2015. The Board training should have a strong emphasis on conflict of interest and OMA.

2. Work with IT to conduct an “enterprise-wide audit” to check for potential "privacy" or "security" breaches.

3. Continue trainings for the respective staff and provider network as it relates to Medicaid overpayments, investigations, and security breaches.

4. Implementation of new software to conduct monthly exclusion checks for Authority employees. Our goal is to utilize the software to check on employees of the provider network as a whole when we internally begin the privileging process for providers.

5. Implement an “audit/monitoring” schedule to selectively assess some of our risks. This may be done through a “third party” contractor.