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PROGRAM COMPLIANCE COMMITTEE MEETING
Wednesday, February 9, 2022
2nd Floor Conference Room
1:00 p.m. - 3:00 p.m.

REVISED AGENDA

I. **Call to Order**

II. **Moment of Silence**

III. **Roll Call**

IV. **Approval of the Agenda**

V. **Follow-Up Items from Previous Meeting - None**

VI. **Approval of the Minutes** – January 12, 2022

VII. **Report(s)**
   A. Chief Medical Officer – ***Deferred to March 9, 2022***
   B. Corporate Compliance

VIII. **Quarterly Reports**
   A. Managed Care Operation
   B. Residential Services
   C. Substance Use Disorder

IX. **Strategic Plan Pillar** - Access

X. **Quality Review(s)**
   A. Quality Assurance Performance Improvement Plan (QAPIP) Description Update FY 2021-23

XI. **Chief Clinical Officer's Report**

XII. **Unfinished Business**
   A. **BA #21-36 (Revised 2)** – Independent Evaluator for Autism Spectrum Disorder (ASD) – Children's Center of Wayne County, Inc.

Board of Directors

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Dorothy Burrell
Kevin McNamara

Kenya Ruth, Vice-Chairperson
Lynne F. Carter, MD
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Dora Brown, Treasurer
Michelle Jawad
William Phillips

Dr. Cynthia Taueg, Secretary
Jonathan C. Kinloch

Eric W. Doeh, President and CEO

XIII. New Business
(Staff Recommendations):

A. **BA #22-47** – Mental Health First Aid (MHFA)
B. **BA #22-49** – Tri-County Crisis Counseling Program
C. **BA #22-53** – Sleeping Bags/Coats - The Empowerment Plan
D. **BA #22-54** – Jail Plus – DWIHN's Provider Network
E. **BA #22-55** – American Rescue Plan Act (ARPA) – DWIHN's Provider Network

XIV. Good and Welfare/Public Comment

Members of the public are welcome to address the Board during this time up to two (2) minutes ***(The Board Liaison will notify the Chair when the time limit has been met)***. Individuals are encouraged to identify themselves and fill out a comment card to leave with the Board Liaison; however, those individuals that do not want to identify themselves may still address the Board. Issues raised during Good and Welfare/Public Comment that are of concern to the general public and may initiate an inquiry and follow-up will be responded to and may be posted to the website. Feedback will be posted within a reasonable timeframe (information that is HIPAA related or of a confidential nature will not be posted but rather responded to on an individual basis).

XV. Adjournment

PROGRAM COMPLIANCE COMMITTEE

MINUTES **JANUARY 12, 2022** **1:00 P.M.** ***VIRTUAL MEETING***

MEETING CALLED BY	I. Dr. Cynthia Taueg, Program Compliance Chair at 1:13 p.m.
TYPE OF MEETING	Program Compliance Committee
FACILITATOR	Dr. Cynthia Taueg, Chair
NOTE TAKER	Sonya Davis
TIMEKEEPER	
ATTENDEES	**Committee Members:** Dorothy Burrell; Dr. Lynne Carter; Michelle Jawad; and Dr. Cynthia Taueg **Staff:** Brooke Blackwell; Jacquelyn Davis; Judy Davis; Eric Doeh; Dr. Shama Faheem; Monifa Gray; Jennifer Jennings; Cassandra Phipps; Vicky Politowski; Ebony Reynolds; April Siebert; Yolanda Turner; Michele Vasconcellos; and Dan West

AGENDA TOPICS

II. Moment of Silence

DISCUSSION	The Chair called for a moment of silence.
CONCLUSIONS	Moment of silence was taken.

III. Roll Call

DISCUSSION	The Chair called for a roll call.
CONCLUSIONS	Roll call was taken by Board Liaison, Lillian Blackshire. There was a quorum.

IV. Approval of the Agenda

DISCUSSION/ CONCLUSIONS	The Chair called for approval of the agenda. **Motion:** It was moved by Dr. Carter and supported by Mrs. Burrell to approve the agenda. Dr. Taueg asked if there were any changes/modifications to the agenda. There were no changes/modifications to the agenda. **Motion carried**

V. Follow-Up Items from Previous Meetings

DISCUSSION/ CONCLUSIONS	A. **Year-End Reports (Clinical Practice Improvement)** – Provide more information/plan and feedback for Returning Citizens' Initiative – Ebony Reynolds, Clinical Officer of Clinical Practice Improvement submitted and provided more information for the Returning Citizen's Initiative. Ms. Reynolds reported any member that expresses a desire to work can be referred to our Individual Placement and Support (IPS) program which can assist them finding employment and employers who are willing to work with our Returning to Citizens with felonies. The IPS program does have a non-exclusion policy which means that a person's incarceration history, probation or parole status does not prevent them from finding employment for the individual. There is a very comprehensive list of felony-friendly employers provided to DWIHN by one of our jail providers, Central City Integrated Health (CCIH). It is located on the Re-entry Works website. It is used to link returning citizens to jobs and temporary agencies. Development Centers is also able to work with any Detroiter including those with a felony background. This program is in partnership with Detroit Economics Solutions Corporation. All of our jail providers do require background checks in which they do consider the offense and timeframe in which the offense was committed. Ms. Reynolds stated that she will look into the IPS program to see if there are any individuals that are Returning Citizens, separate that population and report on it during the Clinical Practice Improvement's quarterly report. The committee requested that staff track and provide a written report on a quarterly basis the success rate of those individuals that sought employment and were successful in receiving employment. **(Action)**

VI. Approval of Meeting Minutes

DISCUSSION/ CONCLUSIONS	The Chair called for approval of the November 10, 2021 meeting minutes. **Motion:** It was moved by Dr. Carter and supported by Mrs. Burrell to approve the November 10, 2021 meeting minutes. Dr. Taueg asked if there were any changes/modifications to the meeting minutes. There were no changes/modifications to the meeting minutes. **Motion carried.**

VII. Reports

DISCUSSION/ CONCLUSIONS	A. **Chief Medical Officer** – Dr. Shama Faheem, Chief Medical Officer submitted and gave highlights of her Chief Medical Officer's report. Dr. Faheem reported: 1. ***Behavioral Health Outreach*** – DWIHN provided outreach and assistance to schools, teachers and students after the tragic Oxford shooting as well as other school threats and lockdowns. DWIHN's School Success Initiative's team and providers also provided support and outreach. DWIHN continues the advocacy and outreach efforts towards the COVID-19 cases and the new variant. Staff provided mental health support and outreach through the Tri-County training on "Is there a healthy response to stress?" to Peer professionals in November 2021. The three CMHs were the starting point of this outreach, but will expand to adding providers, hospital groups, etc. DWIHN and the Detroit Police Department (DPD) Pilot partnership continue their efforts to provide behavioral health for the homeless. 2. ***Quality Improvement Indicators*** – **Indicator 1 (Pre-admission Crisis Screening in three hours)** – Staff continue to meet the criteria for children

screening and working on meeting the criteria for adults in FY 2022 Q1. **Indicator 2a (Access of services or completion of Biopsychosocial within 14 days of request)** – This has been relatively lower than other Regions though the State does not have a standard compliance cut-off yet. Staffing shortages with providers putting holds to new intakes as well as to certain types of services and member no-show have been significant barriers. Staff is working closely with providers on identifying their plan for resuming intakes as well as to highlight the importance of meeting this standard. **Indicator 4a (Hospital discharge follow-up in seven (7) days)** – DWIHN continues to meet this standard for adults throughout FY 21 and met the standard for children in FY 21 Q4. Indicator 10 (Recidivism or readmission in 30 days) – DWIHN continues to meet this standard for children. DWIHN has had a trend of increasing compliance for adults with a significant increase between the last two quarters that was submitted to the State. The improvement trend as well as the preliminary data from FY 22 indicates possibility of meeting the criteria in FY 2022 Q1.

3. ***Performance Improvement Projects*** – MDHHS/HSAG has notified DWIHN about concentrating on the upcoming PIP topic to "Reduce racial and ethnic disparities in healthcare and health outcomes." Staff did not find disparities for a number of measures and indicators tested but found some disparity and opportunity for improvement with our hospital discharge 7-day follow-up appointment data. The brief description has been submitted to HSAG and awaiting their response. The review and analysis of the Michigan Mission Based Performance Indicator (MMBPI) reporting data for PI# 4a (The percentage of discharges from a psychiatric inpatient unit that were seen for follow-up care within 7days) has revealed a racial disparity with the African American population as compared to the White population served. DWIHN has submitted the Performance Improvement Project (PIP) topic to HSAG and to date, HSAG has not yet accepted the selected PIP. Dr. Taueg opened the floor for discussion. Discussion ensued. The Chair noted that the Chief Medical Officer's report has been received and placed on file.

B. **Corporate Compliance Report – *Deferred to February 9, 2022***

VIII. Quarterly Reports

A. **Crisis Services** – Dan West, Director of Crisis Services submitted and gave highlights of the Crisis Services' quarterly report. Mr. West reported:

1. ***FY 21/22 Accomplishments*** – DWIHN's Hospital Liaisons staff were involved in 999 cases receiving crisis services for Q1 of FY 21/22. The overall diversion rate from inpatient care was 48%. Staff received 812 AOT orders in collaboration with Probate Court which were uploaded into MH-WIN and monitored monthly in coordination with the CRSP. CRSPs continue to be educated on crisis alerts and coordination of processes are taking place to involve more peer-to-peer reviews to influence recidivism. Staff working with law enforcement in real-time to utilize the CSUs as opposed to the emergency departments depending on concerns.
2. ***FY 21/22 Q1 Area of Concern*** – Individuals testing positive for COVID in the ED, needing inpatient placements and being denied.
3. ***Plans for FY 21/22 Q2*** – Continued efforts to solidify a process to educate and utilize AOT orders with the 36th District Court and relevant staff. Develop RFP for Crisis Assessment Center; Work with inpatient facilities to address difficulties related to placement with COVID positive members; and

	Work with CRSPs to establish procedures for crisis alerts to address recidivism. Dr. Taueg opened the floor for discussion. Discussion ensued. B. **Utilization Management** – Jennifer Jennings, Director of Utilization Management submitted and gave highlights of the Utilization Management's quarterly report. Ms. Jennings reported: 1. ***Serious Emotional Disturbance Waiver (SEDW)*** – As of December 2021, 52 youth were enrolled in the SEDW, slightly down from previous quarters. 2. ***General Fund*** – There were 1,152 approvals for General Fund authorizations. 3. ***Provider Network Hospital Admissions*** – There were 2257 inpatient admissions for Q4 (44% increase from Q3-2247). Staff continues to conduct bi-weekly case conferences with DWIHN's physician consultant to decrease the average length of stay and hospital admissions. 4. ***State Facilities*** – State hospital census counts remain consistent during Q1 despite restricted admissions. 5. ***Substance Use Disorder (SUD)*** – For Q1 of FY '22, there were 465 urgent authorizations (458 were approved within 24 hours); 2920 non-urgent authorizations (2520 were approved within 14 days by SUD/UM reviewers) slightly below the 90% threshold. 6. ***Milliman Care Guidelines (MCG)*** – For Q1 of FY 22, 2,581 members were screened. Since data was pulled early (12/16/21) due to the holiday, it is anticipated the screening volume will be similar to last quarter's report (3,089 cases). Staff continue using the guidelines to review member's length of stay and continued stay. 7. ***Interrater Reliability (IRR)*** – Annual testing for FY 20/21 is complete. The annual IRR report and the use of the 25th edition of the MCG guidelines were approved at the Improving Practices Leadership Committee meeting on 11/2/21. 8. ***Denials and Appeals*** – The three denials that did not meet the MCG medical necessity criteria for continued inpatient hospitalization and Applied Behavior Analysis (ABA) services and one appeal for the Q1. Dr. Taueg opened the floor for discussion. Discussion ensued. The Chair noted that the Crisis Services' and Utilization Management's quarterly reports have been received and placed on file.

IX. Strategic Plan Pillars

DISCUSSION/ CONCLUSIONS	A. **Customer** – Michele Vasconcellos, Director of Customer Services submitted and gave highlights of the Strategic Plan Customer Pillar's report. Ms. Vasconcellos reported that the Customer Pillar is at 93% completion. There are three goals under this pillar: 1. Enhance the Provider experience by September 30, 2022 – 82% completion 2. Ensure inclusion and Choice for members by September 30, 2021 – 97% completion 3. Improve person's experience of care and health outcomes by September 30, 2022 – 91% completion Dr. Taueg opened the floor for discussion. Discussion ensued. B. **Quality** – April Siebert, Director of Quality Improvement submitted and gave highlights of the Strategic Plan Quality Pillar's report. Ms. Siebert reported that the Quality Pillar is at 83% completion. There are four organizational goals under this pillar: 1. Ensure consistent Quality by September 30, 3022 – 72% completion

	2. Ensure the ability to share/access health information across systems to coordinate care by December 31, 2021 – 95% completion 3. Implement Holistic Care Model: 100% by December 31, 2021 – 85% completion 4. Improve population health outcomes by September 30, 2022 - 78% completion Dr. Taueg opened the floor for discussion. There was no discussion. The Chair noted that the Strategic Plan Pillars' Customer and Quality have been received and placed on file.

X. Quality Review(s) -

DISCUSSION/ CONCLUSIONS	A. **QAPIP Work Plan Update** – April Siebert, Director of Quality Improvement submitted and gave highlights of the QAPIP Work Plan Update. Ms. Siebert reported: 1. ***Michigan Mission Based Performance Indicators (MMBPI) preliminary data for Q4 PI#10 (Adult Recidivism) – The percentage of readmissions to an inpatient psychiatric unit within 30 days of discharge from psychiatric inpatient unit*** – DWIHN's efforts has continued to show improvement through Recidivism Workgroups which includes our CRSP providers. These initiatives have led to a decrease with the adult recidivism rate from 22% during Q2 in FY 20 to 15.01% for Q4 in FY 21, with a total population rate of 14.51%. This is the second lowest rate in the last two years and the threshold for PI#10 is 15% or less. 2. ***Behavior Treatment Advisory Committee*** – DWIHN organized the two system-wide training events on the Technical Requirements of Behavior Treatment Plans (BTP). The first training event was for Habilitation Supports Waiver (HSW) providers on MDHHS' requirements for the beneficiaries of HSW and BTP. DWIHN hosted the virtual technical assistance with MDHHS for network providers on the requirements of Behavior Treatment review and Occupational Therapy Evaluations in FY 20/21with 133 participants in attendance. All delegated contracted CRSP providers are to have the BT review process in place and the requirements are included in the CRSP contract for FY 20/21. The Behavior Treatment Category has been implemented in MH-WIN Critical and Sentinel Reporting Module to improve the systemic under-reporting of the four reportable categories for the members on BTP. DWIHN submits quarterly data analysis reports to MDHHS. 3. ***Critical/Sentinel Event Training*** – Staff has completed 100% review of backlog events for FY 19/20 with 95% closure rate and now focusing on review of FY 20/21 events. During FY 20/21, 316 staff throughout the provider network participated in the Critical/Sentinel Event training via the webinar platform. The Critical/Sentinel Event Guidance Manual was updated as the Performance Improvement team worked with the IT department to streamline and improve the MH-WIN electronic reporting access in the Critical/Sentinel Event Module. The Sentinel Event/Peer Review Committee (SEC/PRC) has expanded and revamped processes to include broader representation from DWIHN's department leaders. Staff along with ORR is working with the IT department to rectify glitches in data entry/data pull directly related to our Death Reporting and Closure process. Dr. Taueg opened the floor for discussion. There was no discussion. The Chair noted that the QAPIP Work Plan Update has been received and placed on file.

XI. Chief Clinical Officer's (CCO) Report

DISCUSSION/ CONCLUSIONS	***The Chief Clinical Officer's (CCO) Report has been deferred to February 9, 2022***

XII. Unfinished Business

DISCUSSION/ CONCLUSIONS	A. **BA #20-49 (Revised2)** – OBRA/PASARR Services – Neighborhood Service Organization (NSO) – Staff requesting board approval for a one-year extension for an estimated amount of $2,229,120.00 starting April 1, 2022 through March 31, 2023. The total cost of the contract would increase to $6,687,360.00. Dr. Taueg opened the floor for discussion. There was no discussion. B. **BA #21-13 (Revised3)** – Wayne County Health, Human and Veteran's Services – Third Circuit Court, Clinic for Child Study – Staff requesting board approval to amend this contract with The Third Circuit Court (3CC), Clinic for Child Study and increase funding by $940,000.00 in general fund dollars for the fiscal year ended September 30, 2021. The amendment will include the Youth Assessment Screening Instrument (YASI). Approval of this amendment would bring the total amount of 3CC's allocation to $1,540,000.00. Dr. Taueg opened the floor for discussion. There was no discussion. C. **BA #21-69 (Revised)** – DWIHN Proposed General Fund Program Allocation – The Children's Center Foster Care Program – Staff requesting board approval to amend this board action to include The Children's Center (TCC) Foster Care Program. No additional funds are requested as funds allocated to the other programs in this board action will be re-allocated to the foster care program. Also, this board action is to include Wayne Health as the provider for the Mobile Outreach Unit. Funds will be re-allocated between these specific programs without board approval to reduce the risk of lapsing funds to MDHHS. Dr. Taueg opened the floor for discussion. There was no discussion. The Chair bundled the board actions and called for a motion on BA #20-49 (Revised 2); BA #21-13 (Revised 3); and BA #21-69 (Revised). **Motion:** It was moved by Dr. Carter and supported by Ms. Jawad to move BA #20-29 (Revised2); BA #21-13 (Revised 3); and BA #21-69 (Revised) to Full Board for approval. Dr. Taueg opened the floor for further discussion. There was no further discussion. **Motion carried.**

XIII. New Business: Staff Recommendation(s)

DISCUSSION/ CONCLUSIONS	A. **BA #22-41** – Michigan Child Collaborative Care Program (MC3) and the Behavioral Health Consultant – Starfish Family Services – Staff requesting board approval for a one-year contract for an amount not to exceed $79,922.00. Starfish Family Services will provide local oversight, in collaboration with MC3 program of the Behavioral Health Consultant as they implement MC3 in Wayne County as well as work in concert with other regional Behavioral Health Consultants. The State of Michigan identified the agency to provide the Behavioral Health Consultant. Dr. Taueg opened the floor for discussion. Discussion ensued. B. **BA #22-42** – Substance Use Disorder (SUD) Parenting Postpartum Women Pilot – Elmhurst/Naomi's Nest and Central City Integrated Health Network – Staff requesting board approval for a one-year contract of the Parenting Postpartum

	Women Pilot that has been awarded by MDHHS for $267,302.00. Central City Integrated Health and Elmhurst/Naomi's Nest are the two providers that have been selected to implement this program. DWIHN has the discretion to allocate the funds among the providers based upon utilization as long as the total amount of the contract does not increase. Dr. Taueg opened the floor for discussion. Discussion ensued. C. **BA #22-43** – Wayne Health-Mobile Outreach Clinic – Wayne State University Physicians' Group - Staff requesting board approval for a one-year contract for the fiscal year ended September 30, 2022 for an amount not to exceed $565,000.00 with WSU's Physicians Group dba Wayne Health. Wayne Health provide physical health screening, COVID Testing, COVID vaccinations and behavioral health screening. Dr. Taueg opened the floor for discussion. There was no discussion. D. **BA #22-44** – Infant and Early Childhood Mental Health Consultation in Home Visiting (IECMHC-HV) – Development Centers, Inc. – Staff requesting board approval for a one-year contract for the fiscal year ending September 30, 2022 for an amount not to exceed $53,913.00. This is a prevention based, indirect intervention that teams a mental health professional with home visiting programs to improve the social, emotional and behavioral health of children. Dr. Taueg opened the floor for discussion. Discussion ensued. The Chair bundled the board actions and called for a motion on BA #22-41; BA #22-42; BA #22-43; and BA #22-44. **Motion:** It was moved by Dr. Carter and supported by Ms. Jawad to move BA #22-41; BA #22-42; BA #22-43; and BA#22-44 to Full Board for approval. Dr. Taueg opened the floor for further discussion. There was no further discussion. **Motion carried.**

XIV. Good and Welfare/Public Comment

DISCUSSION/ CONCLUSIONS	***There was no Good and Welfare/Public Comment to review.***

ACTION ITEMS	Responsible Person	Due Date
1. **Follow-Up Items from Previous Meeting – Year-End Report (Clinical Practice Improvement) Returning Citizen's Initiative** – Track and provide a written report on a quarterly basis the success rate of those individuals that sought employment and were successful in receiving employment.	Ebony Reynolds	**March 9, 2022**

The Chair called for a motion to adjourn the meeting. **Motion:** It was moved by Dr. Carter and supported by Mrs. Burrell to adjourn the meeting. **Motion carried.**

ADJOURNED: 2:28 p.m.
NEXT MEETING: Wednesday, February 9, 2022 at 1:00 p.m.

CORPORATE COMPLIANCE MEMORANDUM

TO: Dr. Cynthia Taueg, Chairperson
Program Compliance Committee

FROM: Nichole Hunter
Corporate Compliance Department

DATE: February 9, 2022

RE: **REPORT TO PROGRAM COMPLIANCE COMMITTEE**

1. **Update on Provider Audit** – Compliance was in the process of auditing a provider relative to billings by one of the provider's clinicians with respect to T1017. The provider is in the due diligence phase of merging with another entity which is anticipated to be completed by March 2022. In December 2022, Corporate Compliance is still in the process of obtaining copies of a thorough compilation of the clinician's billing of T1017 to determine whether inappropriate billing occurred and if recoupment is necessary.

2. **Update on Provider Audit –** Compliance was in the process of auditing a provider to determine whether double billing occurred after the closure of one of its facilities – January 24, 2022 – it was found that no evidence of double billing occurred.

3. **Update on Provider Audit** – Compliance has been working with Customer Service to counsel a Provider to determine whether a resident of Michigan that has been living in Indiana has met the requirements mandated under MDHHS to continue residency in Michigan for receipt of services in the state. This matter was reported to the OIG in July 2021, the OIG recommended that the Provider seek counsel directly from MDHHS prior to ceasing services.

4. **New Audit** - On February 2, 2022, Compliance received a referral to conduct an audit at the request of the OIG. Documents are being reviewed to determine next steps.

5. **Update on Provider location closures –** Since January 1, 2022, approximately 11 residential sites are in the process of closing for reasons that span from operational funding, low member residency, and/or lack of staff to support the program.

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Detroit Wayne Integrated Health Network (DWIHN)
1st Quarter Report
October 2021- December 2021
Contract Management --Manage Care Operations (MCO)

Managed Care Operations

Contract Managers and Providers:
There were over 400 contracts sent out for signature to our provider network for the new fiscal year 2022.

New Providers/ Merger/Closures Changes to the Network /Provider Challenges:

Providers continue to struggle with staff shortages to maintain staff in homes as well as staff in general among all of our providers resulting from the pandemic.

Closure recap for the 4rd Quarter are as follows:
Summary of Closures:

Provider Closure/Mergers FY 21-22					
Description	1st Qtr.	2nd Qtr.	3rd Qtr.	4th Qtr.	YTD Totals
Licensed-Residential Homes	2				
Unlicensed /Private Home Services (SIL's)	3	7			
Clubhouse services	1				
Outpatient services, SUD services	4	1			
Provider Organization Merger(s)	1				
Total	11	8			19

Although our network has experienced challenges we continue to support the network

a. Through training, and educating providers
b. Deployed IT equipment to providers providing them with laptops/iPad
c. Paying out a one-time lump sum retention payment to clinical and non-clinical employees
d. Paid out a provider stability payment for Overtime payments to providers
e. Issued a direct care wage increase
f. Implemented a 5% increase among all codes in our network
g. And DWIHN also continues to meet with providers to find solutions that will better all during these times.

SERVICE AVAILABILITY – PROVIDERS:

Provider biggest challenge to date is the staff crisis/ shortage.

MHWIN system cleanup of records/Online Directory:

Over the last quarter has the team has worked on cleaning up records in MHWIN. There were several gaps identified and addressed

a. Cleaned up Staff records in MHWIN, that need NPI #'s
b. Added ADA site accommodation(s) fields in MHWIN with hours of operations for MDHHS requirements.
c. Reviewed the SAP database for accuracy that was submitted to the State.
d. Met with our IT Dept in an effort to make the directory more compliant with State requirements

Internal /External-Training Meetings Held:

a. Met with 5 CRSP providers regarding the 14-day intake calendar slots where providers are experiencing staff shortages in the intake department for new intakes
b. Held the first internal meeting to discuss network adequacy and provider gaps in services
c. Reviewed all changes to the Provider Manual for 2022, will be finalized end of Feb 2022.
d. Weekly meeting with Continuum of Care Board (COC), to discuss HUD/Homeless projects.

PIHP Email Resolutions and Phone Provider Hotline:

For the month of January, we received/answered 84 emails and 10 phone messages from providers with concerns related to claims billing, IT concerns, Procedure Code changes, Single Case agreements, and changes with the FY 2022 State Code/Modifier changes.

NEW PROVIDER /NEW PROGRAMS:

We have not added any new providers for the quarter, but we continue to received daily new request to become part of our network.

Provider and Practitioner Survey 2021

The Provider/Practitioner survey is a way for DWIHN to get feedback from providers and practitioners on how well we are doing as a manager of care, this survey also helps us identify any gaps in process or procedures as well as reveal any areas for improvements.
This survey allows us to gain a better understanding of how we can support and maintain a strong provider network that will provide high quality supports and services to our members.

Goals Executed:

- Improve relationships with providers through training and one on one provider virtual visits quarterly.
- Improved the Online Provider/Practitioner Directory.
- Enhance/improve our Provider Manual
- Monitor compliance and non- compliant providers in regards to recipient rights complaints, timely billing and proper utilization of service codes.
- Ensure our compliance and network adequacy with state regulations based on members served to the number of provider/ practitioners and type of services.
- Improve/implement a network adequacy process/procedure that will assist in structuring our network based on the needs of the members to identify any gaps in services we offer

Provider /Training Meetings Held:

We have resumed our Outpatient and Residential Providers every 6weeks which started on January 7th (10am-12:30pm) and will continue to the end of the year.

Submitted by June White 1/31/22

Detroit Wayne
Integrated Health Network
Residential Services

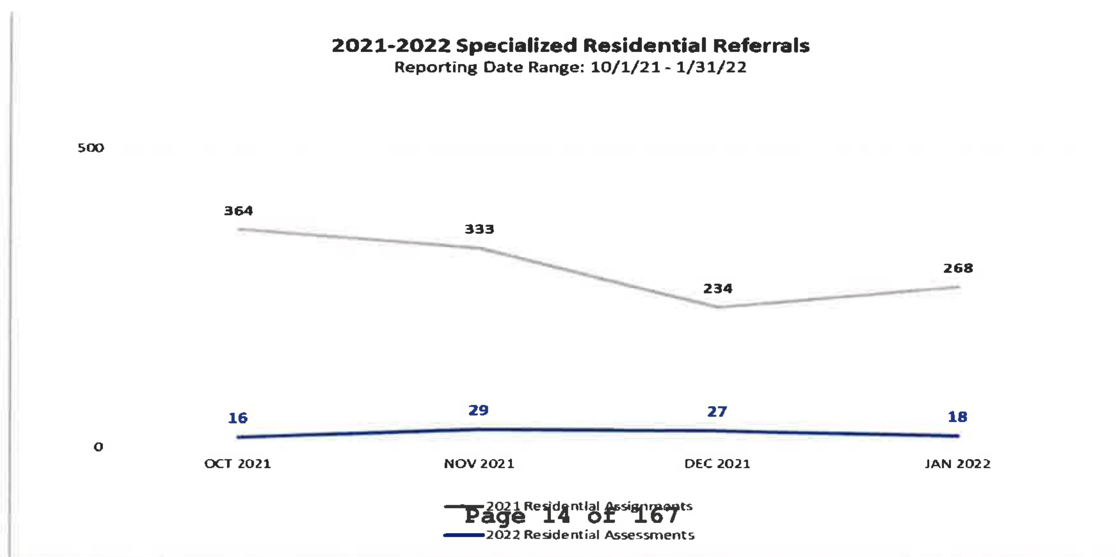
FY 2020-21 Department Summary: Quarter #1
Residential Director, Shirley Hirsch, LMSW
Report Date Range: 10/1/21 – 1/31/22

Residential Assessment Productivity

		Q1	January	TOTALs
2021	# of Referral Requests	931	268	1,199
2022	**# of Referral Requests**	513	227	**740**
	AMI Requests	217	164	**381**
	IDD Requests	296	63	**359**
	Assessments in Specialized Setting	30	11	**41**
	Crisis Residential Units	11	8	**19**
	CRSP	203	55	**258**
	Emergency Departments	34	22	**56**
	Inpatient Hospitals	195	107	**302**
	Nursing Homes	15	10	**25**
	Out-of-County	1	0	**1**
	Pre-placement (C.O.P.E.)	10	3	**13**
	SD-to-Specialized Residential Services	8	6	**14**
	Youth Aging Out (DHHS)	6	5	**11**

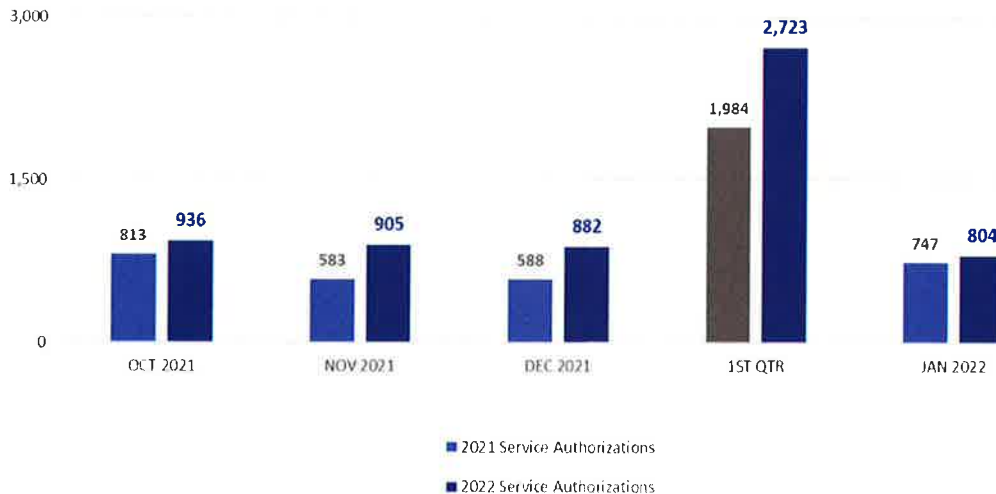
Quarter #1 Referral Outliers

- Inpatient Penetration Rate: QTR 1 – **0.89%** JAN 2022 – **0.68%**
- HAB Waiver Referrals: QTR 1 – **13** JAN 2022 – **19**
- Facility Closures: QTR 1 – **13** JAN 2022 – **19**



Service Authorizations

	Q1	January	TOTALs
2021	**1,984**	**2,863**	**12, 317**
2022	**2,743**	**804**	**3,527**
Auth requests COMPLETED	1,379	330	1,709
Internal Requests (residential staff)	558	175	733
Requests returned to CRSP	806	299	1,105
Interim IPOS (Entered by team)	104	22	126
MHWIN Queues requests	2,165	629	2,793
AMI Requests	1,019	269	1,288
IDD Requests	1,704	535	2,239
Approved >14 Days	1,908	476	2,384
Returned > 14 Days	799	328	1,127
Approved < 14 Days	9	0	9
Returned < 14 Days	7	0	7



Authorization Team Projects

- Bundled Authorizations for H2X15/T2X27 Billing Unit Shortage (October 2021)
- H2X15/T2X27Standardized Process Development (November 2021)
- Day-Time Monitoring Auth Extensions (November/December 2021)
- New CPT Rates-5% Increases (January 2022)
- H2X15 Unit Shortage (January 2022)

COVID-19

Reported Cases/Deaths

		Q1	January	TOTALs
2021	COVID-19 Positive Cases	56	33	173
	COVID-19 Deaths	1	0	7
2022	COVID-19 Positive Cases	35	60	**95**
	COVID-19 Deaths	1	1	**2**

- Conclusion of department COVID-19 case and vaccination tracking and reporting. (October 2021)
- Wayne County Health Dept Collaboration with DWIHN to continue in-home education of vaccine to residential providers/residents for those who've expressed interest. (October 2021)
- Project Reach Out initiated verifications of vaccinated members & DCW Staff eligible for boosters. (December 2021)
- Specialized residential facilities impacted by members/DCW staff testing positive for COVID-19 (January 2022)

Quarantine Facility Utilization

		Q1	January	TOTALs
2021	# of Members Serviced at Quarantine Facilities	57	15	72
2022	# of Members Serviced at Quarantine Facilities	**20**	**14**	**34**

- The department downsized the initial 5 quarantine facilities to 3 (9 beds) due significant decline in quarantine referrals prior to the end of 2021.

Vaccination Booster Reporting

- Report is attached for review.

1st Quarter/January 2022 Completed Process Implementations

Residential Assessment Development

- **October 2021**: Completed 6 IDD CRSP trainings; with a total of **160 CRSP attendees**:
- **November 2021**: ***Special Assignment:*** Currently developing process flow and form to utilize for HAB waiver referrals for eligible IDD members
- **November 2021**: Completed 5 AMI CRSP trainings; with a total of **34 CRSP attendees**:
- **December 2021**: ***Reviews and Training***: Trained supports coordination staff of ***Community Living Services*** and ***Wayne Center*** review of the DWIHN Residential Assessment
- **December 2021**: ***DWIHN Residential Assessment:*** Completed 20 residential assessment reviews with the staff of ***Wayne Center, Community Living Services***, and ***All-Well Being Services***
- **January 2022**: ***Trainings:*** Special request to train new case management hires of ***Team Wellness Center-Eastern Market*** on the DWIHN Residential Assessment and alignment of clinical documentation with the IPOS for DWIHN members: ***completed on Monday, 1/24/2022 at 10 AM*** ()

Department Meetings/Trainings

- **CRSP/Residential Services Monthly Meetings**:
  - *Quarter #1 # of Meetings held: 44; # of Attendees: 205*
  - *January 2022 # of Meetings held: 12; # of Attendees: 58*
- **CRSP Case Management/Supports Coordinating Monthly Management Note training:**
  - *Tuesday, 12/14/21 in Teams (10 AM – IDD & 2 PM – AMI)*
  - *# of Attendees: 364 (71 – IDD & 56 – AMI)*
- **CRSP Authorizations Refresher Trainings**:
  - *Quarter #1 # of Sessions: 6; # of Attendees: IDD (122) and AMI (68)*
  - *January 2022 # of Sessions: 2; # of Attendees: IDD (47) and AMI (34)*
- **CRSP/Residential Providers Monthly/Bi-Monthly Meetings:**
  - *Quarter #1 # of Sessions: 10 (6 – AMI & 3 – IDD)*
  - *# of Attendees: 364 (291 – IDD & 73 – AMI)*
  - ***Meetings are scheduled to resume February 2022***
- **CRSP/Residential Provider Advisory Meetings:**
  - *Quarter #1 # of Meetings held: 3; # of Attendees: 37*
  - *January 2022 # of Meetings held: 1; # of Attendees: 16*

Department Goals

Staffing

- Residential Care Coordinator Valerie Karageozian (10/4/21)
  - *HR to repost (1) Residential Care Specialist position.*
- Development of staff metrics
- Reviewing department processes

Automated Productivity Reporting

- Updated residential department documentation utilized by CRSP and residential providers into fillable/electronic documents. (October 2021)
- Residential Hospitalization Penetration reporting: Reporting of inpatient data of members that have received specialized residential services within 30 days of hospital stay. Report confirms residential members inpatient stay is less than 1% overall for 2021 fiscal year. (October 2021)
- Continued reformatting of productivity report to monitor timeliness and response to service requests. (October 2021)
  - *Smartsheet updates for new fiscal year reporting*
- Integrate State Hospital reporting in department monthly report. (November 2021)
- Residential Hospitalization Penetration reporting of inpatient data related to members that have received specialized residential services within 30 days of hospital stay. Report confirms residential members inpatient stay is less than 1% overall. (October 2021 thru January 2022)
- Continuing to refine/reformat productivity report to monitor timeliness and response to service requests

COVID-19 Vaccine Booster Reporting

- Residential Services Department initiated reporting of (eligible) Members that have received Vaccine Boosters on 12/1/21 through **Project: Reach Out**

	# of Members FULLY Vaccinated	Vaccine Booster Received
LICENSED		
City of Detroit	649	**113**
Western Wayne	1,243	**496**
UNLICENSED		
City of Detroit	93	**51**
Western Wayne	678	**79**

Date reporting range: 12/1/21-1/28/22

Substance Use Disorders (SUD) Summary
First Quarterly Report for FY 22
October 2021 to December 2021

DWIHN coordinates prevention, treatment, and recovery efforts for Wayne County residents. Our data collection shows that heroin and alcohol use are higher in our region. While some areas experience more significant consequences, service and associated problems are spread throughout the region. Therefore, DWIHN believes that there is a continued need for SUD education and having a recovery-oriented system of care.

The drug problem escalated, and it was a need to create new innovative initiatives that addressed Heroin/Opioid addiction in the Detroit Wayne County area.

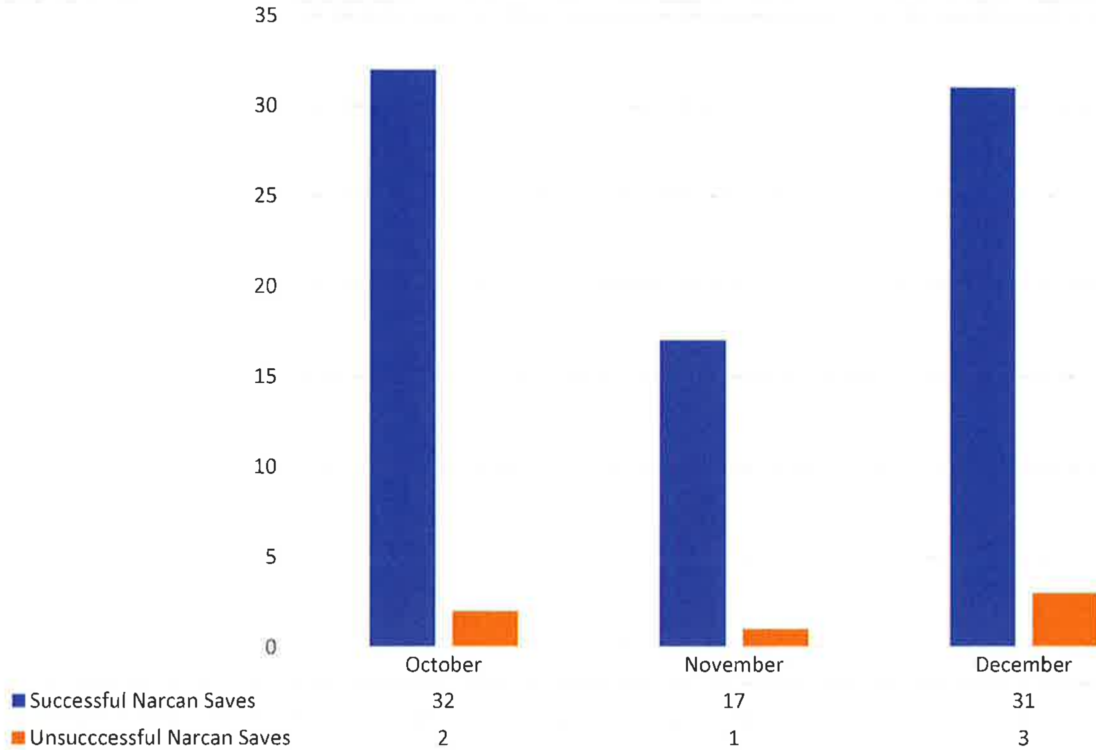
Naloxone Initiative Update

DWIHN's Naloxone Initiative program has saved 790 lives since its inception up to December 31, 2021.

From October to December 2021, DWIHN provided 25 Naloxone training

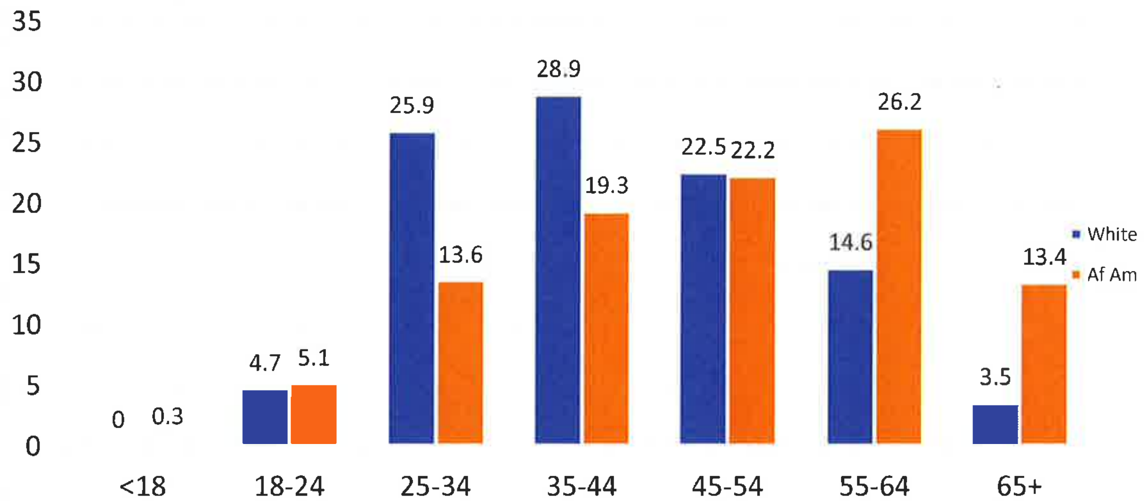
Naloxone Saves in Region 7 from 4th Quarter of FY22

Month	Successful Narcan Saves	Unsuccessful Narcan Saves
October	32	2
November	17	1
December	31	3
Total	**74**	**6**



DWIHN continues to train first responders, its providers, drug court staff, inmates/jail staff and the community on how to reverse an opioid overdose. DWIHN is increasing the number of providers that can train and distribute Naloxone in the community.

The medical examiners provisional data suggest that drug overdose deaths declined by 9.3% since April 2020 to April 2021 in Wayne County. We saw the following: Slight decrease in whites by 1% and a slight increase in African American by 1%.



Prescription and Heroin Efforts

Status Overview:

DWIHN has several initiatives that address the Prescription and Heroin Efforts:

Barbershop Initiative

Men are 24 percent less likely than women to have visited a doctor within the past year and are more likely to be hospitalized for preventable conditions like diabetes complications (Agency for Healthcare Research & Quality). The Barbershop Men's Health Initiative connects barbers and their clients with Naloxone training and health information and services to address men's health issues like diabetes, high blood pressure, oral health, healthy eating, prostate cancer, police brutality, and substance use disorder. Hosting a Barbershop Men's Health Initiative is an excellent opportunity for barbershop owners to share information about health programs and services offered by Detroit Wayne Integrated Health Network with their clients and employees. For the first quarter of the fiscal year, 22 DWIHN provider staff hosted 24 events

Hosting a Barbershop Health Day was successful! DWIHN provider staff will visit shops in the Wayne County Area and set up an information table to provide customers and employees with free SUD and Mental Health resources and education. They can also get customers and employees connected with SUD services in Wayne County. To schedule a Barbershop Health Visit, Barbershop can call DWIHN at 313 833-2500 for more information

State Opioid Response (SOR) Programs

Mobile Units

788 consumers served by a mobile unit
241 referrals to SUD by mobile units
448 drug screens by mobile units
470 peer supports by mobile units
148 naloxone kits distributed on mobile
5 Naloxone saves by a mobile unit

MDOC Program)

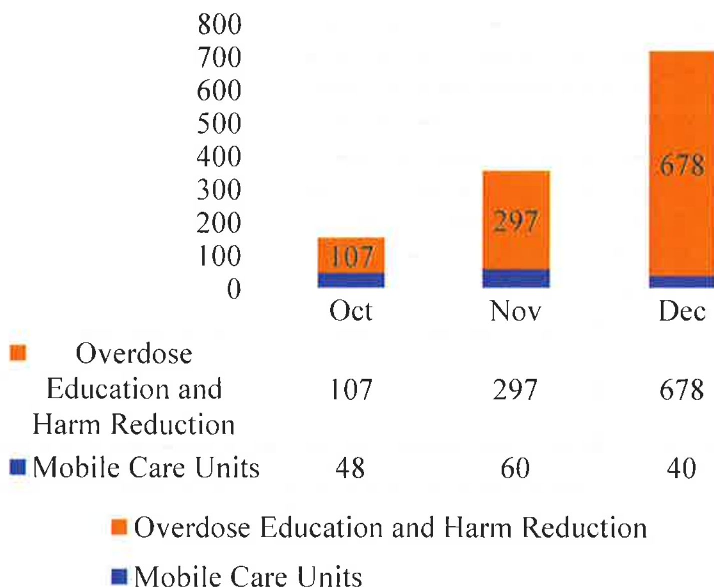
There were 49 probationers/parolees served by DWIHN SUD Programs. The offenders received individual, group and peer support services.

Month	# served	# MAT	#OP	# Residential	#recovery supports
October	22	1	17	5	20
November	17	0	15	2	13
December	10	0	9	1	9
Total	**49**	**1**	**41**	**8**	**42**

SBIRT Screenings for

Name	Number of contacts	Number of follow ups	Total
October	87	32	89
November	63	30	63
December	25	19	24
Total:	**175**	**81**	**176**

Overdose Education and Naloxone Distribution (OEND)



DWIHN has four providers under the SOR Grant conducting OEND trainings with harm reduction enhances and expands our existing Naloxone trainings within different caveats in the community. In FY 22, 1st Quarter our SOR programs distributed 1,082 narcan kits in the community.

DWIHN provides the following harm reduction strategies in the community as appropriate to the audience: access to Naloxone, peer support, latex condoms, fentanyl strips, and deterra bag distribution.

Deterra bags provide a convenient, discreet, environmentally and socially responsible method for getting rid of unused, unwanted, or expired prescription pills, liquids, and patches. Medications are deactivated, rendering them ineffective for misuse or abuse. In addition, the biodegradable bags contain activated carbon that breaks down chemical compounds in the drugs, making them safe for landfill disposal.

Fentanyl testing strips detect the presence of fentanyl and many of its known analogs in a drug sample. Fentanyl and its analogs are highly potent synthetic opioids primarily responsible for increasing heroin-related fatalities. Fentanyl has been found in counterfeit pharmaceutical pills and

cocaine, and other drugs. Fentanyl and various fentanyl analogs are highly potent synthetic opioids between fifty and hundreds of times stronger than heroin.

Latex Condoms aid in addressing the increasing number of substance abusers contracting infectious diseases due to unprotected sex and having unwanted pregnancies due to making poor choices.

February 9, 2022

Strategic Plan – Access Pillar

PCC Status Report

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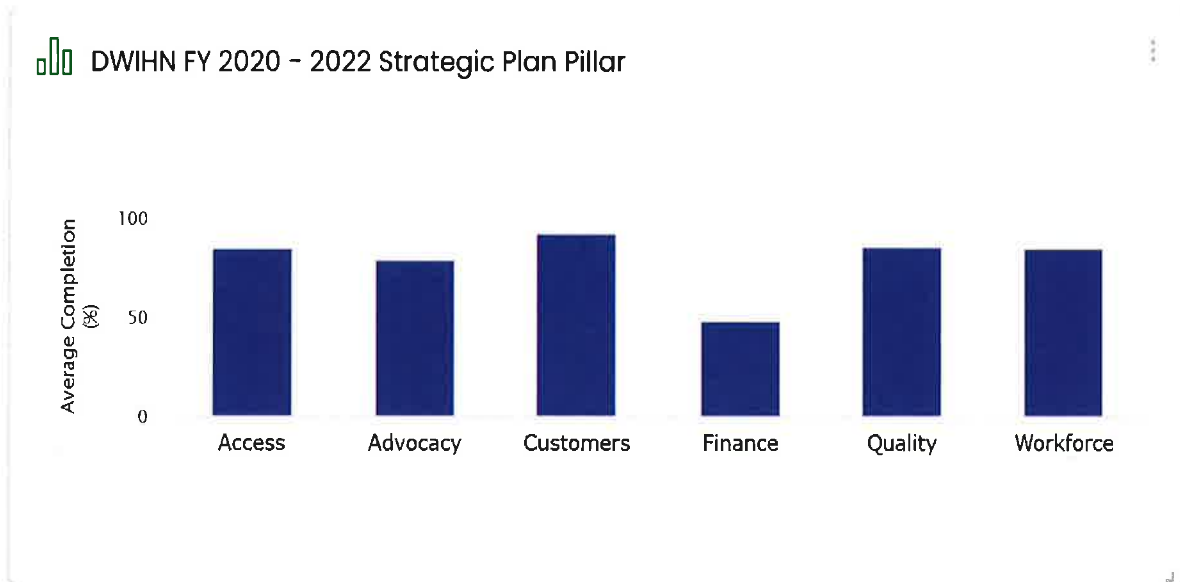
To our board members:

Our commitment to social responsibility includes a dedication to transparency, collaboration and stakeholder engagement as a core component of our business and sustainability strategy, our monthly reporting process, and our activities within the county.

Our Strategic Planning Status Report is our report to our board members. It tells how we are performing against key indicators that measure our performance against the Customer, Access and Quality pillars and impact the areas that matter most to our stakeholders.

Pillar Summary



There are three (3) pillars that are under the governance of the Program Compliance Committee: Customer, Access and Quality.

Summary of Pillar Status

Quality is under the leadership of April Siebert. Overall, we are at 86% completion on this pillar. There are four (4) high level organizational goals under this pillar. They range from 70% - 100% completion.

QUALITY

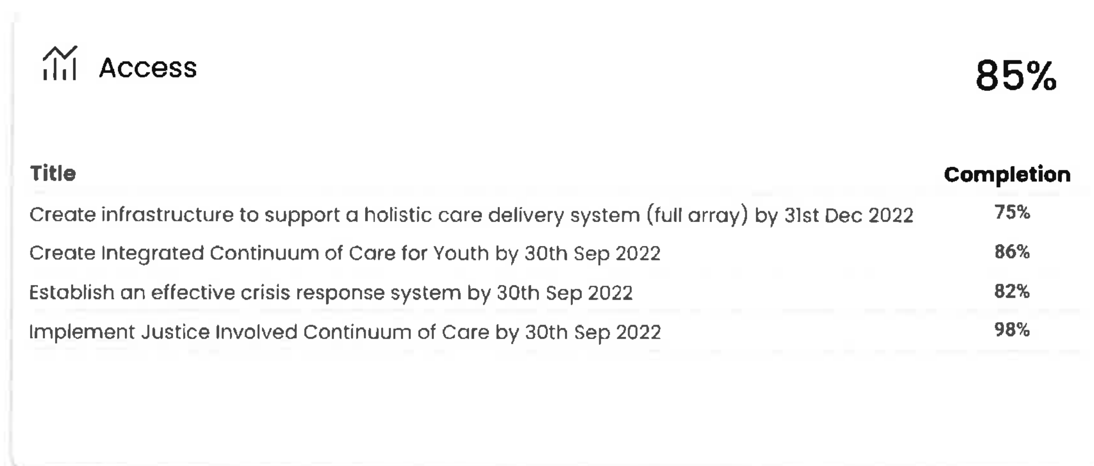
Title	Completion
Ensure consistent Quality by 30th Sep 2022	70%
Ensure the ability to share/access health information across systems to coordinate care by 31st Dec 2021	100%
Implement Holistic Care Model: 100% by 31st Dec 2021	94%
Improve population health outcomes by 30th Sep 2022	80%

Customer is under the leadership of Michele Vasconcellos, Director of Customer Service. Overall, currently reaching 93% completion on this pillar. The three (3) high-level goals range from 82% to 97%.

Title	Completion
Enhance the Provider experience by 30th Sep 2022	82%
Ensure Inclusion and Choice for members by 30th Sep 2021	97%
Improve person's experience of care and health outcomes by 30th Sep 2022	91%

Access Pillar

Access is under the leadership of Jacquelyn Davis, Clinical Officer. Overall, we are at 85% completion on this pillar. There are four (4) high-level goals. They range from 75% - 98% completion.



Access 85%

Title	Completion
Create infrastructure to support a holistic care delivery system (full array) by 31st Dec 2022	75%
Create Integrated Continuum of Care for Youth by 30th Sep 2022	86%
Establish an effective crisis response system by 30th Sep 2022	82%
Implement Justice Involved Continuum of Care by 30th Sep 2022	98%

A detailed report of this pillar will follow.

Access Pillar

Detailed Dashboard

Program Compliance Committee Meeting

February 9, 2022

ACCESS STRATEGY PILLAR

02/03/2022

16

GOALS

85%

GOAL COMPLETION

Draft · Not started · Behind · On Track · Nearly There · Overdue · Complete · → Direct Alignment · ⇢ Indirect Alignment

DWIHN FY 2020 - 2022 STRATEGIC PLAN PLAN

ACCESS

Goal	Details	Due Date	Owner	Task	Update	Current Co...
Create infrastructure to support a holistic care delivery system (full array)		12/31/2022				75% 74.65 / 3% ahead
→ **Create a satellite network: 100%**	Providing services to people directly in our communities - DWIHN to ensure each FY that there is adequate Providers contracted to meet needs across all of Wayne County.	12/31/2022	Manny Singla		NEW **Manny Singla:** Expanded the service array by implementing Clinical programs including *Certified Community Behavioral Health Clinic* (*CCBHC*), Opioid Health Homes that will extend Access , Care coordination. We have also enabled partnership with multiple Health plans to ensure care coordination and holistic care models covering both physical and behavioral health services can be provided . As part of this rollout we also enabled a care coordination platform to avoid data duplication and certified HEDIS measures as part of measuring quality of services. *10/08/2021*	83% 83.29 / 100% 17% behind

Goal	Details	Due Date	Owner	Task	Update	Current Co...
Ensure all Providers receive 80% or greater on Risk Assessment/Score Card for FY 23: 100%	Annually, each Provider will be scored using the ***Risk Management Assessment tool*** to assess overall strengths and areas needing improvement. This data will be tracked in a dashboard and then pull that score into Cascade "by Provider Type" to track overall organizational health.	09/30/2022	June White		NEW **Allison Smith:** In order to obtain accurate numbers for each CRSP, DWIHN rolled out a re-engagement/dis-enrollment module and policies in MMH-WIN to ensure that we are only scoring the providers on members actively engaged in service. This also enhances service delivery by re-engaging members. *02/03/2022*	66% 66 / 100% 31% behind
Create Integrated Continuum of Care for Youth		09/30/2022			NEW **Cassandra Phipps:** Progress is noted regarding the coordination of care with children in Wayne County. This is evidenced by developing a School Success Initiative Referral Flowchart and improving the School Success Initiative Referral Form in MHWIN. In addition, within the last 90 days the Children's Initiative Department developed a Case Consultation spreadsheet to track coordination between Providers, Parents, and other Professionals. Children's Initiative Department also increased outreach efforts in the community to explain about children services. *10/07/2021*	86% 85.61 / 7% behind

Goal	Details	Due Date	Owner	Task	Update	Current Co...
Deliver Integrated model of Care of Care for Children: 100%	Although the authority was not awarded the InCK Grant from CMS in December 2019, working towards the components that help coordinate care for Children still is a priority. There are 2 additional programs that Children's Initiative oversee via the System of Care Block Grant that supports Integrated Model of Care for Children (SKIPP and MC 3).	09/30/2020	Cassandra Phipps		NEW **Cassandra Phipps:** There are 2 Programs that the Children's Initiative oversees through the System of Care Block Grant: Screening Kids in Primary Care Plus (SKIPP) and Michigan Child Collaborative Care (MC3) **Screening Kids in Primary Care Plus (SKIPP)** SKIPP began as a System of Care Initiative related to Pediatric Integrated Healthcare. The project focuses on breaking down silos of care for children by embedding a Behavioral Health Consultant (BHC) in the pediatrician's medical team to provide mental health consultation, resources, screenings, psycho-education, and action plans for pediatric patients. The BHC determines level of care for mental health services and works to ensure patient entry into the correct system for mental health care as needed. **Michigan Child Collaborative Care (MC3)** Program DWIHN and the University of Michigan MC3 program have teamed up to provide a tele-psychiatry consultation model to pediatric practices in Wayne County. The partnership currently provides 1 BHC who is placed on the medical team at Detroit Riverview Pediatrics. The BHC and the MC3 team work together to provide the education, support, and technical assistance to allow physicians access to a pool of psychiatrists who they can consult with for patient mental health and medication needs. The MC3 program is currently seeking out additional practices interested in receiving same-day psychiatric consultations from the University of Michigan's team of pediatric and OB/ GYN psychiatrists. *10/08/2021*	82% 81.84 / 100% 18% behind
Ensure anyone in Wayne County can access crisis services	There is no wrong door. Anyone experiencing a behavioral health crisis in Wayne County can have an assessment completed.	09/30/2022	Dan West		NEW **Allison Smith:** Once the Crisis Care Center has opened at 707 Milwaukee the full continuum will be implemented. *02/02/2022*	75% 75 / 3% behind

Goal	Details	Due Date	Owner	Task	Update	Current Co...
→ **Establish means to enable interoperability using Health Information Exchange to share care plans across providers: 100**	Will help facilitate NCQA CC 1	09/30/2020	Manny Singla		**Manny Singla:** All CRSP providers are now on the HIE platform *09/30/2020*	100% 100 / 100 -
Establish an effective crisis response system		09/30/2022			NEW **Jacquelyn Davis:** The Woodward site is no longer an option for the Crisis Assessment Center due to opposition from the community. DWIHN is presenting plan B to establish 707 Milwaukee at the new site for these services. Upon Board Approval the next steps are to engage community stakeholders and obtain approval from the Board Zoning committee. *10/06/2021*	82% 82.25 / 4% ahead
→ **Ensure all technology aspects are addressed to ensure connectivity, redundancy and access for mission critical operations: 100%**		09/30/2022	Manny Singla		NEW **Allison Smith:** New enhancements are being made to MH-WIN to notify a CRSP when someone presents to the ER so that they can get involved with the member early in the crisis episode. *02/03/2022*	90% 90 / 100% 12% ahead
→ **Ensure anyone in Wayne County can access crisis services**	There is no wrong door. Anyone experiencing a behavioral health crisis in Wayne County can have an assessment completed.	09/30/2022	Dan West		NEW **Allison Smith:** Once the Crisis Care Center has opened at 707 Milwaukee the full continuum will be implemented. *02/02/2022*	75% 75 / 3% behind
→ **Implement Crisis Project Plan: 100%**		09/30/2022	Dan West			82% 81.75 / 100% 18% behind
→ **Ensure individuals are placed in the least restrictive environment**		09/30/2022	Dan West		NEW **Jacquelyn Davis:** DWIHN has added 12 Diversion beds to the network and there are 2 pending. The Residential Unit has secured 18 Out of home Respite beds for Adults. *08/05/2021*	82% 81.75 / 18% behind
Implement Justice Involved Continuum of Care		09/30/2022				98% 98.33 / 2% behind

Goal	Details	Due Date	Owner	Task	Update	Current Co...
Conduct gap-analysis of the Sequential Intercept Model		06/28/2019	Ebony Reynolds		**Andrea Smith:** The Wayne County Jail Diversion Council met December 2020 to review each intercept on the model. *01/19/2021*	100% 100 / -
Implement improvements to existing programming	Based on Gap-Analysis and the identified opportunities for improvement implement any necessary improvements to existing process	09/30/2020	Ebony Reynolds		NEW **Andrea Smith:** A team has been reviewing supplemental training to identify gaps that would allow the recommendation and addition of new educational topics. *10/04/2021*	95% 95 / 5% behind
Implement new programs within the Sequential Intercept Model	Based on the gap-analysis, new programs may need to be developed. 1. Adult 2. Juvenile	09/30/2020	Julie Black		**Julie Black:** In upcoming fiscal year 20-21, three new programs will be implemented for Jail Diversion. Central City Integrated Health will develop and provide programming for the Detroit Homeless Outreach pilot in collaboration with law enforcement. This collaboration is between the City of Detroit, homeless outreach providers and behavioral health providers with the goal of getting the homeless off of the street utilizing available resources, and reducing the negative issues associated with homelessness and behavioral health challenges (SMI/SUD). Northeast Integrated Health and Team Wellness are collaborating with the Detroit Police Department to pilot a Detroit Co-Response Team. The program is founded on the understanding that by working together, behavioral health specialists and law enforcement can respond appropriately to the needs of individuals in the community who are in crisis. Police and behavioral health specialists are being trained on the CIT model. Each provider will participate in the collaborative process including monthly team meetings with DWIHN. *10/02/2020*	100% 100 / -

DETROIT WAYNE INTEGRATED MENTAL HEALTH NETWORK

QUALITY ASSURANCE PERFORMANCE IMPROVEMENT PLAN (QAPIP) DESCRIPTION

Updates

FY 2021-2023

QAPIP Description Changes

The Power point shows the changes that have been made to enhance the QAPIP to ensure stronger alignment with regulatory requirements of MDHHS and NCQA.

The (QAPIP) Program Description covers FY 2021-2023.

Changes to the QAPIP Program include the following:

- List the clinical/non-clinical Performance Improvement Projects (PIPs) (Pg.16)
- Add language to support that residential treatment providers prepare and file Critical Incidents reports (Pg. 18)
- Add a description of how DWIHN analyze, at least quarterly, the critical incidents, sentinel events, and risk events to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents (Pg. 18)
- Add the methodology for assessment of member experience with services to include a qualitative assessment (e.g., focus groups of member experience with services (Pg. 19).

DWIHN
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Detroit Wayne Integrated Health Network

QAPIP Description Changes

- Add a description of how DWIHN ensure the incorporation of members receiving LTSS into review and analysis (Pg.20)
- Add a description of how findings of the QAPIP are incorporated into the recredentialing process (Pg. 8)
- Add a description of how DWIHN verifies whether services are reimbursed by Medicaid were furnished to members by affiliates (as applicable), providers and subcontractors (Pg. 21)
- Add mechanisms to assess the quality and appropriates of care furnished to members receiving Long-Term Services and Supports (LTSS) (Pg. 20).

*QAPIP FY2021-2023 is attached for your review of the identified changes.

DWIHN
Detroit Wayne Integrated Health Network
Your Link to Holistic Healthcare

Questions

DWIHN
Your Link to Holistic Healthcare
Detroit Wayne Integrated Health Network

DETROIT WAYNE INTEGRATED HEALTH NETWORK
QUALITY ASSURANCE PERFORMANCE IMPROVEMENT PLAN (QAPIP) DESCRIPTION
FY2021-2023

Approved:

Approved by the Quality Improvement Steering Committee (QISC)	1/26/22
Approved by Program Compliance Committee (PCC)	
Approved by Full Board of Directors	

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SECTION 1: Introduction

The Detroit Wayne Integrated Health Network (DWIHN), a National Committee Quality Assurance (NCQA) accredited Managed Behavioral Health Organization (MBHO) is the Pre-Paid Inpatient Health Plan (PIHP) and Community Mental Health Service Provider (CMHSP) for Detroit and Wayne County. DWIHN is the largest community mental health service provider in the State of Michigan. The Quality Assurance Performance Improvement Plan (QAPIP) Description provides the structure and governance to guide the formal processes for evaluating and improving the quality and appropriateness of health care services and the health status of the populations we serve. The QAPIP describes the quality activities undertaken by DWIHN to promote and achieve excellence in all areas through continuous quality improvement.

The QAPIP demonstrates to members, advocates, community organizations and health care providers that it has a distinct competency as a high-performing, member-focused, quality-focused, and evidence-based efficient provider of behavioral health and substance use disorder services and is an essential partner in helping healthcare reform to succeed. It has the infrastructure necessary to improve the quality and safety of clinical care and services to our members and to oversee the Quality Improvement (QI) program.

The term of the QAPIP begins October 1, 2021 and ends September 30, 2023. Upon expiration of the term, the QAPIP shall remain in effect until the DWIHN's Board of Directors approves a new QAPIP. The QAPIP incorporates by reference, any and all policies and procedures necessary to operate as a Prepaid Inpatient Health Plan and Community Mental Health Services Program. The DWIHN's Board of Directors hereby approves all current and subsequent policies and procedures through the approval of the QAPIP.

Mission, Vision and Values

The Mission and Vision Statement provides inspiration for DWIHN and describe what we aim to achieve mid-to-long term. The Values are the core principles and define DWIHN culture and identity.

Mission

We are a healthcare safety net organization that provides access to a full array of integrated services that facilitate individuals to maximize their level of function and create opportunities for quality of life.

Vision

To be recognized as a national leader that improves the behavioral and physical health status of those we serve, through partnerships that provide programs promoting integrative holistic health and wellness.

Values

- We are an *advocate*, person-centered, family and community focused organization.
- We are an *innovative*, outcome, data-driven, and evidence-based organization.
- We respect the dignity and diversity of individuals, providers, staff and communities.
- We are *inclusive*, culturally sensitive and competent.
- We are fiscally responsible and accountable with the highest standards of integrity.
- We achieve our mission and vision through partnerships and collaboration.

Quality Assurance Performance Improvement Plan (QAPIP) Description

The QAPIP provides the framework necessary to improve the quality, safety and efficiency of clinical care. The QAPIP provides structure and governance to guide the formal processes for evaluating and improving the quality and appropriateness of health care services and the health status of the populations we serve. It also defines the authority, scope and content of the QI program, including the roles and responsibilities of committees and individuals supporting program implementation. Member participation and involvement in the development and ongoing monitoring of DWIHN's QAPIP is critical.

The QAPIP contains the core functions of DWIHN's Board approved Strategic Plan, and the (6) pillars which serve as the foundation of the commitment of DWIHN to continuously improve the quality and safety of clinical care and quality of service. These functions will be conducted by DWIHN and its network of contracted service providers. It is the responsibility of DWIHN to ensure that the QAPIP meets the requirements of the Balanced Budget Act (BBA) of 1997, Public Law 105-33 and 42 Code of Federal Regulations (CFR) 438.358 of 2002. The QAPIP also reflect concepts and standards appropriate to the population of persons served under the Managed Specialty Supports and Services Waiver Program.

Scope of the QAPIP

The functional areas of the QAPIP are detailed through assigned Standing Committees. DWIHN has created committees to provide oversight and implementation of all quality improvement activities. The Compliance Committee focuses on regulatory compliance as well as corporate compliance issues to ensure service provision in network as required. The Improving Practices Leadership Team (IPLT) develops and monitors clinical service areas such as clinical practice guidelines, evidence-based practices, care integration processes, home and community-based services transition planning to ensure quality of clinical care, safety of clinical care, quality of service, and enhance members' experience. The Credentialing Committee focuses on ensuring network practitioners and providers have the appropriate qualifications to provide services to ensure safety and quality of clinical care. The Quality Improvement Steering Committee (QISC) focuses on performance indicator data, conducting and analyzing satisfaction survey data, oversight of performance improvement projects, and monitoring QI plans to ensure quality of services, and evaluate members' experience.

The Critical Sentinel Events Committee (CSEC) focuses on reviewing and monitoring critical and sentinel events to ensure safety of clinical care, and quality of service and Utilization Management Committee focuses on underutilization of services within the network to ensure quality and safety of clinical care and quality of service. The quality improvement activities are achieved through a complex infrastructure which includes key stakeholders and process owners, and cross-functional units and committees. It identifies the important processes and aspects of care, both clinical and non- clinical, required to ensure quality supports and services for persons in the system. DWIHN requires all contracted Clinical Responsible Service Providers (CRSP) and substance use disorder providers to have a quality improvement plan relevant to the services they provide. DWIHN assures that all demographic groups, care settings and types of services are included in the scope of the QAPIP by including members, advocates, contracted service providers and community groups in the quality improvement process using a Continuous Quality Improvement (CQI) perspective.

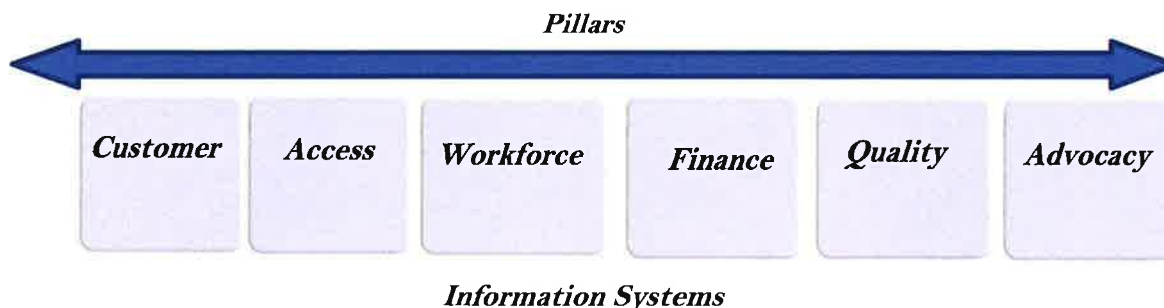
DWIHN has an adequate organizational structure which allows for clear and appropriate administration and evaluation of the QAPIP. DWIHN's QISC is the decision-making body of the QAPIP and the evaluation which reports to PCC and to the full Board of Directors for review and approval. There is a designated senior official and Chief Medical Officer (CMO) responsible for the QAPIP implementation. There is active participation of providers and persons served in the QAPIP processes. The participating practitioners are external to the organization and part of the organization's network, providing input on process improvement, program planning, and program evaluation, through data collection and analysis. DWIHN believes the structure supports effective governance and align key strategic initiatives to ensure adequate guidance to help DWIHN reach goals and objectives.

Quality Improvement (QI) Program

DWIHN's Quality Improvement Program is based on the principles of Continuous Performance Improvement (CPI) which is adopted and utilized throughout the organization. The Centers for Medicare and Medicaid Services (CMS) Medicaid Bureau mandates that QIP be a part of Pre-Paid Inpatient Health Plans. DWIHN has several contracts with the Michigan Department of Health and Human Services (MDHHS) for the provision of Managed Specialty Supports and Services (Medicaid), General Fund and waiver services for mental health and substance abuse and must comply with Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY19 Attachment P7.9.1 and CMHSP Managed Mental Health Supports and Services Contract FY19: Attachment C6.8.1.1 "Quality Assessment and Performance Improvement Programs for Specialty Pre-Paid Inpatient Health Plans" and the "Department of Community Health Michigan Mission Based Performance Indicators", the Balanced Budget Act, External Quality Review, and the Application for Renewal and Recommitment. DWIHN maintains a network-wide commitment to quality and industry best practices and standards as set forth by state and federal regulations, as well as accrediting organizations.

Quality Improvement Program (QIP) Governance

The DWIHN Strategic Plan is an overarching process that works toward common goals, establish agreements around intended outcomes/results, and assess and adjust the organization's direction in response to a changing environment. The QIP provides a systematic approach to assessing services and improving them on a priority basis. The DWIHN's approach to quality improvement is based on the following six pillars. The six pillars are the focus areas that help realize the vision and a call to action with Information Systems as the foundation for supporting success across each of the pillars.



DWIHN's ability to understand and meet the unique health needs of our members is supported by our capabilities to effectively access, integrate, and analyze data. We have built and continue to invest in our members and technology to support industry-leading capabilities in data analytics. DWIHN's understanding of health care analytics and statistics enables us to develop and adjust standard methodologies to achieve targeted accurate results.

Cultural and Linguistic Needs

DWIHN's objectives for serving a culturally and linguistically diverse membership is a commitment to innovation, affordability, professional competence, continuous learning, teamwork and collaboration. The racial and ethnic disparities in behavioral health care have been well documented. Data analysis has demonstrated that racial and ethnic disparities contribute to lower HEDIS effectiveness of care scores. DWIHN seeks to improve the overall care of members by identifying the racial and ethnic composition so that potential health care disparities can be identified. This is accomplished by systematic monitoring and evaluation of provided services and by actively pursuing opportunities for improvement. DWIHN includes the following principles into its QIP:

- The importance of culture
- The assessment of cross-cultural relations
- Expansion of cultural knowledge, and
- The adaptation of services to meet the specific needs of our members

DWIHN and its Provider Network shall demonstrate an ongoing commitment to linguistic and cultural competence that ensures access and meaningful participation for all individuals receiving behavioral health services. Such commitment includes acceptance and respect for the cultural values, beliefs and practices of the community, as well as the ability to apply an understanding of the relationship of language and culture to the delivery of supports and services. Professional competence includes a general awareness of the cultural diversity of the service area including race, culture, religious beliefs, regional influences in addition to the more typical social factors such as gender, gender identification, sexual orientation, marital status, education, employment and economic factors, etc.

DWIHN Medversant software captures the capacity to recruit providers of diverse racial and ethnic background by documenting the provider's self-identified ethnicity, culture and race (if provided). The software also includes a question about other languages spoken by providers to indicate their linguistic diversity – this information can also be found in the provider e- directory and provider directory for informational purposes to members. In addition, to ensure a competent work force of qualified practitioners, DWIHN utilizes Detroit Wayne Connect (DWC) for ongoing cultural diversity training. DWIHN monitors the delivery of care and services in relation to the provision of culturally competent services through review of Staff Training Records, Member Satisfaction Surveys and Provider Satisfaction Surveys.

Credentialing and Re-Credentialing

The QAPIP contains written procedures to determine whether physicians and other health care professionals, who are licensed by the state and who are employees of the provider network or under contract with DWIHN, are qualified to perform their services. The QAPIP also has written policies and procedures to ensure that non-licensed providers of care or support are qualified to perform their jobs. DWIHN policies and procedures for credentialing process are in compliance with the MDHHS Credentialing and Re-Credentialing processes, and includes the organization's initial credentialing of practitioners, as well as its subsequent re-credentialing, re-certifying, and/or reappointment of practitioners. The qualifications of physicians and other licensed behavioral healthcare practitioners/professionals employed by or under contract with DWIHN are reviewed by DWIHN's Credentialing and Re-Credentialing policy and procedures. Within this framework, the DWIHN credentials all organizational providers under direct contract with DWIHN and its own CMHSP behavioral healthcare practitioners. Conversely, DWIHN has delegated to each contracted providers the responsibility of credentialing of all organizational providers under direct contract to the organization; and all behavioral health practitioners employed directly or under contract to the CMH as part of its panel network. DWIHN has delegated to each SUD Treatment Provider the responsibility of credentialing all behavioral health practitioners employed by the provider. All CMHs and SUD Treatment Providers will have Credentialing policies in place that are approved by DWIHN and that cover all behavioral health care practitioners.

Providers are also bound by DWIHN contract requirements and MDHHS standards to provide training for all new staff and periodic training and staff development activities for all staff. This requirement includes Recipient Rights training. Other specific trainings are designated for non-licensed staff to ensure competency skills. DWIHN and its Provider Network's Staff Training program will ensure, regardless of funding mechanism (e.g., voucher), that staff possess the appropriate qualifications as outlined in their job descriptions, including the qualifications for all the following: educational background; relevant work experience; cultural competence; and certification, registration, and licensure as required by law. A program shall train new personnel regarding their responsibilities, program policy, and operating procedures.

DWIHN Credentialing Unit conducts bi-annually reviews of the delegates (accredited Behavioral Health and Substance Use Disorder Providers and Credentialing Verification Organizations). DWIHN's Credentialing Review Procedure will include but are not limited to the following:

- Review of the delegate Credentialing Policy and Procedures,
- Review of the Minutes of the delegate's Credentialing Committee,
- Review of Credentialing/Recredentialing files for the period specified by DWIHN Credentialing Unit, and
- Review of other information (Delegate reports, evidence of monthly monitoring of sanctions, organizational sanctions, complaints, etc.

DWIHN auditing procedure for the electronic files in the primary source verification database (Medversant). The Data and documentation that is stored in Medversant is reviewed for accuracy, completeness and quality during the credentialing and re-credentialing process by the Virtual Review Committee. Data in the Medversant is audited between credentialing cycles utilizing various data integrity reports and queries. Erroneous data is corrected in the application as it is identified to ensure credentialing data is correct and up to date. The DWIHN Credentialing Unit randomly select 15% of the universe of files received by the Virtual Review Committee the previous month. The sample of files are identified using the Medversant IDs and generated through the use of the Microsoft Excel Randomization Function. The Credentialing Committee provides oversight of the auditing process. The findings summarized in the Monitoring/Audit Report will be presented to the Credentialing Committee and Quality Improvement Steering Committee. When poor quality issues are identified appropriate sanctions will occur from technical assistance to revocation of delegated credentialing function. The contracted providers shall train new staff regarding their responsibilities, program policy and operating procedures.

Framework for Quality Improvement

1. **F**ind a Process to Improve
2. **O**rganize to Improve
3. **C**larify Current Knowledge of the Process
4. **U**ncover Causes of Process Variation or Poor Quality
5. **S**tate Plan Do Study Act (PDSA)
    i. **P**lan the Improvement Process
    ii. **D**o the Improvement, Data Collection, and Analysis
    iii. **S**tudy the Results and Lessons Learned
    iv. **A**ct by Adopting, Adjusting, or Abandoning the Change

To ensure compliance of the QAPIP methodology, the use of quality improvement process management/improvement tools and techniques will consistently be included using the following four steps:

1. Identify - Determine what to improve
2. Analyze - Understand the problem
3. Develop - Hypothesize what changes will improve the problem
4. Test/Improvement - Test the hypothesized solution to see if it yields improvement. Based on the results, decide whether to abandon, modify, or implement the solution.

Key cultural components also ensure the success of improvement efforts include: leadership involvement, data informed practice, use of statistical tools, prevention over correction, and continuous quality improvement. Strong leadership, direction and support of quality improvement activities by the governing body and CEO are key to performance improvement and audit readiness. This involvement of organizational leadership assures that quality improvement initiatives are consistent with the DWIHN mission, vision, values and strategic plan.

Successful QI processes create feedback loops, using data to inform practice and measure results. Fact- based decisions are likely to be correct decisions, for continuous improvement of care, tools and methods needed to foster knowledge and understanding. Processes must be continually reviewed and improved. Small incremental changes do make an impact, and providers can almost always find an opportunity to make things better.

Continuous Quality Improvement Activities

The Quality Program encompasses all aspects of care and service delivery. Components of DWIHN's quality improvement activities include but not limited to:

- Clinical components across the continuum of care from acute hospitalization to outpatient care
- Organizational components of service delivery such as case management, discharge planning, prior authorizations, as well as other procedures or processes that affect care including access to care
- Processes that impact our members or providers of care such as claims, interpreter services, enrollment, customer services, credentialing/recredentialing and utilization management
- Member satisfaction
- Member safety

These quality improvement activities emerge from a systematic and organized framework for improvement. This framework, adopted by the leadership, is understood, accepted and utilized throughout the system, as a result of continuous education and involvement of staff at all levels in performance improvement. Quality Improvement involves two primary activities:

- Measuring and assessing the performance of processes and services through the collection and analysis of data.
- Conducting quality improvement initiatives and acting where indicated, including the redesign of processes, design of new services, and/or improvement of existing services.

The Michigan Department of Health and Human Services (MDHHS) requires that DWIHN provide a written description of the QAPIP plan for approval by the Board of Directors. The contract with MDHHS requires DWIHN to annually conduct an effectiveness review of its QAPIP. The effectiveness review includes an analysis of whether there have been improvements in the quality of health care and services for members as a result of quality assessment and improvement activities and interventions carried out by DWIHN. The analysis takes into consideration trends in service delivery and health outcomes over time and include monitoring of progress on performance goals and objectives.

The QAPIP is also reviewed for effectiveness of the methods used to implement, monitor and evaluate the quality improvement processes and for any necessary revisions and adjustments on a monthly basis. The review of the QAPIP includes members, providers, Quality Improvement Steering Committee (QISC), Program Compliance Committee (PCC) of the DWIHN's Board of Directors, and other stakeholders. Information on the effectiveness of DWIHN's QAPIP is provided annually to our stakeholders and to members upon request.

At a minimum, the QAPIP specifies the following elements:

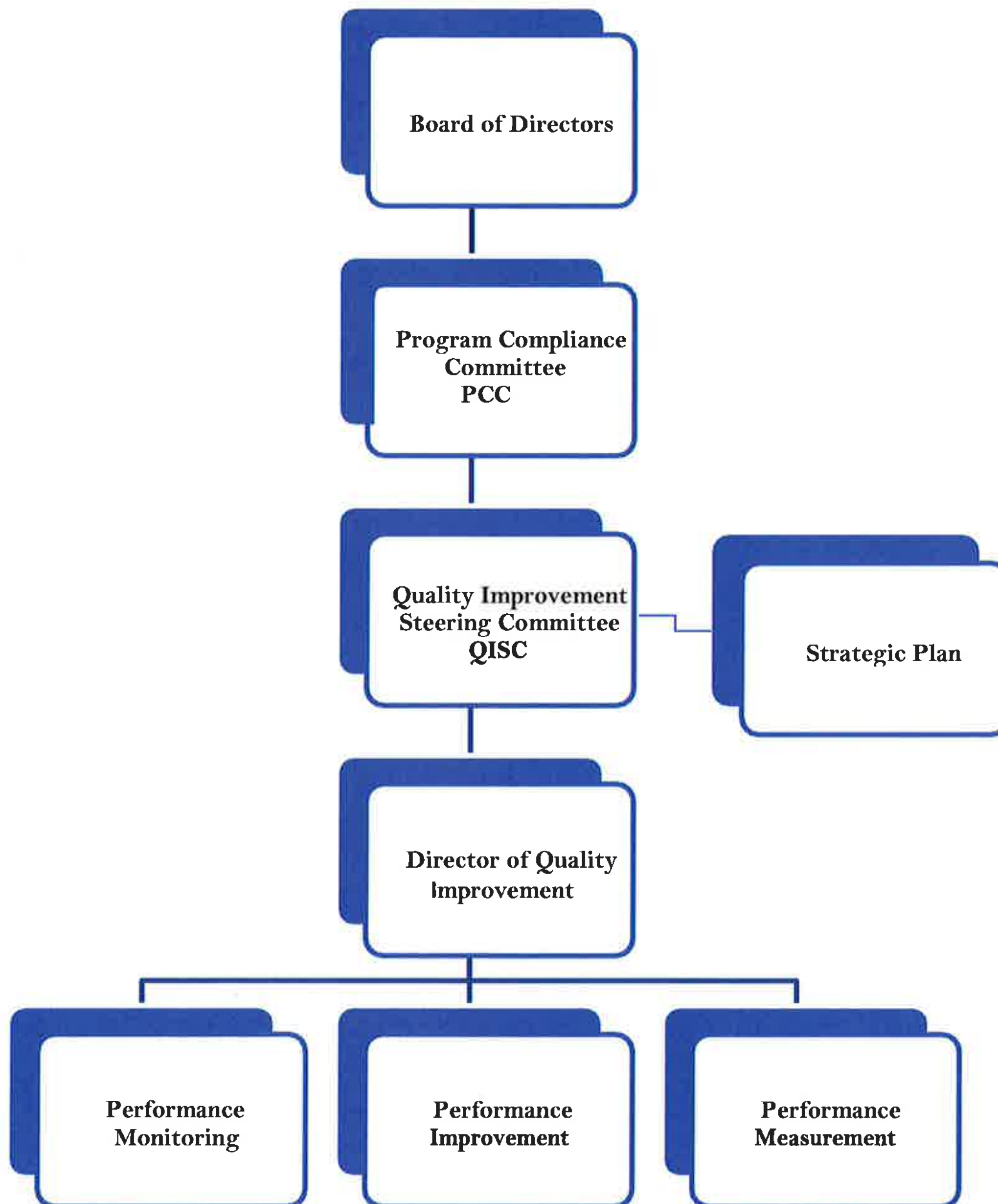
a. An adequate organizational structure that allows for clear and appropriate administration and evaluation of the QAPIP.
b. Responsibilities of the governing body for monitoring, evaluation and making improvements to care.
c. Objectives and timelines for implementation and achievement.
d. Role of recipients of services and other stakeholders in the QAPIP plan.
e. Mechanisms or procedures used for adopting and communicating process and outcome improvements.
f. Description of a designated senior official responsible for QAPIP implementation.
g. Performance measures to address access, availability, quality, efficiency and outcome of services, using standardized indicators based upon the systematic, ongoing collection and analysis of valid and reliable data.
h. Performance improvement projects that address clinical and non-clinical aspects of care that are directed as the state and the DWIHN established aspects of care. Clinical areas include high volume services, high-risk services and continuity and coordination of care. Non-clinical areas include grievances and appeals, complaints and access to and availability of services.
i. Process from the review and follow-up of Critical/ Sentinel Events and events that place members at risk of harm.
j. Periodic quantitative (i.e., survey) and qualitative (i.e., focus group) assessments of member experiences with services. These assessments must address issues of quality, availability and accessibility of care.
k. Process for the incorporation of members receiving services into the review and analysis of the information obtained from quantitative and qualitative reviews.
l. Written procedures to determine whether physicians and other licensed health care professionals are qualified to perform their services.
m. Written procedures to ensure non-licensed providers of care or support are qualified to perform their jobs.
n. The organization's process for the initial credentialing and re-credentialing of providers.
o. Identification of staff training needs and provision of in-service training, continuing education and staff development activities.
p. DWIHN process to verify whether services reimbursed by Medicaid were actually provided to enrollees by affiliates and service providers.

The Quality Improvement Unit reviews the response received regarding the effectiveness of the methods proposed or used to implement, monitor and evaluate the quality improvement processes. The results and recommendations are incorporated in the QAPIP for the next fiscal year cycle.

DWIHN quality improvement goals are integrated and communicated throughout the organization with structured work plans, goals and objectives that are owned at the department level. Our organizational monitoring activities and reports are reviewed throughout the year to identify opportunities for needed changes and improvements. These activities, in addition to ongoing improvement projects, form the basis of the organization's work plan and support all services offered by DWIHN.

SECTION 2: Leadership and Structure

Leadership. The key to the success of the Continuous Quality Improvement (CQI) process is leadership. Consistent with a total quality improvement philosophy, the following is the structure of the organization in which the Quality Improvement Unit resides.



GOVERNING BODY

DWIHN's Program Compliance Committee (PCC) is the governing body for the QAPIP plan. PCC formally reviews on a periodic basis a written report on the operation of the QAPIP activities. PCC delegates direct oversight of all QI functions to the Quality Improvement Steering Committee (QISC), which serves as the oversight body and has responsibilities for the day to day management of the QI program. PCC annually reviews the specific goals and objectives of DWIHN, including a description of the services provided. This includes, but is not limited to, the QAPIP, Year End Evaluation, and periodic review of quality improvement progress reports. The Director of Quality Improvement provides monthly and quarterly reports on QI activities to PCC. As the governing body, PCC, with recommendations from appropriate clinical personnel, act on all major contracts and other arrangements affecting the delivery of health care services. PCC actively supports the Quality Improvement Program as demonstrated by ongoing involvement in the policy making process of the organization. The final approval of the QAPIP is retained by DWIHN's Full Board of Directors.

Director of Quality Improvement

The Director of Quality Improvement has the overall responsibility for implementation of the QAPIP. Under the Director of Quality Improvement's leadership, an integrated interdivisional approach to improving DWIHN services and systems is undertaken. The Director of Quality Improvement is also responsible for the following:

1. Assisting staff in understanding and participating in the Continuous Quality Improvement (CQI) process.
2. Establishing regular communication throughout DWIHN's network about CQI issues, problems, status and progress.
3. Assisting the PCC Committee and the Full Board of Director's understanding of the CQI process.
4. Developing and implementing a data collection system that yields real-time meaningful data for needs assessment, program planning, outcome evaluations and operationalizing quality improvement opportunities.
5. Pursuing opportunities for partnership between DWIHN and other public and private entities involved in quality improvement efforts.
6. Participating on quality improvement teams and work groups at DWIHN and state levels.
7. Assisting in the Strategic Planning process.
8. Developing a DWIHN Audit Ready philosophy.
9. Standardized protocols for ensuring appropriate use for telehealth services, appropriate billing codes and quality measures.

SECTION 3: Quality Improvement (QI) Unit

The Quality Improvement Unit is responsible for performing quality improvement functions assuring that program improvements are occurring within the Pre-Paid Inpatient Health Program (PIHP) and the Community Mental Health Services Program (CMHSP). The QI unit provides support for all departments in the organization for quality improvement projects.

The QI Unit operates in partnership with stakeholders, members, advocates, contracted providers, and DWIHN staff. The QI Unit achieves the scope of continuous quality improvement through three functions: performance monitoring, performance measurement and performance improvement.

Performance Improvement

Performance Improvement is a formal approach to the analysis of performance and systematic efforts to prevent, reduce or eliminate waste, and problems that will lead to improvement in service quality. As the steward of the system, the Performance Improvement component ensures guidance is provided to the system through the provisions of policy directives. This approach is system-wide, and addresses DWIHN and its service provider network. All service providers are required to have certain policies in place which mirror DWIHN's policies. The policies address those areas that are contractually mandated in the contract with MDHHS, and describes the process for ensuring compliance. DWIHN's policies undergo a public comment period before becoming final. This process allows for stakeholders to comment and provide feedback on proposed policies. In addition, approved policies are reviewed and disseminated to DWIHN service provider network via Quality and Provider meetings. Approved policies are located on DWIHN's website.

To meet the regulatory requirements for MDHHS and NCQA, DWIHN conducts Performance Improvement Projects (PIPs) that are approved through the Improving Practices Leadership Team (IPLT) and the Quality Improvement Steering Committee (QISC). The QISC provides oversight to the Performance Improvement Projects. The purpose of each PIPs is to achieve through ongoing measurements, demonstrable and sustained improvement in both clinical and non-clinical services that will have beneficial health outcomes and member satisfaction. The clinical areas include, but not be limited to high-volume services, high-risk services and continuity and coordination of care. Non-clinical areas include, but not be limited to appeals, grievances, trends, and patterns of substantiated recipient rights complaints as well as access and availability of services. The methodology DWIHN works to improve clinical issues involves the following:

- Collecting data appropriate for the clinical issues
- Conduct quantitative and qualitative analysis of data that compares results against goals
- Identifying opportunities for improvement
- Implementing interventions to improve performance
- Measuring the effectiveness of interventions

Clinical/Non-Clinical PIPs

DWIHN have engaged in at least two (2) projects during the waiver renewal period.

- Improve children and adults within DWIHN provider network with follow-up services within 30 days after discharge from a psychiatric inpatient hospital. This study topic aligns with the Performance Bonus Incentive metric "Follow-up After Hospitalization for Mental Illness within 30 days". The PIP performance targets have been set to exceed performance standards.
- Increase the Number of New Habilitation Supports Waiver Program Enrolled Members and Improve the Utilization Rate of Habilitation Supports Waiver Program Slots that are allocated to DWIHN from the MDHHS. Refer to the FY2022 Workplan for the listing of additional Performance Improvement Projects.

Once the performance of a selected process has been measured, assessed and analyzed, the information gathered by the above performance measures are used to identify DWIHN's defined continuous quality improvement initiative to be undertaken. The decision to undertake the initiative is based upon DWIHN priorities. The purpose of an initiative is to improve the performance of existing services or to design new ones. The models utilized for analysis Focus-Plan-Do-Study-Act (PDSA) and the Ishikawa Fishbone Diagram.

DWIHN requires its provider network to participate in the PIPs related to their respective programs and services. The Substance Use Disorder Providers and the Clinical Responsible Service Providers (CRSP) are expected to participate in DWIHN's PIP related to their programs and services. They are also expected to conduct PIPs based on their own self-assessment of need, risk, frequency and performance. DWIHN's contract with MDHHS requires a State mandated performance improvement activity as well as, activities identified by IPLT and QISC.

Oversight of the quality improvement infrastructure is achieved through collaboration with members, advocates, providers, DWIHN's Chief Medical Officer, and other stakeholders. Planned, systematic activities are implemented so that quality requirements for community mental health services are fulfilled by DWIHN and contracted service providers.

In partnership with stakeholders Quality Improvement activities include:

- Assessment of needs, quality of services, accessibility of care, availability of care, outcomes of services provided and beneficiary experiences with services
- Evaluation of systems, programs and services
- Collect performance data utilizing effective quantitative metrics that are specific, measurable, actionable, relevant and timely for Michigan Mission Based Performance Indicator System, MDHHS and DWIHN Performance Improvement Projects, QAPIP Status/Outcomes, Satisfaction Surveys (Member and Provider), Standardized HCPCS Code Utilization, Medicaid and Other Claim Verification, MDHHS and DWIHN Needs Assessments, and Network Policies
- Identification of positive and negative process trends
- Analysis of causes of positive and negative statistical variation and outliers
- Identification of opportunities for improvement

- Determination of goals and objectives
- Decision making and planning
- Stakeholder education/information sharing
- information and technical assistance regarding the quality improvement issues, trends, techniques and proposed outcomes
- Implementation of performance improvement activities
- Measure and monitor progress toward goal achievement
- Evaluate outcomes and modify performance improvement process as needed
- Implementation of standardized performance improvement activities
- Strategic and annual planning

Some of the tools and techniques used in the continuous quality improvement process include Problem Solving Methodology, Process Mapping, Force Field Analysis, Cause and Effect Diagrams, Brainstorming, Pareto Analysis, Control Charts, Check Sheets, Bar Charts, Scatter Diagrams, Matrix Analysis, Tally Charts and Ishikawa Fishbone Diagram.

Quality Assurance and Improvement functions include informing practitioners, providers, members, and the Governing body of assessment results, and facilitates a process of evaluating the effectiveness of the assessments and outlining systematic action steps to follow-up on findings.

The Leaders support QI activities through the planned coordination and communication of the results of measurement activities related to QI initiatives and overall efforts to continually improve the quality of care provided. This sharing of QI data and information is an important leadership function. Leaders, through a planned and shared communication approach, ensure the Board of Directors, staff, members and families have knowledge of and input into ongoing QI initiatives as a means of continually improving performance.

This planned communication may take place through the following methods:

- Story boards and/or posters displayed in common areas
- Recipients participating in QI Committee reporting back to recipient groups
- Sharing of the annual QI Plan evaluation
- Newsletters and or handouts
- Dashboards
- DWIHN website

Critical Incidents, Sentinel Events, Unexpected Deaths and Risk Event Management

DWIHN Reporting of Consumer Critical Event, Sentinel Event, and Death policy establishes the guidelines for reporting and reviewing possible Sentinel Events and/or Critical Incidents. The policy states that DWIHN will conduct administrative reviews and follow-up of Sentinel Events to determine if the event meets the criteria and definition for a critical event, critical incidents, risk events, sentinel event, media events, or risk thereof and is related to a practice or standard of care. The Sentinel Event Committee/Peer Review (SEC/PRC) Committee reports Sentinel Event findings for review and analysis, and document follow-up and system improvement efforts, as required by MDHHS practice guidelines. The SEC/PRC Committee also conducts review and analysis of sentinel event reports submitted by the CRSP/SUD Providers. The SEC/PRC submits no less than annually to the Governing Body a periodic summary and recommendations for action response and disposition. The SEC/PEC committee may require follow-up action on the part of the provider in the form of a Corrective Action Plan / Improvement Plan or Root Cause Analysis (RCA).

The QI Department may convene the SEC/PRC Committee ten (10) times per year to review cases in the five (5) reportable category areas as required by MDHHS, and other cases identified by the Chief Medical Officer and/or SEC/PEC Committee members. The identified reportable categories for members include Suicide; Non-Suicide Deaths; Arrest of Member; Emergency Medical Treatment due to injury or Medication Errors. The QI Department is responsible for tracking of trends and patterns through this review process. The QI Department also provide annual data reports based on monthly and quarterly review of events. The reports are forwarded through the QISC, PCC, and to the full Board of Directors for review and approval.

DWIHN Critical Incident Reporting System captures information on specific reportable events which include but not limited to suicide, non-suicide death, emergency medical treatment due to injury or medication error, hospitalization due to injury or medication error, and arrest of member. The population on which these events must be reported differs slightly by type of event. The SEC/PEC ensures that all critical incidents, sentinel events, and risk events are analyzed to determine what action needs to be taken to remediate the problem or situation and prevent the occurrence of additional events and incidents.

Each Clinically Responsible Service Provider (CRSP) is responsible to enter the Critical Event, Critical Incident, Sentinel Event, and Risk Events into the Critical/Sentinel Event Module in MH-WIN for members actively receiving services in their organization within 24 hours of knowledge of the event. The Residential Treatment Providers are responsible for submitting and notifying CRSP timely of events involving members and also must provide hospital documentation or police reports when applicable. DWIHN has expanded reporting to include data for each CRSP and the SEC/PRC trends and patterns with recommendations. SEC/PRC is represented by the Chief Medical Officer, clinicians and administrative staff members of DWIHN.

All unexpected deaths of Medicaid beneficiaries who at the time of their death were receiving specialty supports and services are reviewed by the CRSP Provider. Refer to DWIHN policy on Reporting of Consumer Critical Event, Sentinel Events and Death Reporting for specific review and procedures.

DWIHN has a process for analyzing additional critical events that put individuals at risk of harm. This analysis is used to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents. These events minimally include: actions taken by individuals who receive services that cause harm to themselves; actions taken by individuals who receive services that cause harm to others; two or more unscheduled admissions to a medical hospital (not due to planned surgery or the natural course of a chronic illness, such as when an individual has a terminal illness) within a 12-month period; police calls by staff of specialized residential treatment providers or other provider agency staff for assistance with an individual during a behavioral crisis situation regardless of whether contacting police is addressed in a behavioral treatment plan; and emergency use of physical management by staff in response to a behavioral crisis.

DWIHN requires all contracted CRSP to have Behavior Treatment Plan Review Committee (BTPRC). As an option, the network providers and Mental Health CRSP may collaborate on developing and operating a joint BTPRC. It is DWIHN's expectation that it is the responsibility of the providers joining as partners in the BTPRC and CRSP to ensure that the joint BTPRC will provide the required review of proposed Behavior Treatment Plan (BTP) in real-time or during emergent situations. DWIHN contracted CRSP (Mental Health) monitor and ensure their implementation of Behavior Treatment policies and procedures.

The QAPIP quarterly review analysis of data for reporting to the QISC and PCC from the BTPRC intrusive or restrictive techniques that have been approved for use with members and where physical management or 911 contacts with law enforcement have been used in an emergency behavioral crisis. DWIHN also submits quarterly data analysis reports on system-wide trends of BTP to MDHHS. Data includes numbers of interventions and length of time the interventions were used per person. The techniques that have been approved during person-centered planning by the beneficiary or his/her guardian and are supported by current peer-reviewed psychological and psychiatric literature may be used with members.

Member Experiences with Services

The QAPIP is designed to improve the quality of care and service provided to members. Issues of quality, availability, and accessibility of care are evaluated through periodic quantitative (e.g., surveys) and qualitative (e.g., focus groups) assessments of member experiences with services. The assessments will be representative of the persons served and supports offered. The survey instruments used include the Experience of Care and Health Outcomes (ECHO) survey for (Adult/Children) and the National Core Indicators (NCI) survey (I/DD Population).

The QAPIP annual review analysis and data from the ECHO and NCI surveys are forwarded to the QISC, PCC and the full Board of Directors for review and approval. DWIHN and its Providers uses the assessment results to improve services for members. Processes found to be effective and positive will be continued, while those with questionable efficacy or low member satisfaction will be revised using the following methodology:

- Takes specific action on individual cases as appropriate,
- Identifies and investigates sources of dissatisfaction,
- Outlines systemic action steps to follow-up on the findings
- Informs practitioners, providers, recipient of service and the governing body of assessment results.

Long-Term Services and Supports (LTSS)

The QAPIP includes mechanisms to assess the quality and appropriateness of care furnished to members receiving LTSS. The process includes an assessment of care between care settings and a comparison of services and supports received with those set forth in the member's individual plan of service. Members receiving long-term supports or services (e.g., customers receiving case management or supports coordination), are included in the Quality Improvement process, as survey participants, as members of Consumer Advisory Councils, and as members of the DWIHN's Board. In this way members are incorporated into the review and analysis of information obtained from quantitative and qualitative methods. The LTSS cases or persons with special needs are tracked and reported on the MDHHS OBRA dashboard as established in response to the provisions of the federal Omnibus Budget Reconciliation Act (OBRA) of 1987, which amended the Medicaid program requirements for all nursing facilities. DWIHN Integrated Health Care unit has monthly meetings with the providers and quarterly meetings with MDHHS as required to discuss monthly and quarterly analysis of DWIHN's LTSS activities.

DWIHN continually evaluate its oversight of "vulnerable" individuals to determine opportunities for improving the health care and outcomes of members. DWIHN will continue to work with MDHHS to develop uniform methods for targeted monitoring of vulnerable individuals as well as review and approve corrective action plans that result from identified areas of non-compliance and follow-up on the implementation of the plans at the appropriate interval. Reports of the annual monitoring and plans of correction shall be subject to MDHHS review.

The QAPIP describes the process for the adoption, development, implementation and continuous monitoring and evaluation of practice guidelines when there are nationally accepted or mutually agreed upon clinical standards, evidence-based practices, practice-based evidence, best practices and promising practices that are relevant to the individual served. The clinical protocols and practice guidelines are utilized as a tool to determine eligibility for services and assist in making determinations regarding continued necessity of care. DWIHN refers to these protocols and guidelines to determine medically necessary supports, services, or treatment for those we serve. DWIHN develops its clinical practice guidelines from scientific evidence, professional standards and/or a consensus of board-certified health care professionals in the particular field. Where ever possible, guidelines are derived from nationally recognized sources and are evidence-based in their foundation. For any DWIHN developed clinical guidelines, a literature search is conducted, including a search for established practice guidelines from national organizations and professional associations. With the support of the Improving Practices Leadership Team (IPLT) and the direction of the Chief Medical Officer develops and maintains up to date clinical Practice Guidelines that are well researched and well documented in the literature for DWIHN's provider network.

The following criteria are considered when establishing priorities for adopting Clinical Practice Guidelines relevant to the membership: the incidence or prevalence of the diagnosis or condition, the degree of variability in treatment approaches or outcomes for the diagnosis or condition, the availability of scientific and medical literature related to the effectiveness of various treatment approaches. The final step occurs when the guidelines are posted on DWIHN website for provider use and access. Additionally, all providers utilize the practice guidelines to assist in ongoing treatment decisions and methods of behavioral health care.

Public review and comment are also an integral piece of the developmental process. Following a series of clinical trainings and postings on the DWIHN website of the most updated clinical protocols and practice guidelines, implementation takes place via the proposed policies process. DWIHN may choose to send the draft version of the clinical practice guidelines to contracted providers who treat the condition for feedback. The IPLT has ultimate responsibility for ensuring effective, evidence-based practice which is accomplished by the development or adoption of robust clinical guidelines. All clinical practice guidelines must be presented to the DWIHN's IPLT for approval.

DWIHN staff under direction of the Chief Medical Director assumes responsibility for continuous monitoring and updating of all practice guidelines and clinical protocols, regarding the latest literature, state/federal rules and regulations, and most effective standards of care. The Clinical Practice Guidelines are reviewed and updated at least every two (2) years or more frequently if national guidelines change during that two (2) year period. DWIHN expects its contracted practitioners to adopt these guidelines in their practice and encourages the use of evidence-based practices but recognizes the inability of the guidelines to address all individual circumstances. DWIHN monitors providers compliance with clinical guidelines through reports, treatment chart reviews, and/or process indicators. DWIHN supports its members in self-management of their conditions by making practice guidelines available on their website and through specific quality improvement initiatives/activities.

Verification of Services

The QAPIP addresses how DWIHN verifies whether services reimbursed by Medicaid were furnished to members by affiliates (as applicable) providers and subcontractors. The Individual Plan of Services (IPOS) is the conduit in which the Claims Verification process begins. DWIHN conducts claims verification reviews of randomly selected contracted providers encompassing all funding streams (MI-HEALTH LINK, Medicaid, SUD, Autism, Grants and General Fund) through desk audits, compliance investigations and on-site provider reviews. Bi-annually, DWIHN generates a statistically sound random sample, obtained from a pool of "Paid Encounters/Claims". The review sample size complies with the Office of Inspector General (OIG) minimum sampling standards. All program and clinical case records must comply with DWIHN's policy and procedures, existing requirements, and state guidelines as defined by MDHHS. Annually, DWIHN submits a report to MDHHS which contains its methodology for verification and its findings from the process, as well as providing any follow up actions that were taken because of the findings.

Verification for service includes testing of data elements from the individual claims/encounters to ensure the proper code is used for billing; the code is approved under the contract; the eligibility of the member on the date of service; that the service provided is part of the members IPOS (and provided in the authorized amount, scope and duration); the service date and time; services were provided by a qualified individual and falls within the scope of the code billed/paid; the amount billed/paid does not exceed the contract amount; and appropriate modifiers were used following the HCPCS guidelines.

Performance Monitoring

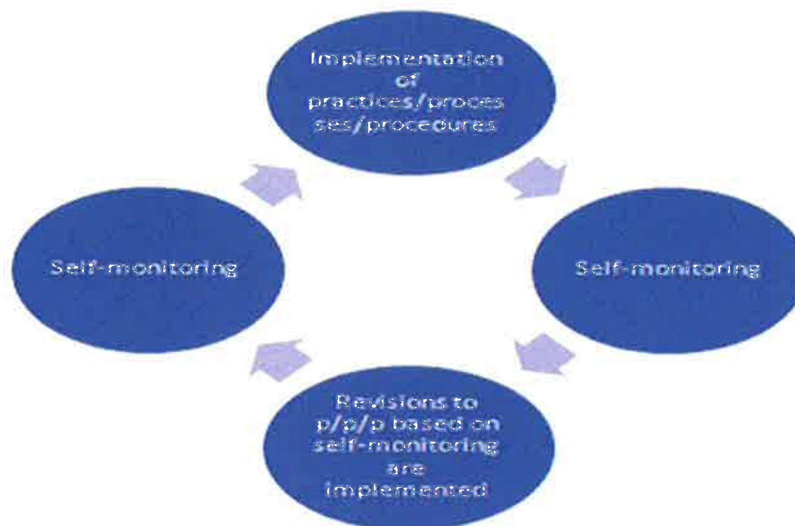
DWIHN annually monitors its provider network including any affiliates and subcontractors to which it has delegated managed care functions, including service and support provision. The process includes review and follow-up on any provider network monitoring of its subcontractors. The standards used to assess contractors are the applicable sections of the Social Security Act, the Code of Federal Regulations (CFR), the Center for Medicare and Medicaid (CMS), MDHHS Operations Manuals, Michigan's Medicaid State Plan, and the Michigan Medicaid Provider Manual.

In an ever-changing economy, quality services and supports that result in positive outcomes for persons that receive services in a cost-effective manner are crucial. DWIHN continues to move toward a system that ensures accountability and transparency relative to service quality and cost. As a result, DWIHN's QI Unit will continue to develop, train and implement a standardized system in which to measure performance and outcomes. These measurements will ensure accountability and transparency relative to the quality of services and cost. DWIHN's monitoring, which includes but is not limited to onsite, virtual and provider self-monitoring these monitoring measures are a component of the CQI process.

This process is designed to provide an organized documented process for assuring that eligible Detroit and Wayne County residents are receiving quality services for members with Serious Mental Illness, Severe Emotional Disturbance, Substance Use Disorders, Intellectual Developmental Disabilities, and Co-Occurring Disorders that are both medically necessary and appropriate standards of care while achieving the member desired outcomes.

DWIHN has adopted a performance monitoring process to support a CQI practice in an on-going effort to improve services through consistent evaluation, resulting in process/procedure/program refinements by on-going monitoring improvements as seen in Figure 1.

Figure 1.

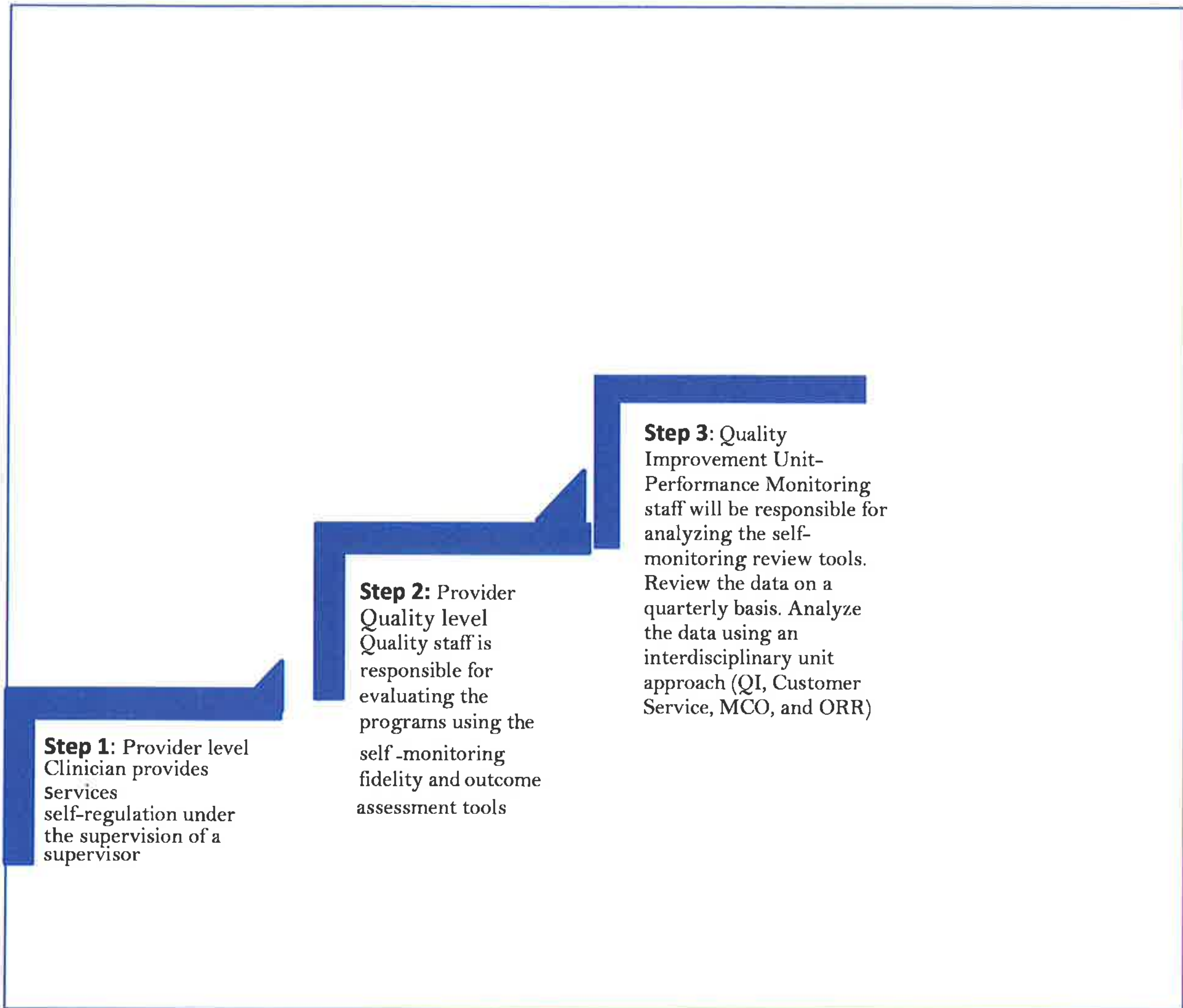


The Performance Monitoring Plan is geared to improve quality and measure our performance in the delivery of service and compliance with required standards. This plan requires the involvement, skills, expertise and input from DWIHN's Service Provider Network and internal staff. Requiring self-regulation and monitoring by all partners (DWIHN, Contracted Providers, Practitioner and Members).

As part of the monitoring process, DWIHN developed multiple levels using a standardized self-monitoring/self-regulating approach. This multilevel monitoring approach begins at the service provider level and cascades up to DWIHN's Quality Improvement Team. The "Monitoring Process" standardized tools assist in the documentation to ensure that:

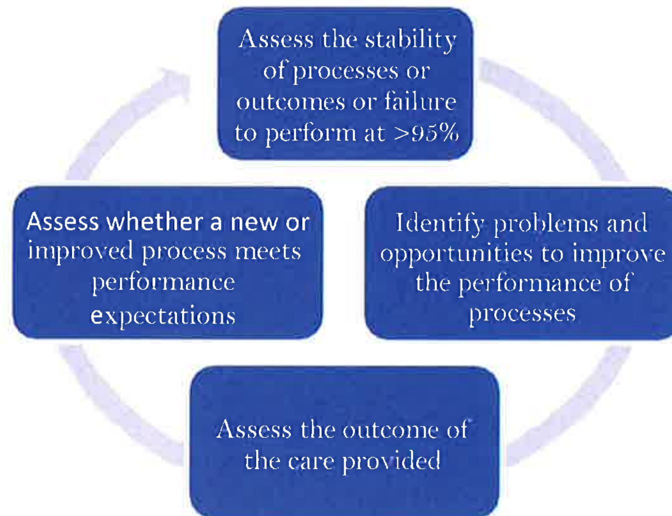
- Actions and/or process requirements are not open to different interpretations
- The process is made easier to understand
- Non-value-added steps are eliminated
- Effectiveness and efficiency are increased
- The process can be benchmarked to determine if it is excellent or to set new performance goals
- DWIHN and Contracted Provider staff can collect evidence relying on process conformity to increase validity and reliability in findings.

Process Steps of Performance Monitoring Pathway (defined by QI)

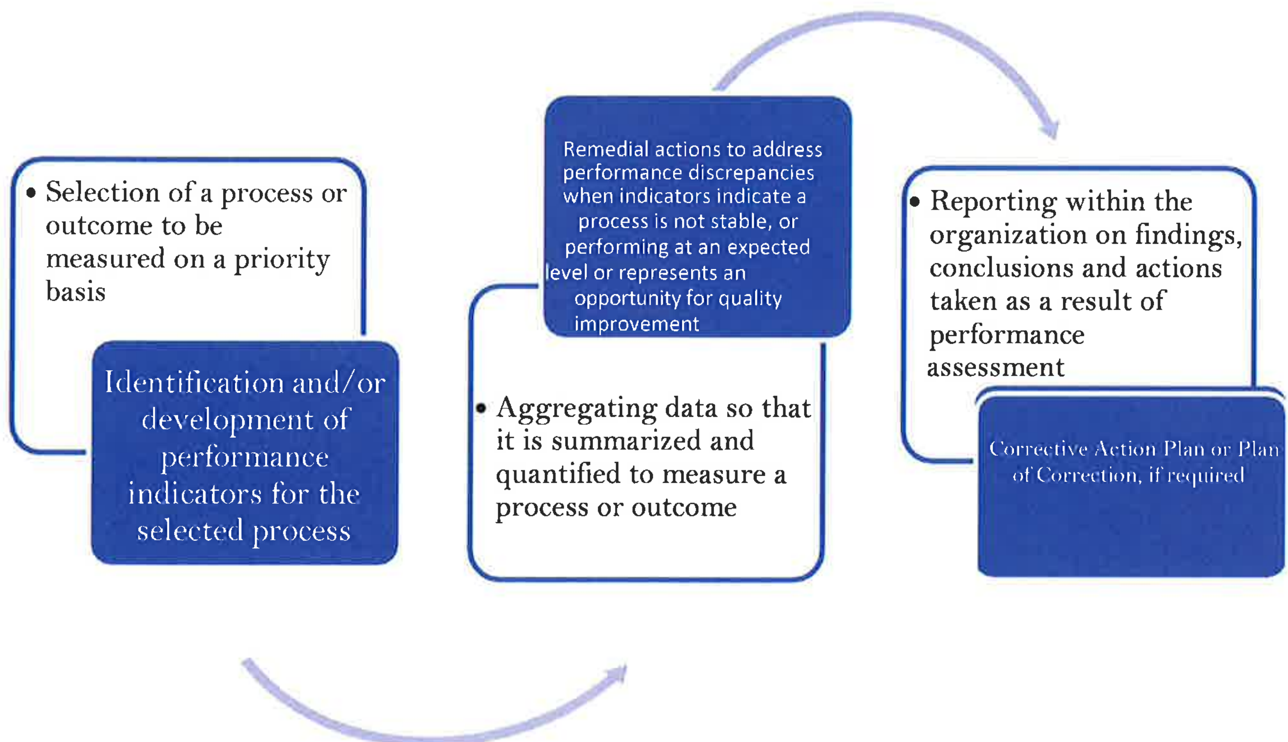


Performance Measurement

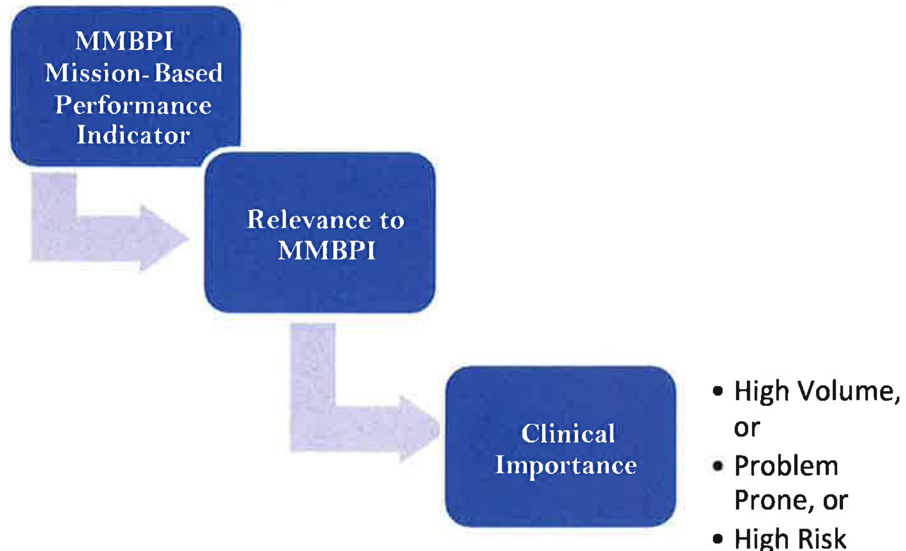
Performance measurement is a critical component of the PDSA cycle. Performance Measurement is the process of regularly assessing the data results produced by a program. The ***purpose*** of measurement and assessment is to:



Measurement and assessment ***involve***:

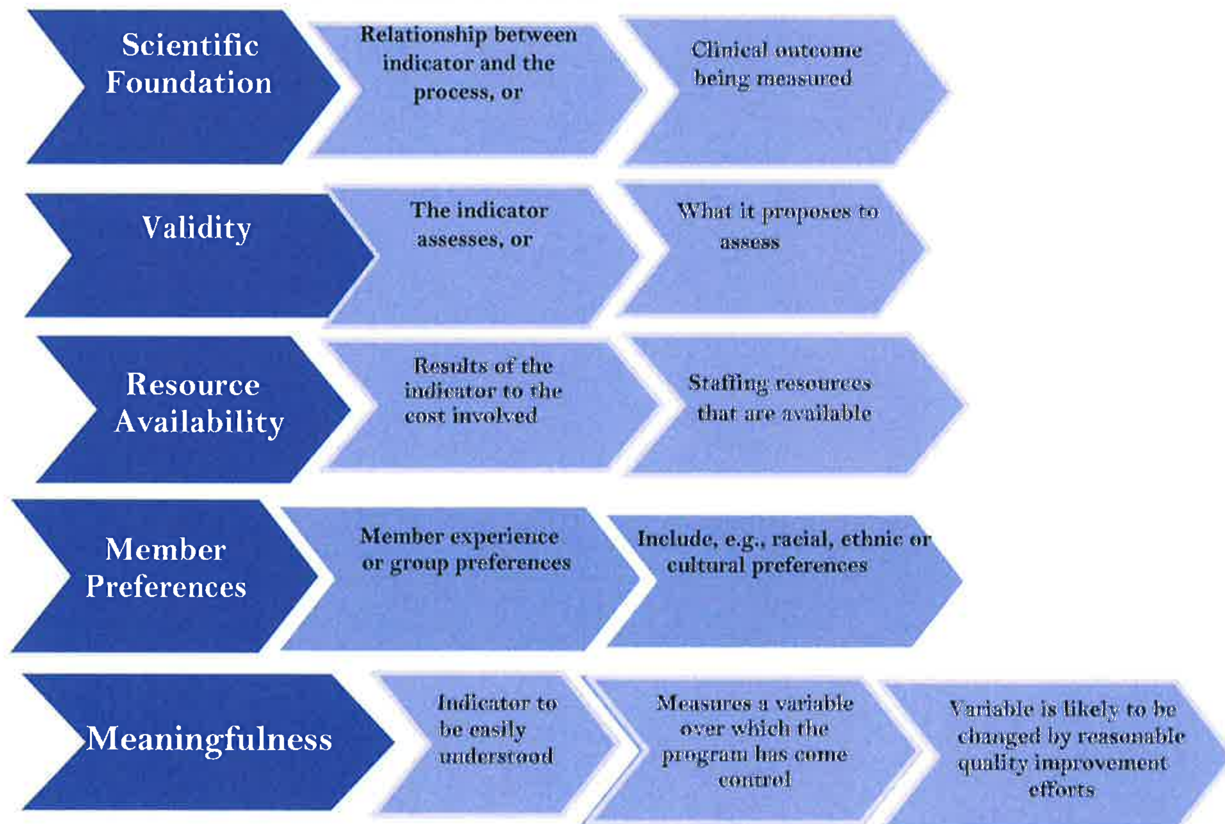


Selection of a Performance Indicator



Characteristics of a Performance Indicator

Factors to consider in determining which indicator to use include:



The Performance Indicators Selected for the DWIHN'S Quality Improvement Plan FY21-23 from the Strategic Plan

For purposes of this plan, an indicator(s) comprises five (5) key elements: name, definition, data to be collected, the frequency of analysis or assessment, and preliminary ideas for improvement. The following ten (10) performance indicators will be the focus using the Board approved Strategic Plan, Pillars and Focus Areas.

Measure of Service	
Name	***Michigan Mission Base Performance Indicators (MMBPI)***
Definition	*This includes the indicators found in the MDHHS Code Book.*
Data Collection	*The data is collected through MH-WIN, and the remainder is calculated by MDHHS.*
Assessment Frequency	*The Quality Improvement Steering Committee will assess information associated with the indicator on a monthly basis and submit to MDHHS Quarterly.*
Measure of Service	
Name	***Member Grievances***
Definition	*An expression of dissatisfaction with any aspect of the operations or activities by the Service Provider or DWIHN.*
Data Collection	*Primarily collected through MHWIN.*
Assessment Frequency	*The Customer Service Committee will assess information associated with the indicator on a Quarterly basis.*
Measure of Service	
Name	***Member Satisfaction***
Definition	*Measure of how services meet or exceed member expectation*
Data Collection	*MH-WIN, Survey, Member Questionnaire*
Assessment Frequency	*The Customer Service Committee will assess information associated with the indicator on a Quarterly basis.*
Measure of Service	
Name	***Clinical Practice Improvement***
Definition	*Measure of Model Fidelity or Measure of outcomes of persons served within various Evidence-Based, Practice-Based Evidence, Best Practices*
Data Collection	*Through Provider Data, MH-WIN*
Assessment Frequency	*The Quality Improvement Committee will assess information associated with the indicator on a Quarterly basis.*

Measure of Service	
Name	***Finance***
Definition	*Ensure financial solvency of DWIHN and Network Providers*
Data Collection	*Site Reviews, Audits, Financial Reports*
Assessment Frequency	*The Quality Improvement Steering Committee will assess information associated with the indicator on a Quarterly basis or as needed.*
Measure of Service	
Name	***Crisis Services***
Definition	*Completion of Crisis/Safety Plans as applicable for each member by Contracted Providers*
Data Collection	*MH-WIN, Performance Monitoring*
Assessment Frequency	*The Quality Improvement Steering Committee will assess information associated with the indicator on a Quarterly basis.*
Measure of Service	
Name	***7 Day Follow-up***
Definition	*Ensure appointments are scheduled and attended by members*
Data Collection	*Performance Indicator Module in MH-WIN*
Assessment Frequency	*The Quality Improvement Steering Committee will assess information associated with the indicator on a Monthly and Quarterly basis.*
Measure of Service	
Name	***30 Day Follow-up***
Definition	*Ensure appointments are scheduled with Mental Health Professionals and attended by Members.*
Data Collection	*MH-WIN, Performance Monitoring*
Assessment Frequency	*The Quality Improvement Steering Committee will assess information associated with the indicator on a Monthly and Quarterly basis.*

Measure of Service	
Name	***Critical Event/Sentinel Event/Death Reporting***
Definition	*Reporting of health and safety incidents and 911 calls by Contracted Providers*
Data Collection	*MH-WIN*
Assessment Frequency	*The Quality Improvement Steering Committee, Critical Sentinel Event, Peer Review and Death Review Committees will assess information associated with the indicator on a Monthly and Quarterly basis.*
Measure of Service	
Name	***Advocacy***
Definition	*Identify ways to improve community inclusion and integration.*
Data Collection	*MH-WIN, Site Review, Performance Monitoring, HCBS*
Assessment Frequency	*The Quality Improvement Steering Committee and Constituents Voice will assess information associated with the indicator on a Quarterly basis.*

Performance Indicators Assessment

The Assessment of the Performance Indicators is accomplished by comparing actual performance on an indicator with:

- Self over time
- Pre-established standards, goals or expected levels of performance;
- Information concerning evidence-based practices;
- Other systems or similar service providers

Specific, measurable, actionable, relevant and timely data is a critical element of Quality Improvement operations. Quality Improvement unit staff is engaged in on-going processes for identification of data process deficiencies and opportunities to improve accuracy and completeness of the DWIHN's datasets in MH-WIN and in the state's data warehouse.

The Quality Improvement Unit has responsibility for oversight of the Michigan Mission Based Performance Indicator (MMBPI) System data. Standardized indicators, based on the systematic, on-going collection and analysis of valid and reliable data are utilized. Performance measures utilized have been established by MDHHS in the areas of access, efficiency and outcome. This data is reported to MDHHS according to established timelines and formats. Data is also reported quarterly to various factions of the quality Improvement infrastructure (i.e., Program Compliance Committee, Quality Improvement Steering Committee, Quality Operations Technical Assistance Workgroup, etc.).

SECTION 4: Committee Structure

To promote quality throughout DWIHN's organization, DWIHN has created committees to provide oversight and implementation of all quality improvement activities.
The quality improvement activities are achieved through a complex infrastructure which includes key stakeholders and process owners, and cross-functional units and committees. Due to the Covid-19 global pandemic, committees have been utilizing virtual meeting platforms. The structure is depicted below:

Program Compliance Committee (PCC)

The Program Compliance Committee (PCC) is a committee of the Board of Directors, and provides leadership for the Quality Improvement process through supporting and guiding implementation of quality improvement activities at DWIHN; and reviewing for changes, evaluating, need for Board Actions and approving the QAPIP Description biennial, the QAPIP Evaluation and Work Plan annually.

Membership:

DWIHN's PCC Committee consists of members of the Board of Directors. The Chief Clinical Officer is the liaison to the committee. Meeting notices are posted in public places and on DWIHN's website. Meetings are open to the public.

Function of the Committee:

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

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

Quality Improvement Steering Committee (QISC)

DWIHN's Quality Improvement Steering Committee (QISC) is an advisory group with responsibility for ensuring system-wide representation in the planning, implementation, support and evaluation of DWIHN's continuous quality improvement program. The QISC provides ongoing operational leadership of continuous quality improvement activities for DWIHN. It meets at least monthly or not less than nine (9) times per year. The QISC provides leadership in practice improvement projects and serves as a vehicle to communicate and coordinate quality improvement efforts throughout the quality Improvement program structure.

Membership:

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

Function of the Committee:

- Establish and annually review committee operational guidelines, such as confidentiality, meeting frequency, management of information requests, number of members required for a quorum, membership, etc.
- Establish committee goals and timelines for progress and achievement.
- Participate in the development and review of quarterly/annual reports to the Program Compliance Committee and the Full Board of Directors regarding the Quality Improvement System.
- Annually review and evaluate the effectiveness of the Quality Assessment Performance Improvement Program.
- Oversee a circular communication process in order to ensure that all involved constituencies, including the Board of Directors, DWIHN staff, and members, providers and other stakeholders are a part of the Quality Improvement Process.
- Provide recommendations and feedback on process improvement, program implementation, program results and program continuation or termination.
- Examine quantitative and qualitative aggregate data at predetermined and critical decision-making points and recommend courses of action.
- Review reports from regulatory DWIHN reviews.
- Review of DWIHN improvement plans and make recommendations based on these reviews.
- Monitor progress and completion of plans of correction in response to recommended remedial actions identified for the DWIHN or by regulatory organizations.
- Review quality Improvement operating procedures and propose changes in procedures as needed.
- Oversee a process for establishing, continuing or terminating subcommittees, standing committees, improvement teams, task groups and work groups.

- Identify training needs and opportunities for staff development in the quality Improvement process.
- Identify future trends and make recommendations for next steps.
- Develop standardized forms required for the work of the Steering Committee.
- Initiate and participate in recognition and acknowledgement of successes in quality Improvement for the DWIHN and the community mental health system.
- Leadership in practice improvement projects.

Improving Practices Leadership Team (IPLT)

DWIHN endeavors include implementation and support of Best and Evidence-Based Practices (EBP). The purpose of the Improving Practices Leadership Team (IPLT) is to oversee and monitor these practices. IPLT is charged with developing work plans, coordinating the regional training and technical assistance plan, working to integrate data collection, developing financing strategies and mechanisms, assuring program fidelity, evaluating the impact of the practices, and monitoring clinical outcomes.

Membership:

The IPLT committee is chaired by the Clinical Officer and includes Improving Practice Leadership Specialists in the following areas:

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

Function of the Committee:

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

- Identify and mobilize program leaders or change agents within the organization to implement the activities required to achieve the desired outcomes.
- Develop an on-going process to maximize opportunities and overcome obstacles.
- Monitor outcomes and adjust processes based on learning from experience.
- Align relevant persons, organizations, and systems to participate in the transformation process.
- Support Membership of a Member/Certified Peer Support to represent the PIHP/CMHSP on the Recovery Council of Michigan.
- Assess parties' experience with change.
- Establish effective communication systems.
- Ensure effective leadership capabilities.

- Enable structures and process capabilities.
- Improve cultural capacity.
- Demonstrate their progress in system transformation by implementing evidence based, promising and new and emerging practices.

Standing Committees

DWIHN's quality Improvement system consists of standing committees that oversee on-going monitoring, peer evaluation, and improvement functions, including receipt and review of data related to their identified areas of responsibility. This structure is designed to improve quality of care to members, improve operations of providers and promote efficient and effective internal operations. Standing Committees may be assigned quality indicators to use in monitoring aspects of care and service or may establish indicators for which data will be collected and monitored.

The standing committees consist of qualified representatives of DWIHN units, providers and in some cases, stakeholders and members. The committees define aspects of services and supports to be monitored for opportunities to improve, based on priorities established in the MDHHS contract and on the needs of high-risk members and high volume/problem-prone programs. Results from DWIHN's Performance Indicators System, which is an extension of the MDHHS data collection program, are a key source for identification of aspects to be monitored. The committees develop plans by which data for their scope of responsibility will be reviewed and opportunities for improvement identified. QI staff work with the committees and assure that the principles of data based continuous quality improvement are followed. The standing committees monitor improvements that are implemented for effectiveness and improved outcomes.

Standing committees identify and recommend needs for quality improvement teams, as appropriate, and may bring in outside resources, if needed, to facilitate the work of teams and to facilitate involvement of internal staff, providers, members, stakeholders and various outside groups, as needed. The standing committees are:

Critical/Sentinel Events Committee (CSEC)

The Critical/Sentinel Event process involves the reporting of all unexpected incidents involving the health and safety of the members within DWIHN's service delivery area. Incidents include, at a minimum, member deaths, medication errors, behavioral episodes, arrests, convictions, physical illness and injuries. The CSEC retains the right to make the final decision whether an incident is a Critical/ Sentinel Event. As applicable, when necessary to respond to questions/concerns of the CSEC others will be requested to attend.

Membership includes but not limited to:

- Medical Director
- Utilization Management
- Managed Care Operations
- Quality Improvement
- Substance Use Disorders Initiatives
- Office of Recipient Rights

Function of the Committee:
The mission and goal of the CSEC is to ensure the Contracted Providers and/or Clinically Responsible Service Providers (CRSP) conduct a thorough review of incidents with an action plan to ensure the incident does not reoccur or the risk of the incident reoccurring is minimized.

The CSEC uses a four-tiered system of peer review activity. In the first tier, the Critical Events are reviewed by QI Critical/Sentinel Event Liaison for data collection, reviewed for quality of care issues, request for additional documents, completeness of the information and notification of high-risk critical incidents to DWIHN's QI Director and the DWIHN's Administration.

In the second tier, the Critical/Sentinel Events are reviewed by the Medical Director, Chief Clinical Officer and the QI Critical/Sentinel Event Liaison for clinical issues, standards of care and potential Sentinel Events.

In the third tier, the Critical/Sentinel Events are reviewed by DWIHN's Peer Review Committee, if needed, as a peer review activity. Findings can include requests for corrective action plans, if needed. Repeated deficits or failures to correct identified deficits may result in recommendations for performance sanctions as defined by DWIHN policy, procedures and contracts.

In the fourth tier, the data collection is reviewed by DWIHN's Critical/Sentinel Event Committee for policy review and implementation, patterns, trends, compliance, education and improvement and presentation to DWIHN PCC.

Death Review Committee (DRC)
All unexpected* deaths of Member who at the time of their deaths were receiving specialty supports and services must be reviewed and must include:

- Screens of individual deaths with standard information (e.g., coroner's report, death certificate).
- Involvement of medical personnel in the mortality reviews.
- Documentation of the mortality review process, findings, and recommendations.
- Use of mortality information to address quality of care.
- Aggregation of mortality data over time to identify possible trends.

* Unexpected deaths include those that resulted from suicide, homicide, an undiagnosed condition, accidental, or suspicious for possible abuse or neglect. As applicable, when necessary to respond to questions/concerns of the DRC other persons will be requested to attend.

Membership includes but not limited to:

- Medical Director
- Clinical Practice Improvement
- Managed Care Operations
- Quality Improvement
- Office of Recipient Rights
- Integrated Health Care
- Substance Use Disorders

Function of the Committee:

The mission and goal of the DRC is to ensure that a thorough review of the Member's death has been conducted by the Member's respective Service Provider, CRSP, Recipient Rights and Clinical Practice Improvement Units. All reviews are conducted in accordance with DWIHN's Death Reporting Policy and procedures, state and federal laws and regulations that govern death review activities.

Peer Review Committee (PRC)

The PRC Committee is a peer review activity responsible for the clinical peer review of critical incidents involving, at a minimum, Member deaths, Critical/ Sentinel Events, incidents involving the media or special requests from DWIHN's Medical Director or Administration. All peer review activities are privileged, confidential and are in accordance with the state and federal laws and regulations that govern peer review activities. As applicable, when necessary to respond to questions/concerns of the PRC Committee other persons will be requested to attend.

Membership:

- Medical Director
- Clinical Practice Improvement
- Managed Care Operations
- Quality Improvement
- Office of Recipient Rights
- Integrated Health Care
- Substance Use Disorders

Function of the Committee:

The mission and goal of the PRC Committee is to ensure the Service Providers and CRSP conduct a thorough review of incidents and provide an action plan that will ensure similar incidents do not reoccur and that the risk of reoccurring is minimized. The goal of the PRC Committee is to review the processes at the Service Provider and CRSP when conducting a thorough clinical review of the incident in accordance with DWIHN's Peer Review Policy and Procedures. All Peer Review activities are privileged, confidential and are in accordance with state and federal laws and regulations that govern Peer Review activities.

Behavioral Treatment Advisory Committee (BTAC)

DWIHN's Behavioral Treatment Advisory Committee is charged with the oversight of nine (9) Behavioral Treatment Plan Review Committees (BTPRC) in the network. The committee takes the lead for implementing a systematic approach to monitor service providers and compliance with the MDHHS standards for BTPRC. The committee reviews system-wide BTPRC trends and patterns compared to key indicators such as psychiatric hospitalization, behavior stabilization, reductions or increases in the use of interventions, crisis plans, and behavior treatment plans. The representatives from the network providers are invited for the case validation review process at the BTAC as part of continuous quality improvement at the PIHP level. The committee submits quarterly BTPRC data analysis reports to MDHHS.

Membership:

The committee consists of DWIHN's Medical Director, licensed psychologist, Member, DWIHN staff, provider representatives and Office of Recipient Rights (ORR). The representative of DWIHN's ORR is required to attend each Behavior Treatment Review Committee (BTRC) on Behavior Treatment Plan Requirements for the service provider network.

Each of the providers BTRC consists of a licensed psychologist, a licensed physician/psychiatrist and DWIHN's ORR who assigns a representative. Each committee sends representative(s) to the monthly DWIHN's Behavior Treatment Advisory Committee.

Function of the Committee:

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

- Percent of provider Behavior Management committees with active Recipient Rights representation.
- Types of challenging behaviors resulting in intrusive and/or restrictive interventions.
- Percent of Member exhibiting challenging behaviors per the client record with behavior treatment plans.
- Types of interventions used.
- Frequency and duration of interventions used.
- Frequency of review of behavior management plans.
- Percent of interventions matching behavior management plans.
- Percent of charts labeled appropriately.
- Number of Critical/Sentinel Events involving challenging behaviors.
- Percent of care staff at all levels trained in behavior management (i.e., positive behavior management, the culture of gentle teaching, management of challenging behaviors, etc.).
- Percent of care staff at all levels who demonstrate the required behavior management competencies.
- Number of behavior management related Office of Recipient Rights complaints.

Credentialing Committee

The purpose of the committee is to delineate and describe the functions and oversight of DWIHN's Credentialing Verification Organization (CVO) and the responsibilities of the Service Providers, and to implement credentialing/re-credentialing functions.

In compliance with MDHHS' Credentialing and Re-credentialing processes, DWIHN has established written policy and procedures for ensuring appropriate credentialing and re-credentialing of the provider network. Quality Improvement monitors the provider network qualification of staff to ensure compliance with federal, state, and local regulations. Performance monitoring is completed no less than annually through an established process to ensure providers of care or support are qualified to perform their jobs.

Membership:

- Medical Director
- Network Providers
- DWIHN Staff

Risk Management

The purpose of the committee is to review incidents involving Member and the provider system under the protection of protected information. The Risk Management Committee is an ad-hoc committee and meets as required.

Membership:

- Chief Financial Officer
- Medical Director
- Corporate Compliance Officer
- Deputy CEO/COO
- Others as needed

Function of the Committee:

- Continuously improve member safety and minimize and/or prevent the occurrence of errors, events, and system breakdowns leading to harm to patients, staff, volunteers, visitors, and others through proactive risk management and patient safety activities.
- Minimize adverse effects of errors, events, and system breakdowns when they do occur.
- Minimize losses to the organization overall by proactively identifying, analyzing, preventing, and controlling potential clinical, business, and operational risks.

Cost Utilization Steering Committee

The utilization, standards, access etc. to clinical services, Cost Utilization looks at where our spending is occurring, analyzes the trends, and makes recommendations for the system based on Strategic Initiatives, Market Forecasts, and our historical data.

Membership:

- Chief Financial Officer
- Deputy Financial Officer
- Chief Information Officer
- Deputy CEO/COO
- Medical Director

Function of the committee:

- To receive data from the Cost Integrity Group (CIG), Procedure Code Work Group, along with the contractual expectations.
- Review the needs for improved clinical outcomes (UM/QM/CPI data or input), state mandates (such as EBPs).
- Finds ways fund necessary functions or services. It contemplates state funding (revenue) and network funding (costs) and fund source management along with cost and utilization data integrity and even system processes.
- As a steering committee it would set the priorities for managing our funding to achieve our operating expectations.

Compliance Committee

The Compliance Committee shall meet, at a minimum, on a bi-annual basis during the fiscal year. However, the Compliance Officer can schedule additional meetings as deemed necessary. A majority of the Committee constitutes a quorum for the transaction of business. The Committee shall act by the affirmative vote of a majority of the Committee Member present at a duly held meeting.

Membership:

- Corporate Compliance Officer
- Deputy CEO/COO
- Chief Financial Officer
- Medical Director

Function of the Committee:

- Assist the Compliance Officer with risk assessment and the need for and design of compliance reviews within the organization.
- Advise the Compliance Officer on compliance training needs within the organization and assist in arranging for and conducting such compliance training.
- Assist the Compliance Officer with developing organizational policies supporting the Compliance Plan.
- Assist the Compliance Officer with implementation of the Compliance Plan.
- Assist the Compliance Officer with evaluation of the effectiveness of the Compliance Plan.
- Refer all matters to the Program Compliance Committee (PCC) and the Board for review that relate to the following:
  - Violations that require notification to federal, state, and/or local agencies.
  - Violations that have an economic impact (i.e. budgetary) on the Network and/or require funds to be returned to federal or state agencies.
  - Any other information that the Compliance Committee deems appropriate for Board notification.

Customer Service Committee

The purpose of the committee is to provide procedural and operational guidance on Customer Service functions to DWIHN, the Access Center, Crisis services vendor, and Service Providers. The Customer Service Committee meets on a quarterly basis.

Membership:

- Customer Service Director
- Grievance Coordinator
- Appeals Coordinator
- Provider Customer Services, Grievance, and Appeal staff
- Others as needed

Function of the Committee:

The quarterly meetings are facilitated by DWIHN's Customer Service Department to coordinate with the Customer Service, Grievance and Appeals management at the Service Provider levels that addresses Customer Service, Grievance and Appeals related updates and issues. It also provides for a venue to network and share programs, processes and upcoming events that are occurring in their respective networks.

Recipient Rights Advisory Council (RRAC)

The RRAC is mandated by the Michigan Mental Health Code (MCL 330.1757). The RRAC meets bi-monthly, on the first Monday of every odd-numbered month, from 1:00 – 3:00. The meetings are governed by the Open Meetings Act and the public is welcome to attend.

Membership:

Is broadly based so as to best represent the varied perspectives of the CMHSP's geographical area. At least 1/3 of the Membership shall be primary Member or family Member, and of that 1/3, at least ½ shall be primary Member.

Function of the committee:

- Protect the Office of Recipient Rights (ORR) from pressures that could interfere with the impartial, even-handed, and thorough performance of its functions.
- Serve in an advisory capacity to the executive director and the director of ORR Other specific functions.
- Review the process for funding ORR.
- Recommend candidates for the Director of ORR to the Executive Director.
- Consult with the Executive Director regarding any proposed dismissal of the Director of ORR.
- Receive education and training in ORR policies and procedures.
- Review the Semi-Annual report submitted to the MDHHS.
- Review the Annual report submitted to MDHHS.
- Provide "Goals for ORR" and "Recommendations for ORR" for the Annual Report.
- The RRAC also serves as the Recipient Rights Appeals Committee.

Access Committee (AC)

The Access Committee is charged with developing strategies and working within the organization to provide oversight for the timeliness standards set by our Regulatory agencies. Data along with operational obstacles, and strategies to address challenges will be discussed and action steps will be developed to ensure availability. Recommendations would include documentation and implementations of provider expectation, identifying and addressing barriers, corrective action when those expectations are not met around access standards. The Committee will ensure quality of care monitoring is being developed by setting up additional monitoring mechanisms around access standards. i.e. monitoring access complaints received, % of Availability of appointments within a standard established, etc.

Membership includes but not limited to:

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

Function of the committee:

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

Research Advisory Committee (RAC)

The purpose of the committee is to implement a research proposal review process, recommend research and evaluation aligned with DWIHN's strategic priorities, and to oversee the protection of any human subjects/members and staff involved in research initiatives. The RAC shall meet at least quarterly or as often as necessary to carry out its charge.

Membership

- Chief Financial Officer
- Medical Director
- Quality Improvement
- Clinical Practice Improvement
- Utilization Management
- Service Providers

Function of the committee:

- Act as a collaborative body to encourage the development of research and evaluation proposals within the framework of a research agenda informed by DWIHN's strategic priorities
- Provide recommendations regarding research and evaluation projects
- Encourage and promote the utilization of research-based practice

Constituent's Voice

The Constituents' Voice (also known as the "CV") is a DWIHN Member advisory group. The body is charged with advising the Network, and specific to driving policies and agendas that facilitate community inclusion.

Membership:

The diverse group of Member, advocates and providers meets monthly. Generally, meetings are held at DWIHN on the fourth Friday of each month from 10:00am -12:00pm.

Function of the Constituent's Voice:

The CV provides oversight for hosting an annual conference that focuses on trending community inclusion issues. The education of stakeholders about community inclusion, i.e. personally, valued participation and interactions with others. The solicitation of funds and sponsorships for the mini-grant project – The George Gaines & Roberta Sanders Fund for Community Inclusion, which was established in 2015. The body also sponsors various advocacy and community efforts to advance inclusion. Events include the annual Michigan Walk-A-Mile in My Shoes event and voter registration drives.

Quality Improvement Teams, Ad Hoc Committees and Workgroup

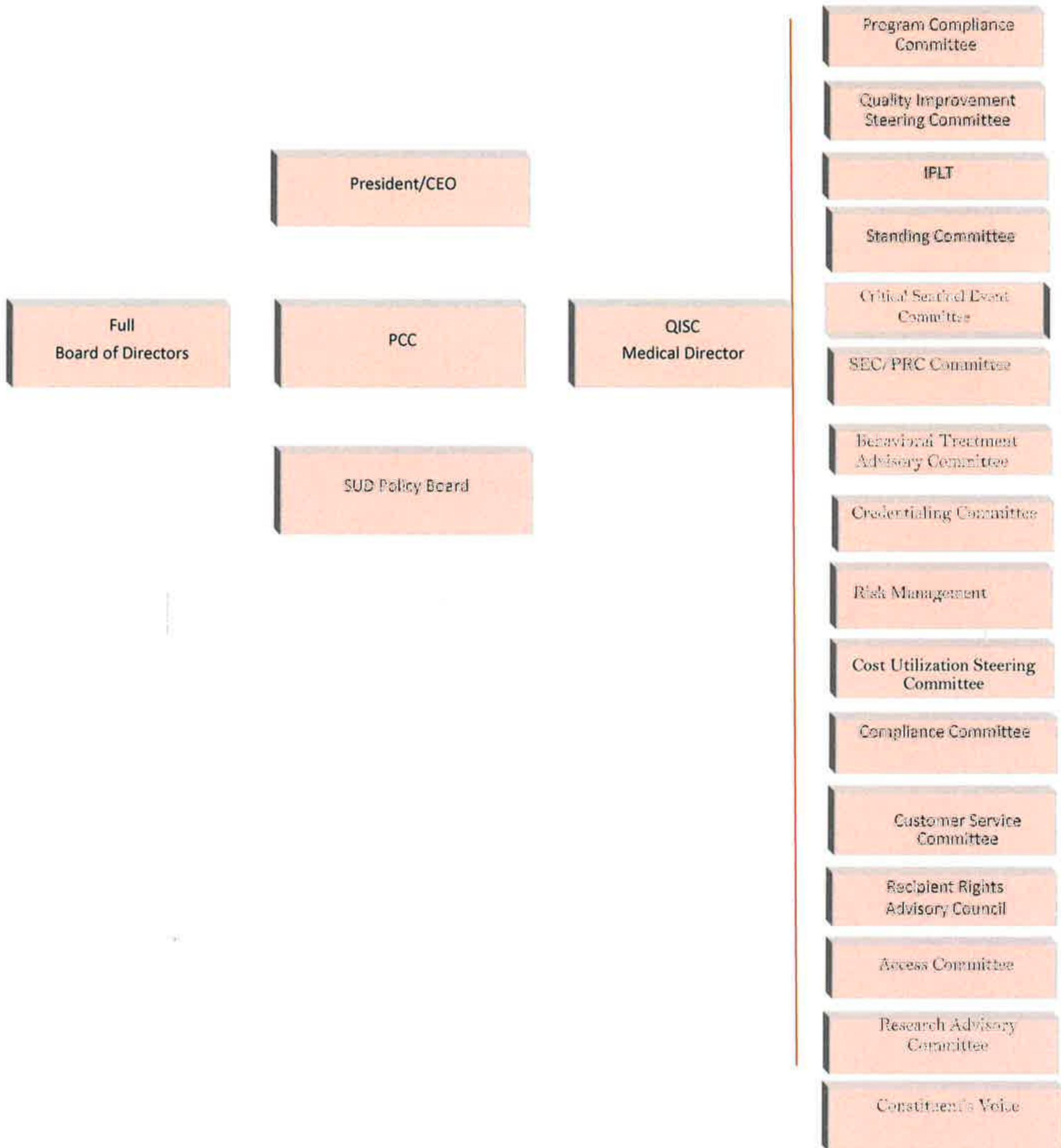
DWIHN may identify opportunities for improvement that do not fit into the existing standing committee structure. Ad hoc teams, workgroups and quality circles are appointed for a limited period of time for a specific task by the Quality Improvement Steering Committee, Quality Improvement or a Standing Committee based on organizational need. Reports from the various Committee(s), Ad hoc team(s), DWIHN Unit(s) and workgroup(s) will include outcome measures and are forwarded to the Quality Improvement Steering Committee (QISC).

Utilization Management (UM)

The Utilization Management (UM) program is an integral part of the DWIHN's QAPIP. DWIHN is required to have a written Utilization Management Program Description which includes procedures to evaluate medical necessity, criteria used, information sources and the process used to review approve the provision of medical services. The UM program has mechanisms to identify and correct under-utilization as well as over- utilization. Prospective (preauthorization), concurrent and retrospective procedures are established and include:

- Review, deny or reduce service decisions
- Efforts to obtain all necessary information, including pertinent clinical information and consultation with the treating physician as appropriate.
- The reasons for the decisions clearly documented and available to the member.
- Well-publicized and readily available appeals mechanisms for both providers and service recipients, and notification of denial.
- Decisions and appeals made in a timely manner as required by the exigencies of situation.
- Mechanisms to evaluate the effects of the program using data on member satisfaction, provider satisfaction, or other appropriate measures.

To ensure the above goals are achieved, DWIHN UM department has developed a comprehensive UM Program Description Plan for the provider network to ensure that these standards are met. The activities conducted to detect underutilization (for example, various service utilization reports, performance measures, adherence to CPGs, provider/member profiling, appeals and grievances, financial reports, etc.) includes analyze over and underutilization data on a scheduled and ad-hoc basis and report results at least annually to UM Committee for further review and action. Refer to the UM Program Description Plan for specific processes and procedures implemented.



President/CEO
Full
Board of Directors
PCC
QISC
Medical Director
SUD Policy Board
Program Compliance
Committee
Quality Improvement
Steering Committee
IPLT
Standing Committee
Critical Sentinel Event
Committee
SEC/PRC Committee
Behavioral Treatment
Advisory Committee
Credentialing Committee
Risk Management
Cost Utilization Steering
Committee
Compliance Committee
Customer Service
Committee
Recipient Rights
Advisory Council
Access Committee
Research Advisory
Committee
Constituent's Voice

SECTION 5: Quality Improvement Evaluation

The Quality Improvement evaluation is completed at the end of each fiscal year. The annual evaluation is conducted by DWIHN and submitted to MDHHS and kept on file at DWIHN, along with the QAPIP description. These documents will be reviewed by Health Services Advisory Group (HSAG) and MDHHS as part of the certification process. The evaluation summarizes the goals and objectives of DWIHN's Quality Improvement Work Plan. The Quality Improvement Work Plan specifies quality improvement activities DWIHN will undertake in the upcoming year. The plan includes goals and objectives based on the strengths and weaknesses identified in the previous year's evaluation and issues identified in the analysis of quality metrics. The Work Plan is the mechanism for tracking quality improvement activities and is updated as needed to assess the progress of initiatives. The foundation of the Work Plan addresses the following NCQA focus areas:

- Quality and safety of clinical care
- Quality of service
- Member Experience
- Yearly goals and objectives
- Planned Activities
- Monitoring of previously identified issues
- Evaluation/outcomes
- Time frame for each activity's completion
- The staff member responsible for each activity
- Evaluation of the QI program

The Quality Improvement Work Plan is reviewed and approved by the Program Compliance Committee (PCC) and the Full Board of Directors annually.

Plan Action for 2021

In FY 2021, the QAPIP work plan will be reviewing these areas to achieve continuous quality improvement in the quality and safety of clinical care, quality of service and member experience.

- Maintain NCQA accreditation.
- Telehealth services have emerged as essential technology for providing services to our members during Covid-19. It is imperative to ensure adequate and efficient services are being provided to the people we serve and that proper monitoring of this service delivery is accomplished.
- Establish an effective Crisis Response System and Call Center
- Continuously improve the quality, appropriateness, availability, accessibility, coordination and continuity of health care services to members across the continuum of care.
- Improve member and provider satisfaction.
- Conduct reviews through virtual monitoring to ensure that telehealth services are compliant in accordance with regulatory standards.
- Ensure a high-quality network through credentialing, peer review and contracting processes.

- Continue to collaborate with providers to share ideas and implement strategies to improve care coordination and quality of service.
- Improve and manage member outcomes, satisfaction and safety.
- Maintain excellent compliance with state and federal regulatory requirements, and accreditation standards.
- Ensure DWIHN's organizational initiatives related to cultural competency and diversity for members and providers meet the needs of DWIHN members.
- Demonstrate and communicate DWIHN's commitment to improving progress toward influencing network-wide safe clinical practices.

Upcoming Goals for Fiscal Year Ending, September 30,2021

In FY 2022, the QAPIP work plan will be reviewing these areas to achieve continuous quality improvement in the quality and safety of clinical care, quality of service and member experience.

- Maintain NCQA accreditation.
- Continue coordinated regional response to COVID-19 pandemic, including expansion of the use of telehealth for a broad array of supports/services.
- Establish an effective Crisis Response System and Call Center.
- Continuously improve the quality, appropriateness, availability, accessibility, coordination and continuity of health care services to members across the continuum of care.
- Continue implementation transition of Home and Community Based Services Waiver.
- Improve member and provider satisfaction.
- Conduct reviews through virtual monitoring to ensure that telehealth services are compliant in accordance with regulatory standards.
- Ensure a high-quality network through credentialing, peer review and contracting processes.
- Establish and revised/improved regional standardized contract and provider performance monitoring protocols for autism service providers, fiscal intermediary services, specialized residential providers and inpatient psychiatric units.
- Continue to collaborate with providers to share ideas and implement strategies to improve care coordination and quality of service.
- Improve and manage member outcomes, satisfaction and safety.
- Maintain excellent compliance with state and federal regulatory requirements, and accreditation standards.
- Ensure DWIHN's organizational initiatives related to cultural competency and diversity for members and providers meet the needs of DWIHN members.
- Address regional role in statewide training and provider performance monitoring reciprocity activities.

- Continue efforts to participate in children/family outreach by attending community events, schools, and working with children service providers to increase mental heath awareness, information, and access to services.
- Continue efforts on children services. In 2022, DWIHN will begin a campaign/initiative called "Mental Health Care—No Child Left Behind". We are going to extend our scope and resources to reach the over 285,000 school-aged kids we have in Wayne County.
- Support DWIHN in establishing improved performance metrics for services and supports and for MDHHS incentive payment metrics (including follow-up after hospitalization for mental illnesses, follow-up to persons with a SUD diagnosis following contact with an Emergency Room; identification and follow up activities related to health disparities; better support for veterans and expanded population health and performance monitoring metric.
- Demonstrate and communicate DWIHN's commitment to improving progress toward influencing network-wide safe clinical practices.
- Support DWIHN strategic planning efforts related to becoming a Certified Community Behavioral Health Home (CCBHC), Behavioral Health Homes (BHH) and increase Opioid Health Home (OHH) provider services.
- Continue to increase the training of providers, health care workers, jail staff, drug court staff, community organizations and members of our region on how to use Naloxone to reverse opioid overdose.

CHIEF CLINICAL OFFICER EXECUTIVE SUMMARY
PROGRAM COMPLIANCE COMMITTEE
February 9, 2022

COVID-19 RESPONSE PLAN:

DWIHN's Covid-19 Response Plan includes maintaining and creating an infrastructure to support a holistic care delivery system, with access to a full array of services. Planning will continue for COVID-19 to ensure access, placement and specialized programs for individuals served by DWIHN.

COVID-19 & INPATIENT PSYCHIATRIC HOSPITALIZATION

	# of Inpatient Hospitalizations	COVID-19 Positive
November 2021	634	11
December 2021	617	32
January 2022	468	19

Inpatient Hospital Admission Authorization data as of 1/31/2022.

COVID-19 INTENSIVE CRISIS STABILIZATION SERVICES - Intensive Crisis Stabilization Services are structured treatment and support activities provided by a multidisciplinary team and designed to provide a short-term alternative to inpatient psychiatric services. Services may be used to avert a psychiatric admission or to shorten the length of an inpatient stay when clinically indicated.

Crisis Stabilization Service Provider	Services	January 2022- # Served
Community Outreach for Psychiatric Emergencies (COPE)	Intensive Crisis Stabilization Services (MDHHS Approved)	185 (36% increase)
Team Wellness Center (TWC)	Intensive Crisis Stabilization Services (MDHHS Approved)	181 (36% increase)

COVID -19 RECOVERY HOUSING/RECOVERY SUPPORT SERVICES

These individuals must be receiving outpatient services from a licensed SUD provider in DWIHN's network via telehealth or telephone communications. The providers may provide up to 14 days for this specific recovery housing service for individuals who are exhibiting COVID-19 symptoms and/or tested for COVID-19 and positive.

Provider	# Served- January 2022
Quality Behavioral Health (QBH)	7
Detroit Rescue Mission Ministries (DRMM)	6
Abundant	6

COVID-19 PRE-PLACEMENT HOUSING - Pre-Placement Housing provides Detroit Wayne Integrated Health (DWIHN) consumers with immediate and comprehensive housing and supportive services to individuals who meet DWIHN admission criteria and eligibility. Pre-Placement Housing provides funding to residential providers contracted to provide short-term housing for a maximum stay of 14- days, meals, transportation and supportive services that promote stable housing and increase self-sufficiency. Due to the COVID-19 emergency, DWIHN Credentialing Department provisionally impaneled the following residential providers, to provide services for those persons identified as COVID-19 positive or symptomatic (mild to moderate).

CHIEF CLINICAL OFFICER EXECUTIVE SUMMARY
PROGRAM COMPLIANCE COMMITTEE
February 9, 2022

Provider	Services	# Beds	January 2022- # Served
Detroit Family Homes	Licensed Residential Home- Adults	4	6
Kinloch	Licensed Residential Home- Adults	3	4
Detroit Family Home- Boston	Licensed Residential Home- Adults	6	4

RESIDENTIAL DEPARTMENT- COVID-19 Impact:

	Fiscal Year 2020	Fiscal Year 2021	Fiscal Year 2022 (Oct 1, 2021- current)
Total # Covid-19- Members Related Deaths	169 34	76 7	95 (60 in Jan. 2022) 2
Total# Covid-19 Staff Related Deaths	71 3	59 0	57 1

VACCINATIONS- RESIDENTIAL MEMBERS:

	# of Members Fully Vaccinated	# Vaccine Booster
Licensed		
City of Detroit	649 (88.7%)	113 (17.4%)
Western Wayne	1,243 (91.3%)	496 (39.9%)
Unlicensed		
City of Detroit	93 (61.1%)	51 (54.8%)
Western Wayne	678 (68.2%)	79 (11.6%)

*The was no change in the number of vaccinations in January 2022 compared to December 2021.

COVID-19 MICHIGAN DATA:

Michigan COVID-19 Cases: February 3, 2022 update: The total number of confirmed COVID-19 cases in Michigan is 1,999,416 with 30,170 confirmed deaths. Wayne County reported 239,281 confirmed Covid cases and 3,690 deaths. The City of Detroit reported 120,156 confirmed Covid-19 cases with 3,033 deaths. (Source: www.michigan.gov/Coronavirus)

Michigan COVID-19 Vaccination Updates:

Area	First dose- Initiation	Fully Vaccinated
State of Michigan	64.6%	58.2%
Wayne County	72.4%	65.7%
City of Detroit	47%	39%

CHIEF CLINICAL OFFICER EXECUTIVE SUMMARY
PROGRAM COMPLIANCE COMMITTEE
February 9, 2022

Health Home Initiatives:

- **Behavioral Health Home (BHH):** DWIHN, in partnership with MDHHS, is on track for an April 2022 roll-out of this health home initiative. This model focuses on care coordination and health education for Medicaid recipients that have an eligible diagnosis, to ensure persons have both their physical and behavioral healthcare needs met. A BHH kick-ff with MDHHS is scheduled for March 3, 2022. All identified Health Home partners have completed their BHH certification. The National Council is currently providing Case to Care Management training for both our identified health home partners and DWIHN internal staff.

- **Certified Community Behavioral Health Clinic- State Demonstration (CCBHC):** The Guidance Center is our region's State designated CCBHC provider. A CCBHC site provides a coordinated, integrated, comprehensive services for all individuals diagnosed with a mental illness or substance use disorder. It focuses on increased access to care, 24/7/365 crisis response, and formal coordination with health care. This model launched on 10/1/2021 and The Guidance Center currently has 2,668 members receiving CCBHC services and 2,489 members have been enrolled in the MDHHS WSA enrollment system.

- **Certified Community Behavioral Health Clinic-** SAMHSA Expansion Grant: This SAMSHA grant provides funds directly to organizations that self-certify that they meet all of the CCBHC requirements. This funding is provided to expand current services and increase individuals access to care. DWIHN is currently working on this expansion grant opportunity to provide additional CCBHC services to individuals we support. It is anticipated that this grant initiative, if awarded, will be implemented Fall 2022.

- **Opioid Health Home:** DWIHN currently has 206 enrolled members receiving this comprehensive array of integrated healthcare services. This is a 22% increase in enrollment since October 2021. There are currently seven (7) Health Home Partners providing OHH services in Region 7.

CHIEF CLINICAL OFFICER'S REPORT
Program Compliance Committee Meeting
Wednesday, February 9, 2022

CHILDREN'S INITIATIVES – Director, Cassandra Phipps

EXECUTIVE SUMMARY REPORT (January 2022)

Pillar 1 Clinical Services & Consultation	**Pillar 2** Stability & Sustainability	**Pillar 3** Outreach & Engagement	**Pillar 4** Collaboration & Partnership

School Success Initiative (SSI)

Provider Meetings: Meeting was held this month with SSI Providers. Main focus involved training on the updated SSI Quarterly Report Form and ensuring data on the quarterly form is consistent with data in Redcap system. Providers provided a list of trainings/resources that were given to various schools regarding school safety. **Michigan Model of Health (MMH):** Identified participants to attend the MMH training in Feb 2022 via Wayne RESA for the Pre-K model. **Redcap:** Met internally to discuss updates to Redcap to include the Risk Factors, Evidenced Based Practices, and other features to improve data collection for SSI program.

Youth United

Youth MOVE Detroit

- January 10th, 2022, Youth United team attended **Youth MOVE National's Youth Mental Health First Aid Training** from 12-5pm via Zoom. A total of seven (7) members of Youth United attended the training.
- Jan. 27, 2022 **Youth MOVE Detroit hosted a Facebook Live** from 5-6pm. Youth played the interactive game "Would You Press the Button' to generate discussion about current youth related topics.

Youth United

- January 7, 2022, the Northwest Regional Youth Coordinator from DWIHN facilitated training titled, **"Breaking Down the Stigma"** with thirteen (13) Parent Support Partner staff.
- January 21st, 2022, Youth United's Northwest Region hosted a **Credit Skills Workshop** from 4:30pm-6pm via Zoom. A total of twenty-seven (27) people were in attendance.
- January 26th, 2022, Youth United hosted a virtual **quarterly Wayne County Youth Involvement Meeting** for youth groups and partners throughout Wayne County. A total of eighteen (18) individuals participated.
- In January 2022, the **results of the surveys** that were disseminated at various youth related events and activities during the **First Quarter FY 21-22** were analyzed. Youth also want to learn more about these identified topics as well as communication skills and stress management skills.

Outreach

Canton / Plymouth School District: Children's Initiative Department met with representatives from Canton/Plymouth School District to discuss plans for Mental Health Fair (4/30/22). DWIHN agreed to participate in the event. Canton/Plymouth High School agreed to work with School Success Initiative via Hegira.

Aijalon Baptist Church: Healing from Past Trauma Revival (Resource Table)

DPSCD Parent Meeting: 1/21/2022 - Clinical Officer (Ebony Reynolds) presented at the Parent Meeting and explained about Children Services.

Constituents Voice: 1/21/2022 - Children's Initiative Director (Cassandra Phipps) presented at the Constituent's Voice meeting to explain about Children Services and Mental Health Care: No Child Left Behind initiative.

Renaissance High School: 1/21/2022 – Youth United presented at Renaissance High School Professional Development Day on Anti Stigma Busting.

Approved Board Actions Jan 2022

BA 21-13 R3: Wayne County Health, Human, and Veteran Services – 3rd Circuit Court Clinic for Child Study

BA 21-69 R: DWIHN Proposed General Fund Program – The Children Center Foster Care Program

BA 22-41: Michigan Child Collaborative Care (MC3) – Starfish

BA 22-44: Infant and Early Childhood Mental Health Consultation in Home Visiting – The Development Center

Collaboratives

Children System of Transformation (CST): Meeting was held this month and discussed Q4 2021 and Q1 2022 MDHHS Performance Indicators for Children Services, MDHHS verification for B3 services to start Oct 1, 2022, DWIHN Initiative Mental Health Care: No Child Left Behind, Waiver Audit in Spring 2022, and Children Provider capacity concerns.

Human Services Community Collaborative (HSCC): MDHHS Director Hertel and Ms. Louis Roubal, Chief Deputy Director of Opportunity attended HSCC meeting on 1/7/2022 with DWIHN Executive Leadership and discussed 3 main areas of focus on Wayne County System of Care: 1). Workforce, 2). Lack of availability for psychiatric hospitalizations, 3). Lack of availability for juvenile justice placements. Thus, HSCC will continue to collaborate with DWIHN and System of Care Partners to identify plans to meet the needs of the community.

MDHHS: Children System Administrative Forum (CSAF) meeting regarding updates from MDHHS. Focused on feedback regarding intensive crisis stabilization services, upcoming evidenced based practices cohorts and guidance for implementing EBP via telehealth. **Association for Children's Mental Health (ACMH):** Various meetings were held with Children Providers, ACMH, MDHHS, and the MI Behavioral Health Collaborative to discuss barriers with the ACMH trainings for Youth Peer Support Partners and Parent Support Partners. Plan to continue to collaborate with ACMH, Children Providers, and MDHHS to ensure continuation of ancillary services. **System of Care Block Grant:** Finalized the budget for FY 2023 and sent to MDHHS on 1/31/2022 for $1,043,582.00.

Outcomes Improvement Committee: 2 children cases were presented at OIC this month due to high risk concerns; in which recommendations were suggested.

Workforce Development: University of Michigan (UofM): A Virtual Job Fair was held 1/13/2022 with several Children Providers (8 students attended). **Trainings:** Children's Initiative Department offered the following:

- **The Children's Mental Health Lecture Series (CMHLS)** for this month was held on January 20th with 101 attendees. The presentation was titled, "Looking at Social Media Through a Cultural Lens". The second training session in the learning series titled "Working with Adolescents: Redefining 'Co-Occurring' as Substance Use and Trauma" occurred on January 24th with 51 participants present. This second session focused on the impact of trauma on brain function and development, observable changes in youth engaging in substance use and the role they play in treatment/intervention planning as well as progression factors connected with adolescent addiction.
- **PECFAS Initial Training** - 19 participants
- **CAFAS Initial Training** - 20 participants
- **CAFAS Booster Training** - 29 participants

CLINICAL PRACTICE IMPROVEMENT – Clinical Officer, Ebony Reynolds

Evidence Based Supported Employment Clinical Specialist Jan 2022 Activity

DWIHN's Evidence Based Supported Employment (EBSE) providers continue to assist members served to achieve steady and meaningful integrated /competitive employment based on their employment goal.

Many EBSE providers continue to deliver EBSE services remotely due to the recent community surge of COVID-19 or in-person if requested by the member. Southwest Counseling Solutions report their IPS-SE team has been working remotely with its members using various virtual platforms and reaching out to potential employers via telephone. Lincoln Behavioral Services shared its employment team continue to sustain services and placements by having an alternate plan via virtual communication. CNS HealthCare/Northeast Integrated Health report its employment specialists have been providing job development and job assistance services during the pandemic using telehealth.

ACCESS report some of its members who have lost unemployment benefits are looking for work despite not wanting to get vaccinated, which most employers require. However, ACCESS mentioned they have gotten many of their members unemployment

benefits as well as new jobs after lay-offs and vaccine concerns. Central City Integrated Health (CCIH) Indicated they were unsuccessful hiring a supervisor or employment

specialist for their EBSE program as one was hired but did not complete their probationary period requirements. CCIH mentioned they have conducted several interviews for which two offers were made. However, both candidates declined citing salary and safety reasons.

To date, there were: (197) referrals, (174) admissions, (101) competitively employed in the community in a variety positions, such as waitress, janitor, Amazon Driver, office manager, caregiver, stock worker and assembly/ production worker with an average hourly wage of ($14.00). Twenty-two (22) members successfully transitioned from EBSE services as their employment goals were met.

CRSP IPOS Audit/ Hospital Recidivism Report Review

Continued to assist with review of standardized IPOS to ensure CRSPs alignment with DWIHN's standardized IPOS core elements and that HSAG's review recommendations are addressed in DWIHN's IPOS audit tool. In addition, improvement plans from CRSPs were reviewed to ensure a plan is initiated to manage members who were identified as having multiple hospital admissions within 30 days for

psychiatric care as well as strategies developed to assist CRSPs with the elimination/reduction of incidents of member multiple inpatient readmissions for psychiatric care.

Project – WC Jail – IST – Probate Court – Returning Citizens Clinical Specialist Jan 2022 Activity

- From December 17- January 28 there were 154 releases from the jail. Of the 154, 55 were linked to the assigned provider; 17 were placed in other correctional facilities or hospitalization; 15 were not in MHWIN; and 67 were in MHWIN as unassigned.
- A meeting was held with Access to continue streamlining the process of tracking members in MHWIN that receive support services from the Jail.
- The quarterly review was held with Naphcare and Wayne County. Naphcare is open and willing to make changes and work collaboratively with DWIHN. Discharge planning was discussed and possible solutions were raised. Continued discussion on a proactive plan to link and coordinate members will continue until a good solution is established.
- During the first quarter 602 persons were screened upon entry into the jail and 239 were admitted for mental health services.
- The IST workgroup committee met and still looking at process changes for misdemeanor cases. It was reported that misdemeanants are more likely to be opined and not likely to attain competence than defendants charged with felonies. 43% of misdemeanants opined IST were also opined not restorable, whereas only 13% of IST felony defendants were opined not restorable. In 2021, CFP received only 45 competency restoration treatment orders for misdemeanants. Diversion of misdemeanants from competency to stand trial evaluations would reduce the evaluation waitlist by over 350 defendants annually, which would allow for more timely scheduling of all evaluations.
- A quarterly meeting was held with Downriver Veterans Court. There are 15 program participants. State funding has been reduced which is affecting the cost for drug testing, as state funding supplemented the testing cost. The court has returned to remote hearings for now.
- The VFW and American Legion assisted with food donations during the holiday season. The court is now using therapeutic and case management services from the Guidance Center.
- The quarterly review was held with CCIH for the HOT program. Staffing continues to be a challenge to fill. In the interim, CCIH clinical staff continues to ride along with Motor City Mitten. During the first quarter there was 384 contacts and 4 persons were secured for mental health treatment.
- CCIH meets weekly with DPD on the program.

Project - Jail Diversion/ ACT Reviews/AOT Orders

- From December 18 - January there was 66 AOT orders. Of the 66, 10 were on a continuing hospitalization order; 9 were not in MHWIN as ever receiving services; 12 were linked to the Access Center for a provider assignment; and 35 had the provider notified of the order.
- A meeting was held with the providers who receive AOT orders. The Med Drop program was explained and discussed as an alternative treatment for members who are on an AOT. The Clinician will cross reference members on an AOT with the Hospital recidivism list.
- Providers who handle the Returning Citizens or jail releases have been asked to compile the data on those who are linked with employment services; are employed; and stay employed.
- From December 17 – January 28 there were 6 returning citizens. Professional Counseling Services reports that they are assisting members with SSI benefits and will be tracking data on this.

Assertive Community Treatment (ACT) CPI Manager January 2021 Activity

CPI Monitored ACT program admissions and discharges of Lincoln Behavioral Services, Community Care Services, Northeast Integrated Health, Hegira, All Well Being Service, Central City Integrated Health,

Development Centers, Team Wellness Center, and The Guidance Center including the appropriateness of the level of care determinations and technical assistance ensure program eligibility requirements were met.

January 2021

CPI manager met with Genoa Health and Team Wellness on ways to start implementation of Med Drop.

CPI manager facilitated quarterly Behavioral Health Learning Collaborative meetings. Topics discussed were performance indicator new incentive, 5% rate increase, AOT population, Review of standardized elements of IPOS OIC workgroup and Med drop expansion.

For the month of January CPI manager participated in procedure code work group meeting, where the updated modifiers and codes were discussed. Readmission IBPS follow up and training discussion, participated in OIC meeting, standardized IPOS where topics discussed are HSAG HCBS standard elements and HSAG compliance cap review (Standard vs coordination and continuity of care).

CPI manager met with Med Drop for a monthly follow up meeting, where it was noted that there are 37 Current Active Clients CCS=14 LBS = 16, CNS/NIH = 5 DCI=2 as of Nov 1st 202135 Current Active Clients CCS= 12 LBS = 16 NIH= 5 DCI =2 as of December 1, 2021, 34 Current Active Clients CCS = 13 LBS = 15 NIH = 3 DCI = 3 as of January 4, 2022.

Also, for the month of January the CPI manager attended the COPE follow up meetings facilitated by COPE and the DWIHN Crisis department. Topics discussed were, COPE/ SUD concerns, State Liaison updates and law enforcement liaison updates. CPI manager also attended the internal Hospital Recidivism workgroup that is facilitated by the quality department.

Other activities completed by the CPI manager include:

- Participated in cascade updates with internal staff.
- Participated in OIC internal meeting.
- Participated in COPE BIWEEKLY follow up meetings.
- Participated in Med drop Expansion meeting (internal)
- Facilitated monthly meetings with Genoa Health coordinator.
- Facilitated a follow up monthly meeting with all pilot program providers for Med Drop, which are Community Care Services, Lincoln Behavior Services, Northeast Integrated Health network/CNS, Hegira, Team Wellness and Development Centers. Topics discussed were ways to increase admissions rates, talking points, AOT population and recommendations for providers with regards to presenting the program to members.

CRISIS SERVICES – Director, Daniel West

Below is the monthly data for the Crisis Services Department for January, 2022 for adults and children.

Children's Crisis Services

Month	RFS	Unique consumer	Inpatient admits	% Admitted	# Diverted	% Diverted	Crisis Stab Cases
December	264	231	53	20%	197	75%	103
January	309	267	60	19%	235	76%	133

- Requests for Service (RFS) for children increased by 15% compared to December. The diversion rate increased slightly from the month of December.
- There were 133 intensive crisis stabilization service (ICSS) cases for the month of January, a 22% decrease from December. Of the 133 cases there were 46 initial screenings.
- There was a total of 30 cases served by The Children's Center Crisis Care Center in January, 9 cases less than last month. In observance of Martin Luther King Jr. Holiday, The Children's Center Crisis Care Center was closed at 8pm beginning Friday, January 14th and remained closed through Monday, January 17th, 2021. Regular operations resumed Tuesday, 1/18/2022.

COPE

Month	RFS	Unique consumer	Inpatient admits	% Admitted	# Diverted	% Diverted	# Inpt due to no CRU
December	624	602	405	65%	203	33%	2
January	912	835	595	65%	296	32%	4

- The number of requests for service (RFS) for adults decreased by 32% from December. The number of diversions remained the same at 32%.
- The Crisis Stabilization Unit (CSU) at COPE served 185 cases in this month, a 36% increase from December.
- The Mobile Crisis Stabilization Team provided services to 93 members in January, up from 31 in December.

Crisis Residential Unit/Hegira:

- The number of available beds is 16.

Referral Source	Total Referrals	Accepted Referrals	Denials
ACT	0	0	Level of Care change – 1 Not medically stable due to SUD – 0 Not medically stable due to physical health – 2 Violent/aggressive behavior – 0 Immediate danger to self – 0 No follow-up from SW/Hospital - 0 Total - 4
COPE	36	33	
DWIHN Res.	3	2	
Step Down (Inpatient)	14	11	
Total	53	46	

**One member was denied, but due to member choice.

Crisis Continuum

- For the month of January, Team Wellness Crisis Stabilization Unit (CSU) provided services to 181 individuals, a 36% increase from the month of December.

ProtoCall

Month/Year	# Incoming Calls	# Calls Answered	% answer w/in 30 secs	Avg. Speed of answer	Abandonment rate
December	662	604	60.4%	66s	7.5

- Call data for the month of January was not included in this month's report.
- ProtoCall continues to address staffing issues and has been working to train incoming members of their workforce. They also continue to share information with DWIHN as it relates to cases that would require follow up, and DWIHN has been able to connect members accordingly.

COMMUNITY LAW ENFORCEMENT LIAISON ACTIVITY REPORT January 2022

- The number of ATRs for the month of January increased by 70% (283 completed for this month as compared to 166 in December).
- Community Law Enforcement Liaison engaged 36 individuals this month.
    - 97% have repeat hospitalizations without follow up by the CRSP. CRSP and MDOC agents were alerted and engaged in discharge planning. 47% have Team Wellness as a CRSP.
    - 22% have as history of SUD.
    - 19% were on court orders.
    - 1% needed residential placement.
- 6 Citizens returned and were connected to DWIHN services upon release from MDOC.
- DWIHN received 69 Assisted Outpatient Treatment (AOT) orders from Probate Court this month and respective CRSPs are notified to incorporate these orders in treatment planning.
- There were 21 ACT consumers referred to COPE: 71% went inpatient, 19% went Outpatient, and 1% were admitted to CRU. No pre-placement or partial day hospitalization was sought during this reporting period. It should be noted 33% of ACT PARs were completed by COPE.

COMMUNITY HOSPITAL LIAISON ACTIVITY REPORT January 2022

Number of Liaison contacts: In January there were 401 contacts made with community hospitals related to level of care services for members in the emergency departments. This was a 40% increase in the number of requests for service in the month of January compared to December (239).

Diversions to lower level of care: Out of the 401 encounters, 220 were diverted to a lower level of care resulting in a diversion rate of 54.86%, an increase in diversion rate by approximately 15% from the month of December.

Admissions to long-term care: One admission was made to Hawthorn for children with 2 children pending on the waiting list, zero admissions to state facilities were made for adults in the month of January.

Cases not on 23-hour report, liaison contacts: Hospital liaisons were involved in 247 out of 401 cases that were NOT on the 23-hour for the month of January. Of the 247 contacts, 116 were diverted to a lower level of care (47%).

Crisis alerts: Hospital liaisons received 27 "crisis alert" calls in January, of which all (100%) were diverted to a lower level of care.

Recidivism: Of the overall 401 contacts in the EDs, zero were considered recidivistic for the month of January.

No requests were made related to veteran's affairs.

DATA SPECIFICALLY RELATED TO 23 HOUR REPORT January 2022

Of those members seen and diverted to lower levels of care, specifically related to the 23-hour report, in January: discharged to outpatient: 184, (including discharges to home, AFC, and shelter).

CRU: 5, CSU: 3, SUD: 11, DWIHN residential referrals 3, Medical admit: 4, Pre-placement 6, AMA 2, JDF 1, Safehaus 1. Of those members admitted to an inpatient level of care: Detroit Receiving 3Q: 12, BCA Stonecrest: 39, Harbor Oaks: 19, Havenwyck: 16, Kingswood: 8, St John Main 3, St John Macomb: 2, St Mary's: 5, Samaritan: 6, Pontiac General: 27, Henry Ford Wyandotte: 2, Sinai: 8, Garden City: 2, Cedar Creek 3, Ford Macomb 2, St Joe Mercy 5, Providence 1, Hawthorn 1, U of M 1, BCM 4.

Res.	CCM	CRU	CSU	PHP	Pre-Placement	OP/Stab	SUD	Other
3	0	5	3	0	6	184	11	4 Medical Admits

MOBILE OUTREACH SERVICES: January 2022

Noteworthy is the DWIHN mobile outreach clinician was not available for a week in January, 2022.

Number of Mobile Events Attended	8
Number of Meaningful Engagements	39
Number of Subsequent Contacts	17
Number of Screenings in the system	0

CUSTOMER SERVICE – Director, Michele Vasconcellos

Administration/Call Center Operations/ Family Support Subsidy/Medical Records

- DWIHN's Customer Service division handled a total of 2,037 calls in the month of January. Front Desk 1,238 with an ABD rate of 0.6%; Call Center 799 with an ABD rate of 15.2%. The ABD rates are out of compliance with contributing factors of phone related issues for the CSRs and there were occasions when calls were going to the Access Center due to the Front Desk staff and the CSRs were assisting lengthy calls.
- Family Subsidy handled 569 telephone inquiries and processed 85 applications for submission to the state.
- Processed and mailed out" Choice" letters to members as a result of provider closures or discontinuance of services.
- Continued to meet to discuss Medical Record retention and Therefore initiative.
- Addressed Special follow-up cases from the state.

Customer Service Performance Monitoring/ Grievance & Appeals

- Disenrollment training was conducted with CRSP on 1/13/22 to ensure participation with Disenrollment initiative.
- As part of the Disenrollment imitative, completed approximately an excess of 400 dis-enrollments for members presenting without an assigned CRSP.
- Participated and submitted information for ICO AmeriHealth audit.
- Participated in Quarterly Statewide CS meeting.

- Participated with POC meeting with Aetna.
- Met with Credentialing and MCO regarding the online directory requested revisions.
- Met with Wayne County Mediation Dispute Resolution Center regarding the first mediation case for DWIHN.
- Revised letter templates and forwarded documents to IT for PCE revisions to Medicaid letters based on HSAG's POC recommendations which included tagline size.
- Revised letter templates and forwarded documents to IT for PCE revisions to MI Health link letters.
- Participated in multiple provider closure meetings and initiated mailing of member choice letters as required.
- Completed 3 Desk Audits for ABDs.
- Conducted various case consultations with DWIHN divisions to address various grievances and appeals that were presented to Customer Service,

NCQA/HSAG

- Staff continued to work on 2 elements of Member Rights related HSAG POC recommendations and providing updates to Quality.
- Met with Quality to discuss upcoming audit for Grievances and Appeals and to address the updated status for POC.

Member Engagement/ Experience

- Concluded National Core Indicator Survey. Exceeded target goal of 220 participants by 7%.
- In collaboration with Wayne State University, exceeded the goal to collect 600 surveys for adult and children's Annual ECHO Surveys.
- Facilitated the following monthly Member Engagement Activity: EVOLVE, Ambassador Outreach, Faith Based Initiative regarding Narcotics, Evening Soul Chat Line, AFC homes basic computer technology training and the What's Coming-Up video production.
- Worked on the development of the Quarterly Person Points of View member newsletter to be distributed in February.

INTEGRATED HEALTH – Director, Vicky Politowski

Please See Attached Report

MANAGED CARE OPERATIONS – Director, June White

Please See Attached Report

RESIDENTIAL SERVICES – Director, Shirley Hirsch

Please See Attached Report

SUBSTANCE USE DISORDER – Director, Judy Davis

LARA WEBINAR ON RULE CHANGES: Michigan's Licensing and Regulatory Affairs (LARA) has been revising the administrative rules in stage processes. This began under the Governor Snyder administration. LARA hosted a webinar in December for individuals impacted by administrative rules for Substance Use Disorder (SUD) Programs. The webinar explained the proposed changes to the SUD administrative rules and answered submitted questions. Proposed changes included but not limited to: · Prevention providers will not require a license · A substance use disorder services program license is not required for an individual

providing psychological, medical, or social services · The policy and procedure may not permit discharge of a recipient due to a return to use so long as the recipient reengages in treatment and complies with program policies and treatment protocol prospectively. · Naloxone access and Naloxone kits. · Additional Trainings, First Aid, Naloxone Administrations and Recipient Right

DWIHN's Naloxone Initiative program has saved **790** lives since its inception. Again, the saved lives are under-reported, especially during this time of the COVID pandemic. The logs are coming in slowly from law enforcement and the community. DWIHN only reports those saves that we have documentation to support this initiative. DWIHN to date has distributed over 11,067 Narcan kits.

The SUD Department has been working tirelessly to address the Opioid Epidemic, which has devastated so many lives and harmed millions nationwide. We will not rest until we dramatically reduce opioid use disorder and overdose deaths and work to provide those suffering from the support they need. Unfortunately, we still have a lot of work to do in this area.

SUD Holiday Drive

During the holiday season in the month of December, the SUD Department is always reminded about the increase of overdoses and death during this season. To combat this issue the SUD team held a Holiday Drive, distributing Naloxone, Fentanyl Strips and Sleeping Coats to the network:

Naloxone 1145 Fentanyl Strips 7200 Sleeping Coats 235

Post-Partum Parenting Women

MDHHS has awarded DWIHN/SUD $267,302, in which $245,802 will be allocated for treatment services, 20,000.00 is for care coordination, and 1,500.00 is for GPRA. DWIHN, as the managed care organization, will recruit Health Home Partners into their developing Opioid Health Home network to implement EBPs and support the needs of pregnant and parenting women and their families. Health Home Partners will include a family medical clinic, Opioid Treatment Programs. They will also provide care coordination and case management to help ensure that all the family's needs are met. The two providers designated for this program are Central City Integrated Health and Elmhurst Home.

Number of COVID Cases in SUD

The SUD Department reported a total of 53 positive COVID cases and no death. In addition, of the number of positive COVID cases, 3 of the individuals said they were fully vaccinated; three had to be hospitalized. 7 Individuals reported they shared a cigarette, and all were diagnosed with COVID. Some individuals chose to quarantine at home. DWIHN is working on more beds to prevent the spread of the virus.

Staff Cases 8 Client Cases 53 Deaths 0 Staff Deaths 0 Vaccinated 3 Hospitalized 3 Quarantined 9 Hospitalizations 0

Admissions by Primary Drug Use

Drug Number Alcohol 1331 Crack/Cocaine 580 Heroin 2080 Marijuana 180

Opioid Settlement

Opioid Settlement Communication to There was a Press Release from the AG to PIHPs to reach out to county level commissioners since the funding will be sent to the county level. The counties will need to register for the funding. There is about $16-$17 million sitting in Treasury for this, and there will be an annual amount being distributed over the next several years. OROSC believes that the funding should go through the PIHPs, but it remains to be seen if this recommendation will be accepted. Legislation is being drafted, but it does not indicate yet, if PIHPs will have a role in the funding

American Rescue Plan Act

On January 7, 2022 the Michigan Department of Health and Human Services awarded the SUD Department $1, 129, 060 from the American Rescue Plan Act (ARPA) grant. with an additional $125k for administrative cost and unmet needs. The award identifies 14 areas of services: Recovery Housing, Recovery Community Organization, Recovery Support Services, Individualized Placement and Support, Youth Community Centers, Prosocial Activities, Telehealth Hubs, Telehealth Technology, Accessing Behavioral Health for African American, Staffing Support, Student Assistance Programming, and Evidence-Based Programming. Providers selected were awarded funding based on RFI submitted to DWIHN: Treatment Providers include Programs awarded

Elmhurst Home/Naomi's Nest, Personalized Nursing Lighthouse, SHAR, Sobriety House, Detroit Rescue Mission Ministries, Growth Works, Detroit Recovery Project, and Team Wellness Center. The selected Prevention Providers include Beaumont, Leaders Advancing and Helping Communities, and the National Council on Alcoholism and Drug Dependence.

Prescription Drug Overdose-Related Deaths

DWIHN will be receiving an award to address and reduce prescription drug/opioid overdose-related deaths and adverse events among residents 18+ in Wayne counties. Project goals include increase capacity of the high need communities to address the project's purpose, reduce access to opioids through implementation of safe prescribing, and enhance opioid education and naloxone distribution. Office of Recovery Oriented Systems of Care (OROSC) will lead the project and partner with Prevention Network for oversight of a mini-grant program to address opioid overdose prevention efforts in the identified communities of high need, Wayne State University School of Social Work for data collection.

UTILIZATION MANAGEMENT – Director, Jennifer Jennings

Please See Attached Report

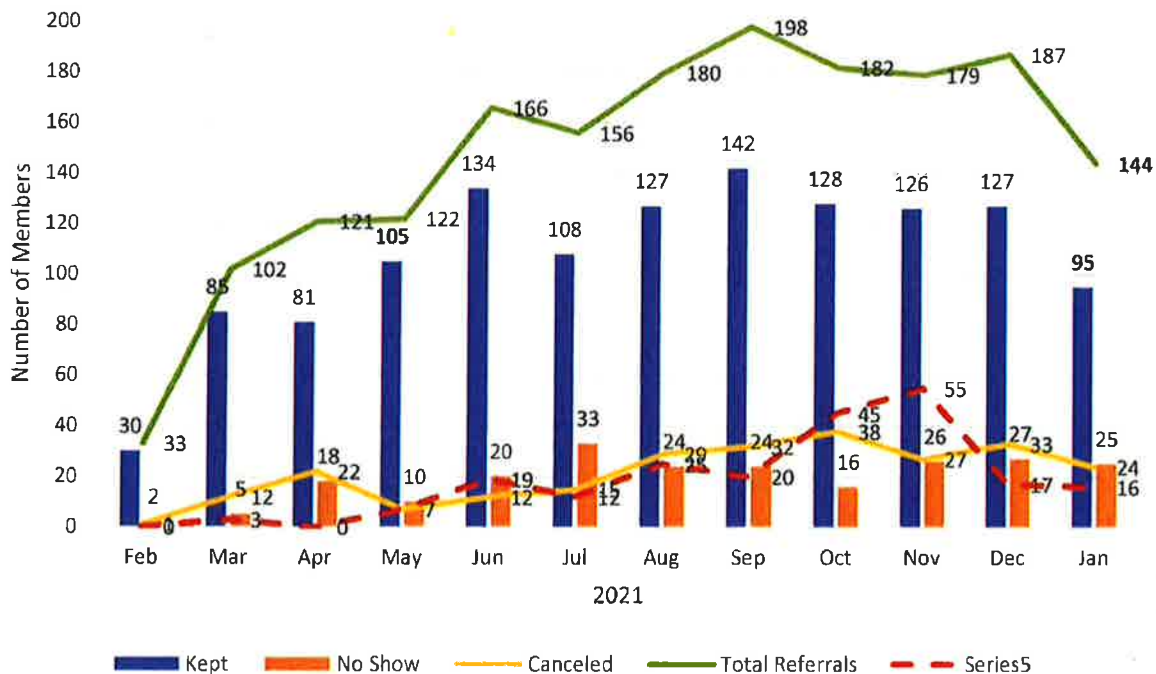
Autism Spectrum Disorder Benefit
January 2022 Monthly Report

Enrolled in ASD Benefit

Total open cases for the month of January is 2120 members.

Summary of Diagnostic Evaluations

Total comprehensive diagnostic evaluation scheduled by the Access Center was 144 and of those scheduled 95 appointments were kept resulting in 10 members not eligible (non-spectrum) and 17 members approved but undecided.



Provider Updates

- ABA providers continue to be supported on coordination of care with CRSP agencies.
- ABA providers have been directed to ensure members are engaged in ABA services and assistance was provided on referring members not engaged to other ABA providers with availability.
- Continued support is provided to the members approved for ASD Benefit but did not accept an ABA placement at time of feedback appointment.

Integrated Health Care Department
Monthly Report
February 9, 2022

Collaboration with Health Department

The Health Department will be focusing on Hepatitis C, DWIHN is preparing for this initiative. DWIHN met with the State in October to discuss data collection and how to roll this initiative out to the Behavioral Health and SUD providers in Wayne County. IHC has developed the quality improvement plan and has added fields to the Integrated Biopsychosocial that is completed by CRSP clinicians to include Hep C treatment questions. IHC met with the SUD providers on January 26th to discuss the initiative.

Quality Improvement Plans

The IHC department manages five Quality Improvement Plans (QIPs) that are in alignment with NCQA requirements. The focus of the QIPs includes the following: 7 and 30 day Follow Up After Hospitalization for Mental Illness, Adherence to Antipsychotic Medication, Diabetes Screening for members prescribed atypical antipsychotic medications, and Hepatitis C treatment. Currently implementing a HEDIS certified platform which will display individual CRSP provider data to allow early intervention and opportunity to improve outcomes. The HEDIS certified platform will also include measures for Opioid Health Home and Behavior Health Home. The HEDIS Quality Scorecard was present to the CRSP Quality Directors on January 26th, 2022. The HEDIS Quality Scorecard will be present to all CRSP's in March. DWIHN and Vital Data continue to work on the HEDIS platforms that show the data for these QIP for providers is correct.

Population Health Management and Data Analytics Tool

DWIHN and Health Plan and Health Plan designee staff continue to meet at least weekly to prepare for implementation of the two platforms, one for providers to view member encounter information and performance on HEDIS measures, and the other for DWIHN and Health Plan designee to utilize to coordinate care for shared members and for DWIHN to view HEDIS measure performance. VDT continues to make corrections and revisions to both platforms based on feedback from DWIHN and Health Plan and Health Plan designee staff. The platform went live on June 1st. To date DWIHN and Health Plan designee staff are meeting on a twice monthly basis to complete coordination of members who are new and in Tier 2 and 3. To date there are 3,180 shared members, 1,886 are in Tier 0/1, 1253 in Tier 2 and 41 in Tier 3.

VDT and DWIHN met on 11/29/2021 how to implement the OHH, BHH and CCBHC measures needed. DWIH has approved the proposal from VDT and will begin work on these added measures.

Data Share with Medicaid Health Plans

In accordance with MDHHS Performance Metric to Implement Joint Care Management, between the PIHP and Medicaid Health Plans, IHC staff performs Data Sharing with each of the 8 Medicaid Health Plans (MHP) serving Wayne County. Mutually served individuals who meet risk stratification criteria, which includes multiple hospitalizations and ED visits for both physical and behavioral health, and

multiple chronic physical health conditions are identified for Case Conference. Data Sharing was completed for **45** individuals in January. Joint Care Plans between DWIHN and the Medicaid Health Plans were developed and/or updated, and outreach completed to members and providers to address gaps in care.

Integrated Health Pilot Projects

DWIHN has identified 3 Health Plans for Integrated HealthCare Pilot Projects.

Health Plan 1:
Collaboration continues between DWIHN and **Health Plan 1** staff with implementation of shared electronic platform with VDT to facilitate information exchange and document care coordination activities. The shared platform went Live June 1st and to date there are **42** members in the program. Health Plan 1 and DWIHN meet bimonthly to discuss individuals in Tier 2 and 3, in the month of January, **6** individuals were discussed. Platform review continues, recommended changes/additions are in process with projected go live of HEDIS measures and scorecards platform (ProviderLink) and Care Coordination platform (PlanLink) in March. Health Plan 1 was incorporated into another health plan and DWIHN is waiting on a new contract from that health plan to be sent.

Health Plan 2:
Care Coordination with **Health Plan 2** was initiated in September 2020, these meetings occur monthly. There were **10** cases discussed in the month of January for the Pilot program. The plan requests the number of cases to be discussed during Case Review. The BCC workgroup met on 1/20/21 to discuss goals and HEDIS measures to be tracked. Health Plan 2 has decided that the shared platform has a benefit and this is being discussed. Leadership and workgroup meeting have been established for the next 6 months once the new contract is completed

Health Plan 3:
Health Plan 3's Leadership continues in the review process. A meeting occurred with DWIHN and Health Plan 3 in March. The Health Plan continue to review plans for collaboration.

MI Health Link Demonstration

IHC department under the MI Health Link Program received total of 325 request for level II in the month of January 2021 from the following ICO organizations below: Pending = not processed yet, Voided = Member was unable to reach, referred in error, or declined assessment, or declined BH services, Active= Level II was sent to ICO.

ICO	Active	Pending	Voided	Totally by ICO
Aetna	19	6	23	48
Amerihealth	2	0	2	4
HAP	4	2	12	18
Meridian	3	0	6	9
Molina	74	35	137	246
TOTAL	**102**	**43**	**180**	**325**

Voided referrals reasons are as follows:

	Member Declined Assessment	Member Declined Services	Member not available before deadline	Referrals in error	Unable to reach
Aetna	0	19	0	0	4
Amerihealth	0	1	0	0	1
HAP	0	9	0	0	3
Meridian	0	4	0	0	2
Molina	3	87	5	35	30
Total	**3**	**120**	**5**	**7**	**45**

Comparison Data for Voided Referrals:

	Number of Voided Referrals	Member Declined Assessment	Member Declined Services	Member not available before deadline	Referrals in error	Unable to reach
March 2021	182	1	85	13	34	49
April 2021	230	2	113	3	44	68
May 2021	173	0	82	1	27	66
June 2021	156	2	79	5	30	42
July 2021	195	2	102	0	20	69
August 2021	178	0	78	2	31	67
September 2021	184	0	88	4	39	53
October 2021	172	5	85	5	24	53
November 2021	152	11	94	2	9	36
December 2021	186	11	125	5	7	38
January 2022	**180**	**3**	**120**	**5**	**7**	**45**

*Increase in number of Member declined servcies, process and interventions to be reviewed.

ICO Meridian is still unable to receive level II responses through the Care Bridge, referrals are logged in MH WIN and manually processed by sending to Meridian through secure email. documents have not been received to share internally with DWIHN.

ICO Molina effective 1/6/2022 to receive level II responses from DWIHN approx. 280 responses were submitted to ICO Molina upon system fix manually push through MHWIN by department.

During this reporting period IHC department has started to share outcome data sheet regarding TOC and FUH follow-up, of the **32** reviewed in January **32** were presented in care coordination **8** returned to hospital post 30 days.

Transition of care services were provided for **45** persons who were discharged from the hospital to a lesser level of care, community outpatient, or additional level of service Behavioral Health or Physical Health.

There were **43** LOCUS assessments completed for the MI HealthLink Demonstration received from Network Providers who service Nursing Home Facilities for Mild-Moderate population.

Care Coordination Activities for the ICO enrollees—**26** – for individuals who have been identified to have a gap in services. This is a combined effort between IHC staff and the ICOs.

ICO Plan Name	Number of cases requested by ICO	Number of cases DWIHN recommended for Care Coordination for the month	Number of cases DWIHN recommended for Care Coordination for next month	Number of cases to refer to Complex Case Management	Number of case reviewed Total
HAP	4	0	0	0	4
AET	10	0	10	0	10
Amerihealth	6	0	4	0	6
MCH	4	0	0	0	4

Plan Name	DWIHN Reviewed Cases for Recommendation	New Cases (not from prior90 days)	Number of Cases from the Prior Month	Closed Cases w/Goals Met	Successful Closed = w/ goals met & 2+ partial goals met	Unsuccessful Close = No Goals met unable to reach	Total Number Active of cases within CC360 = New Cases + Prior Cases	Total number of cases touched.
Priority	2	0	0	0	0	0	2	2
BCC	4	0	0	0	0	0	4	4
Aetna	4	0	0	0	0	0	4	4
HAP	3	0	0	0	0	0	3	3
McLaren	3	0	0	0	0	0	3	3
Meridian	4	0	0	0	0	0	4	4

Molina	3	0	0	0	0	0	3	3
UHC	3	0	0	0	0	0	3	3

Special Care Coordination Project

Plan Name	Number of cases requeste d by Medicaid Health Plan	Number of cases DWIHN recommended for Care Coordination for the month	Number of cases DWIHN recommended for Care Coordination for next month	Number of cases to refer to Complex Case Management	Number of case reviewed Total
Health Plan 2	0	5	2	0	7
Health Plan 1	1	1	0	0	1

AUDITS

DWIHN during this reporting month received communication from ICO Amerihealth who is requesting policy, procedure and files to be submitted in a delegation audit for CY 2021 by January 31, 2022. Submission completed by 2/1/2022.

DWIHN during this reporting month received communication from ICO Aetna request desk audit of policy and procedures to be submitted in delegation audit for CY2021 submission completed 1/4/2022.

DWIHN during this reporting month received communication from ICO Meridian desk audit of policy and procedures to be submitted in delegation audit for CY2021 submission completed by 1/15/2022.

ICO Amerihealth 2020 is still awaiting the BAA agreement, agreement has been sent to ICO Amerihealth for acceptance during this reporting month pending redline edits accepted DWIHN will sign. No updates at this time.

During this reporting period IHC, Claims, Finance and IT internally met to review the MHL demonstration. It was agreed to review claims and projected cost for demonstration including State Hospital and SUD new codes to be reviewed prior to scheduling meeting with ICO Molina and ICO HAP to cost settle. Meeting took place with ICO Molina pending review of claims an additional meeting will be coordinated after January 2022 to review recommendations. ICO Molina meeting took place it was identified that DWIHN is currently in compliance with ICO Molina rates for 2021. ICO HAP meeting will be scheduled in Feb 2022.

FUA report and workflow process has been established meetings have taken place with SUD department workflow will be submitted to SUD and IHC staff first week in January 2022. During this reporting period DWIHN has reviewed **79** cases of which **47** cases 59% were fee for services Medicaid with no MHP affiliation. **9** cases **1%** of the cases have been sent to the respective MHPs as these cases are not open to DWIHN. **23** cases **29%** were open to DWIHN providers were notified and members were called of those cases **8** in which **1%** confirmed connecting with outpatient providers. No additional information is available at this time as all claims for this reporting period have not been collected.

Compliance Meetings for MHL Program

DWIHN has met with all ICOs and marketing material for CY2022 has been approved. Builds for the following areas are still under review for testing UM, Claims, Appeals & Grievances during this reporting period. SARAG reports for 2022 have been tested and approved with collaboration of the IT department.

IHC has forwarded MHL attestations to the compliance department for review and submission to ICO Amerihealth and ICO HAP.

Complex Case Management

Complex Case Management Services require the individual to agree to receive services, have Physical and Behavioral Health concerns and experiencing gaps in care. The enrollee must also agree to receive services for a minimum of 60 days.

For the month of January, there are currently **13** active cases, **2** new case opened, **6** case closures, and no pending cases. Three **(3)** cases were closed due to meeting their treatment goals, **2** met partial goals and **1** was unable to reach.

Care Coordination services were provided to **20** additional members in January who either declined or did not meet eligibility for CCM services. Follow up after hospitalization was competed with **60** consumers to help identify needs.

Complex Case Management staff have been working to identify additional referral opportunities. Ten **(10)** presentations were provided for DWIHN CRSPs and at Provider Meetings.

EMS Friendly Faces:

This pilot list consisted of **21** members that the CCM team provided outreach to due to high ER utilization. Complex Case Management is reaching out to all the members and data will be given in February.

The following Community Providers received information regarding CCM services: CLS, Team Wellness, New Oakland, Lincoln Behavioral Services, Faith Connections, Michigan Guardian Services, St. Mary's Hospital, Henry Ford Kingswood, Henry Ford Wyandotte, Pontiac General, Samaritan, Beaumont Taylor, Hawthorne, Flat Rock Manor, U of M hospital, St. John Oakland

Peer Health Coach Grant:

DWIHN has contracted with four Certified Peer Health Coaches who will be stationed at Central City working with individuals who have multiple medical conditions along with behavior health. All four Peer Health Coaches were onboarded and started May 24th.

The Peer Health Coaches are working to reconnect non-adherent clients to therapy. Teaching other peers motivational intervention techniques. Identifying clients diagnosed to have hypertension that may be interested in participating in a hypertension study that will reconnect them to their PCP.

707 of the 1,665 Members on the DWIHN Disenrollment List for CCIH.

Of those members:

418 (59%) have had letters sent from either PHC/CM/Therapist

114 (16%) have or had scheduled appointments since 12/7/2021

63 (9%) are open files but need closed in eCRS

64 (9%) have closed files already in eCRS

28 (4%) are file not open yet/didn't complete intake

51 (7%) have CRSP issues, which include wrong designations and no CRSP found

27 (4%) are deceased and are included in either open files to be closed or already closed files

19 (3%) do not have an IPOS, which may be misrepresented

15 (2%) have a LOCUS Level of 1 or 2, which are not designated in open files to be closed

13 (2%) have a designation of AFC Home

4 (1%) are incarcerated

1 (.1%) who has a LOCUS Level 6

1 (.1%) who has received face-to-face engagement for the month of January, 65 members were surveyed below are the results for the Peer Health Coaching Participant Questionnaires

1. What would you say your overall health was/is before PHC?

Poor- 2

Fair- 51

Good - 12

Very Good – 0

2. How aware are you of risk factors and ability to manage existing health issues before PHC?

Poor -0

Fair- 30

Good - 32

Very Good - 3

3. Awareness of risk factors and ability to manage existing health issues after PHC?

Poor- 0

Fair - 30

Good - 22

Very Good - 28

16 Satisfaction Surveys were obtained

1. Did the PHC help you understand the importance of follow up care?

Yes- 15

No -

Not Sure -

2. Did the PHC assist and support you to get the care you needed?

Yes - 14

No –

Not Sure – 1

3. Was the PHC attentive and help you work through problems?

Yes - 15

No -

Not Sure -

4. Did the PHC treat you with courtesy and respect?

Yes - 15

No -

Not Sure-

5. How satisfied were you with your PHC?

Very - 15

Some What -

Not Sure -

Monthly Report

Managed Care Operations

January 2022

MCO DEVELOPMENT MISSION:

The department monitors over 400+ providers under 9 Provider Network Managers and 1 HUD specialist Manager. All staff are committed to serving and reaching out to our providers monthly and quarterly to ensure providers know we are here to assist in answering any questions and directing them to the appropriate department for assistance. Questions come in daily through email or calls surrounding adding sites, authorization questions, claims questions as well as possible closing sites, in which we assist in answering.

MHWIN system cleanup of records/Online Directory:

The team is over the last quarter worked on cleaning up records in MHWIN. There were several gaps identified and addressed

a. Cleaned up Staff records in MHWIN, that need NPI #'s
b. Added ADA site accommodation(s) fields in MHWIN with hours of operations for MDHHS requirements.
c. Reviewed the SAP database for accuracy that was submitted to the State.
d. Met with our IT Dept in an effort to make the directory more compliant with State requirements

Internal /External-Training Meetings Held:

a. Met with 5 CRSP providers regarding the 14-day intake calendar slots where providers are experiencing staff shortages in the intake department for new intakes
b. Held the first internal meeting to discuss network adequacy and provider gaps in services
c. Reviewed all changes to the Provider Manual for 2022, will be finalized end of Feb 2022.
d. Weekly meeting with Continuum of Care Board (COC), to discuss HUD/Homeless projects.

PIHP Email Resolutions and Phone Provider Hotline:

For the month of January, we received/answered 84 emails and 10 phone messages from providers with concerns related to claims billing, IT concerns, Procedure Code changes, Single Case agreements, and changes with the FY 2022 State Code/Modifier changes.

New Providers/ Merger/Closures Changes to the Network /Provider Challenges:

Providers continue to struggle with staff shortages to maintain staff in homes as well as staff in general among all of our providers resulting from the pandemic.
DWIHN continues to provide support to the network through training, webinars and recently offering incentive bonuses for all staff. As of October 1, 2021, DW has implemented a 5% increase among all codes in our network which should assist providers with staff retention. DW also continues to meet with providers to find solutions that will better all during these times.

The network has had several home consolidations or closures under the unlicensed settings, which is a result of the members personal health or staff challenges providers have had causing them to merge or close the settings.

Provider Closure/Mergers FY 21-22					
Description	1st Qtr.	2nd Qtr.	3rd Qtr.	4th Qtr.	YTD Totals
Licensed-Residential Homes	2				
Unlicensed /Private Home Services (SIL's)	3	7			
Clubhouse services	1				
Outpatient services, SUD services	4	1			
Provider Organization Merger(s)	1				
Total	11	8			19

Even though, we see constant changes in the network we have maintained a number of providers in our pool that can be potential providers ranging from private clinicians, therapy services, outpatient and residential providers. It they are approved through our credentialing process and approved by the board we can easily shift with any changes within the network.

Housing Resource and Street Outreach to the Homeless:

As reported by the Housing Urban Development (HUD) there are **1,589 homeless individuals** in the Detroit area, including 351 under age 18. That figure is down 19% from 1,965 in 2019, according to HUD data. The report says nationally 580,466 people experienced homelessness during the one-night count in January 2020 — an increase of 12,751 people (2%) over 2019.

As we partner with our providers to assist the homeless with housing and reaching individuals on street to -date we continue to see improvement one month at time.

This report is based on a Calendar quarter not a Fiscal year.

Southwest Counseling Solutions - Housing Resource Center FY 22 Contract Amount: **$1,089,715**		
	1st Quarter	Year-To-Date
# of Persons Served	**3054**	**3054**
# of Persons Screened for Mainstream Services	**2498**	**2498**
# of Persons who received Housing Assistance	**556**	**556**

Neighborhood Service Organization (Detroit Healthy Housing Center) FY 22 Contract Amount: **$902,050**		
	1st Quarter	Year-To-Date
# of Persons Served	**134**	**134**
# of Persons Receiving Emergency Shelter Services	**134**	**134**
# of Persons referred to Permanent Housing	**115**	**115**

Neighborhood Service Organization (Housing First – Clinical Case Management) FY 22 Contract Amount: **$25,000**		
	1st Quarter	Year-To-Date
# of Persons Served	**15**	**15**
# of Persons who applied for Permanent Supportive Housing	**14**	**14**

# of Persons who Exited to Permanent Housing	**2**	**2**
# of Persons enrolled in Medicaid, Primary Health Care, or Community Mental Health Programs	**2**	**2**

Neighborhood Service Organization (PATH - Street Outreach) FY 22 Contract Amount: **$169,493**		
	1st Quarter	Year-To-Date
# of Persons Served	**109**	**109**
# of Persons Enrolled in PATH	**35**	**35**
# of Persons Connected to SOAR	**78**	**78**
# of Persons Enrolled who Exited to Permanent Housing	**18**	**18**

Wayne Metropolitan Community Action Agency (PATH - Street Outreach) FY 22 Contract Amount: **$75,000**		
	1st Quarter	Year-To-Date
# of Persons Served	**47**	**47**
# of Persons Enrolled in PATH	**16**	**16**
# of Persons Connected to SOAR	**0**	**0**
# of Persons Enrolled who Exited to Permanent Housing	**7**	**7**

CNS Healthcare (Covenant House Program) FY 22 Contract Amount: **$132,872.25**

	1st Quarter	Year-To-Date
# of Persons Served	**56**	**56**
# of Persons who assessed and referred to the appropriate level of care	**42**	**42**
# of Persons experiencing mental health crisis that received crisis intervention services.	**14**	**14**

Central City Integrated Health (CoC PSH Program - Match) FY 22 Contract Amount: **$114,754**		
	1st Quarter	Year-To-Date
# of Individuals Served	**49**	**49**
# of Households Served	**35**	**35**

Central City Integrated Health (Leasing Project - Match) FY 22 Contract Amount: **$50,291**		
	1st Quarter	Year-To-Date
# of Individuals Served	**38**	**38**
# of Households Served	**32**	**32**

Quarterly Goals still in progress:

Quarterly goals set for FY 2022.

• The Risk Matrix- The Risk Matric is a web-based software system that our providers can use to coordinate care, manage operations, view cost of services paid and better serve our members. The matrix allows DWHIN to be able to monitor the provider's performance and gain a base line of care services for our members. We are able to track and monitor cost and related services that will assist in finding improvement opportunities in our current care model.
• The Provider Manual- is a tool/ guide for the provider. This manual is an extension of the provider contract/agreement that include requirements for doing business with DWIHN. Together the manual, our policies and the contract give the provider a full picture of the requirements and procedures to participate in our network. The purpose and intent of the Provider Manual is to strengthen our current and future network providers.
• Network Adequacy form/procedure. This internal process will assist in structing our network in a way where we can view our provider services at a glance for better monitoring over our network through this procedure. We will start evaluating the network in the first quarter of the FY 2022.
• Online Directory- Provider/Practitioner. We are working with internal depts (Customer Service/Credentialing unit) to enhance our online contracted provider and practitioner directory to include the type of services along with the disability designations served by the provider or practitioner making the directory more user friendly and informative for the members as well as internal use.

Annual Provider/Practitioner Survey:

The Provider/Practitioner survey is a way for DWIHN to retrieve feedback from providers and practitioners on how well DWIHN does as a manager of care, this survey also helps us identify any gaps in process or procedures as well as reveal any areas for improvements. The Annual Provider/Practitioner Survey closed at the end October. A full analysis of the survey is still under review for presentation in 2022.

Provider Meetings Held:

a. The last CRSP meeting for the year was held on January 24th , topics were discussed about Disenrollment of member process, Intake period process, 1915SPA, and Behavior Health program and Opioid Health Home program overview
b. Residential/Outpatient Provider meetings was held virtually on January 7th, and will be held every 6 weeks the meeting is scheduled for late February 2022.

Submitted by June White 1/31/22

Detroit Wayne
Integrated Health Network
Residential Services Department

Department Monthly Report: **January 2022**

Residential Referrals

December 2021 ***Pending Assignments***	***18***
# of Assigned Referrals for January 2022	**209**
Total Cases	227

Referral Source Breakdown

Source	Count
Assessments Requested for Members currently in Specialized Settings	11
Crisis Residential	8
CRSP	55
Emergency Departments	22
Inpatient Hospitals	107
Nursing Homes	10
Pre-placement (C.O.P.E.)	3
SD-to-Specialized Residential Services	6
Youth Aging Out (DHHS)	5
Total Received Referrals	**227**

Referrals per Disability Designation

Designation	Count
AMI Referrals	164
IDD Referrals	63

Residential Staff Assessment Productivity

Item	Count
Assessments Completed (SALs)	59
Assessment/Referral Cancelled or Rescinded	90
Cases Assigned for Brokering Only	78

Residential Referral Tracking

- Inpatient Penetration Rate – ***0.68%***
- HAB Waiver Requests – ***19***

Detroit Wayne
Integrated Health Network
Residential Services Department

State Hospital Referrals

Pending Discharge: December 2021	*14*
# of Referrals Accepted for January 2022	**6**
Total Cases	20

Members Accepted in to Specialized Placement; Pending Discharge Agreement	5
Residential Assessments to be Completed	7
Referrals Currently in Brokering Process	8

COVID-19

# of Positive Cases Reported (1/1 – 1/31): 60

Per Designation	AMI	IDD
Males	26	16
Females	6	12

# of Deaths Reported (1/1 – 1/31): 1

Per Designation	AMI	IDD
Males	1	0
Females	0	0

COVID-19 Projects (Megan Latimer)

- Specialized residential facilities impacted by members/DCW staff testing positive for COVID-19
  - ***Courtyard Manor of Wixom***
  - ***Garden II Home*** (New Outlook, Inc.)

COVID-19 Quarantine Facility Utilization (Lezlee Adkisson)

Quarantine Facility Name	January 2022 # Members Serviced
Detroit Family Home-Southfield	6
Detroit Family Home-Boston (Detroit)	4
Kinloch Home (Redford)	4
January 2022 TOTALS:	**14**

COVID-19 Vaccine Booster Reporting

- Report attached for review

Detroit Wayne
Integrated Health Network
Residential Services Department

30-Day/Emergency Member Discharge Notifications – AMI/IDD

Carry-over Discharge from December 2021	*4*
Total Member Notifications Received: January 2022	**31**
30-Day Notices from Licensed Facilities	14
Emergency Discharges	15
Rescinded Requests/Self-Discharges	2*

- ***(1) 30-day discharge** and **(1) emergency discharge** were both rescinded by the residential providers after case review determined the members can remain in their specialized placement with additional supports from their designated CRSP.

Residential Facility Closures

The following residential facility closures were processed during January 1-31, 2022 to relocate all members to alternate specialized placements.:

# of Facility Closure Notifications	**8**
Received in January 2022: On-Going/In Process	3
Requests ON-HOLD/PENDING	0
Completion of Facility Closures	5

Karen's Helping Hands-SIL-South Park Plaza #2 - 33169
Provider Notification Received: 9/29/21
Confirmed Closure Date: 1/4/22
Residential provider's notification reports facility closure due to increase of member's rent. Residential Care Coordination team successfully relocated 2 (AMI) members to alternate facilities contracted with DWIHN.
Current Status: **CLOSED**

Fairview Home - 25281
Provider Notification Received: 10/21/21
Confirmed Closure Date: 1/4/22
MCO submitted notification to department advising residential provider is selecting not to continue DWIHN contract due to lack of staffing. Residential Care Coordination team successfully relocated 3 (DD) members to alternate facilities contracted with DWIHN.
Current Status: **CLOSED**

Diamond AFC Home - 28880
MCO ***Suspension*** Notification Received: 9/29/21
MCO submitted notification to department advising residential provider has currently been suspended to receive referrals for specialized placement. Of all 3 AMI members, one (1) was successfully relocated, as the remaining 2 members decoded to stay in the facility. The MHWIN charts have been document to reflect members/guardian are aware the facility is no longer under DWIHN contract.
Current Status: **Member Successfully Relocated, effective 1/14/2022**

Parkgrove Home - 25943
CRSP Notification Received: 1/5/22
Scheduled Closure Date: 2/28/22
CRSP notification received reporting residential provider is closing facility due to lack of staffing. Residential Care Coordination team in process of relocating 5 (IDD) members to alternate facilities contracted with DWIHN.
Current Status: On-Going

Castle Home - 25083
Provider Notification Received: 1/18/22
Scheduled Closure Date: 2/18/22
Provider notification received reporting intent to close facility due to lack of staffing. Residential Care Coordination team in process of relocating 3 (IDD) members to alternate facilities contracted with DWIHN.
Current Status: On-Going

Bloomfield-South - 32702
CEO Notification Received: 1/21/22
Scheduled Closure Date: 2/15/22
Facility closure notification received from DWIHN CEO reporting intent to close facility due to lack of staffing. Residential Care Coordination team in process of relocating 3 (IDD) members to alternate facilities contracted with DWIHN.
Current Status: On-Going

Canterbury #4 Home - 32825
Provider Notification Received: 1/19/22
Scheduled Closure Date: 2/20/22
Provider notification received reporting intent to close facility due to lack of staffing. Residential Care Coordination team in process of relocating 3 (IDD) members to alternate facilities contracted with DWIHN.
Current Status: On-Going

Saltz II Home - 32995
Provider Notification Received: 1/25/22
Scheduled Closure Date: 2/28/22
Provider notification received reporting intent to close facility due to lack of maintenance upheld by the home owner. Residential Care Coordination team in process of relocating 2 (IDD) members to alternate facilities contracted with DWIHN.
Current Status: On-Going

Detroit Wayne
Integrated Health Network
Residential Services Department

Residential Communications

The department has begun quantifying communications received and responded to during the month January 2022; by telephone calls/voicemails, faxes, and/or emails.:

Voicemails: January 2022	**78**
Blank Messages/Fax Machine Calls/No Contact Info from Caller	21
Calls/Voicemails Responded to with **24/48 Hours**	45
Forwarded to Assigned Residential Staff	6
Forwarded to other DWIHN Departments	2
Responses Requiring Director/Manager Review	4

Emails: January 2022 ResidentialReferral@dwihn.org	**128**
Emails Responded to with **24/48 Hours**	73
Forwarded to Assigned Residential Staff	26
Forwarded to other DWIHN Departments	17
Responses Requiring Director/Manager Review	12

Detroit Wayne
Integrated Health Network
Residential Services Department

Department Project Summaries

Authorizations Team

- ***New CPT Rates (5% Increases):*** The Residential Unit updated service authorizations that were not completed as of January 1, 2022 with the 5% rate increase. PCE is working on updating all other service authorizations in MHWIN to reflect the new 5% increase. As of January 28th, the Authorizations Team completed 19 service authorization updates.
- ***H2X15/T2X27:*** The Residential Authorization Team has been working to establish a standardized process for approving H2X15/T2X27 authorizations.
- ***H2X15 Unit Shortage:*** With the implantation of the bundled service authorizations (H2X15/T2X27), it appears that MHWIN has a unusual function when a biller submits a claim "without authorization"; the system reduces the units available on any current authorization by the number of units submitted on claims. Providers were inadvertently using up their authorizations, even though they did not intend to do so.
- ***Specialized Residential Service Authorization Refresher Trainings:*** The Residential Authorization Team continues monthly refresher trainings with IDD (11 AM) and AMI (2 PM) CRSP supports coordination and case management staff every first Thursday in TEAMs.

Residential Sponsored Meetings and Trainings

- ***CRSP/Residential Services Monthly Meetings***
  - 12 meetings (***XX attendees total***)
- ***CRSP DWIHN Residential Service Authorization Refresher Trainings:*** Monday, 1/6/22
  - IDD CRSP – Monday, 1/6 at 11 AM (***35 attendees***)
  - AMI CRSP – Monday, 1/6 at 11 AM (***36 attendees***)
- ***IDD and AMI CRSP/IDD Residential Providers Monthly Meetings***: scheduled to resume February 2022
- ***DWIHN Residential Provider/CRSP Advisory Group***: Monday, 1/24/2022 at 10 AM
  - 16 attendees
  - Meetings guests: CCO Jackie Davis, Starlit Smith, & Eugene Gillespie (QI)

Detroit Wayne
Integrated Health Network
Residential Services Department

Residential Assessment Development *(Darryl Smith)*

- ***Trainings:*** Special request to train new case management hires of ***Team Wellness Center-Eastern Market*** on the DWIHN Residential Assessment and alignment of clinical documentation with the IPOS for DWIHN members: ***completed on Monday, 1/24/2022 at 10 AM*** ()
- ***Reviews and Training***: Trained supports coordination staff of ***Community Living Services*** and ***Wayne Center*** review of the DWIHN Residential Assessment
- ***DWIHN Residential Assessment:*** Completed 20 residential assessment reviews with the staff of ***Wayne Center, Community Living Services***, and ***All-Well Being Services***
- ***Special Assignment:*** Currently developing process flow and form to utilize for HAB waiver referrals for eligible IDD members

Department Tasks

- DWIHN Affirmative Statements completed and submitted for Residential Staff to UM ***(1/4/22)***
- DHHS "Rapid Response Staffing" Services Available for Long-term Care Facilities ***(1/4/22)***
- Managed Care Operations suspension notification: Diamond AFC Home ***(1/6/22)***
- Teleconference Call: Michael Hunter @ TWC Transitional Settings Discussion ***(1/6/22)***
- FEMA Helps Pay for Funeral Costs Related to COVID-19 Deaths ***(1/12/22)***
- Project: Reach Out Vaccine Reporting Process Development & Implementation ***(1/13/22)***
- Residential Department Facility Close-Out Process Revision ***(1/14/22)***
- Medical Directors COVID-19 Discussion presentation ***(1/14/22)***
- At-Home COVID Tests Availability ***(1/16/22)***
- Residential HAB Waiver Referral Reporting ***(1/19/22)***
- Residential Case Management Monthly Monitoring Note Review/Discussion w/ IT ***(1/26/22)***
- Overview of Residential Processes and Procedures with new case management staff of Team Wellness Center-Eastern Market office, hosted by Department Manager Kelly McGhee ***(1/27/22)***

Detroit Wayne
Integrated Health Network
Residential Services Department

Department Goals

Staffing

- HR to repost (1) open Residential Care Specialist position
- Development of staff metrics
- Reviewing department processes

Automated Productivity Reporting

- Residential Hospitalization Penetration reporting: Reporting of inpatient data of members that have received specialized residential services within 30 days of hospital stay. Report confirms residential members inpatient stay is ***less than 1% overall*** for 2021 fiscal year.
- Continued reformatting of productivity report to monitor timeliness and response to service requests
  - *Smartsheet updates for new fiscal year reporting*

COVID-19 Vaccine Booster Reporting

- Residential Services Department initiated reporting of (eligible) Members that have received Vaccine Boosters on 12/1/21 through **Project: Reach Out**

	# of Members FULLY Vaccinated	Vaccine Booster Received
LICENSED		
City of Detroit	649	113
Western Wayne	1,243	496
UNLICENSED		
City of Detroit	93	51
Western Wayne	678	79

Date reporting range: 12/1/21-1/28/22

DWIHN UTILIZATION MANAGEMENT MONTHLY REPORT
January 2022

Executive Summary

- **Autism:** There were 345 authorization requests manually approved during the month of January. There were approximately an additional 160 authorizations approved via the auto approval process for a total of 505 approved authorizations. There are 2,229 cases currently open in the benefit.
- **Habilitation Supports Waiver:** There are 1,084 slots assigned to the DWIHN. As of 01/28/2022, 1023 filled, 61 open, for a utilization rate of 94.4%.
- **County of Financial Responsibility:** The total number of open COFR cases decreased by 6% in the month of January.
- **Denials and Appeals:** For the month of January, there were zero (0) denials reported and two (2) appeals. There were seventeen (17) service authorization administrative denials and three (3) administrative appeal requests
- **General Fund:** There were 345 General Fund Authorization approvals during January 2022.
- **MI Health Link:** The reporting format of MI Health Link authorizations reflects the total number of authorizations requests and the amount of each authorization type for the 5 ICOs. As of 1/28/22, were 35 MI Health Link authorizations received in January. The number of MI Health Link admissions to inpatient, partial and CRU are also included in the Provider Network data.
- **Provider Network:** As of 1/28/22, the UM Team has managed a total of 504 admissions including Inpatient, MI Health Link, Partial Hospital and Crisis Residential. There were 1388 approvals for non-urgent, pre-service authorizations.
- **State Facilities:** There were 4 state hospital admissions for the month and 69 NGRI consumers are currently managed in the community.
- **SUD:** There were 1815 SUD authorizations approved during the month of January compared to 1325 approved in December. This month's data was collected on 1/27/2021. UM reviewed 1185 authorizations in December, compared to 728 in December. Access and SUD Providers generated the remaining 629.
- **Administrative Denials**: During the month of January, the SUD team issued 31 administrative denials compared to 9 the previous month.
- **MCG**: Up until 1/27/22 there were 764 individuals screened in Indica which is an average of 28 cases per day screened using the MCG Behavioral Health Guidelines. Projecting until the end of the month, our per day average is usually between 30-32 screenings each day.

General Report

Utilization Management Committee

The monthly UMC Meeting was held in January and minutes are available for review.

Autism Spectrum Disorder (ASD) Benefit

There were 345 authorization requests manually approved during the month of January. There were approximately an additional 160 authorizations approved via the auto approval process for a total of 505 approved authorizations. There are 2,229 cases currently open in the benefit.

ASD Authorization Approvals for Current Fiscal Year to Date*:

	Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	Aug	Sept
Manual Approvals	473	450	407	345								
Auto Approvals	132	161	173	160								
Total Approvals	**605**	**611**	**580**	**504**								

*Numbers are approximate as they are pulled for this report prior to when all data for the month is available. Specifically, data for January was pulled 1/18/22.

ASD Open Cases and Referral Numbers Per WSA*

Fiscal Year to Date												
	Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	Aug	Sept
Open Cases	2130	2184	2198	2229								
Referrals	98	47	64	Pending Update from the WSA								

*Numbers are approximate as they are pulled for this report prior to when all data for the month is available. Specifically, data for January was pulled 1/28/22.

Habilitation Supports Waiver

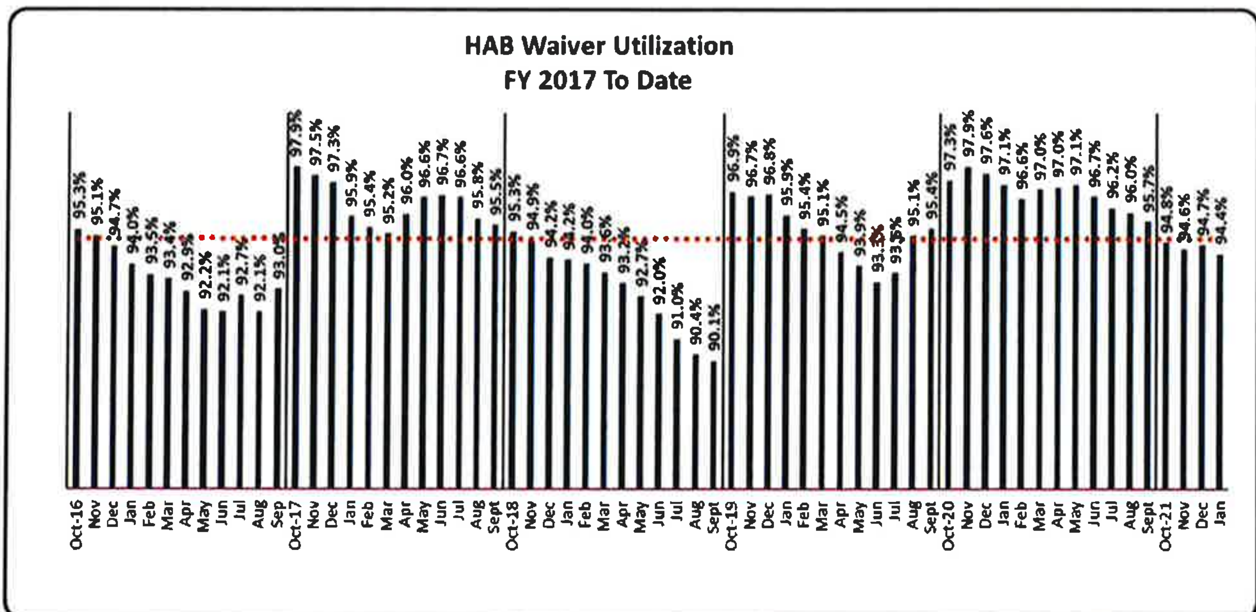
January Utilization (as of 01/28/2022)

HAB Utilization	January
Allocated	1,084
Used	1,023
Available	61
% Used	94.4

Program Details for January

Outcome Measurement	January
# of applications received	7
# of applications reviewed	5
# of app. Pended PIHP level for more information	1
#of pended app. resubmitted	0
# of app. withdrawn	0
Total of application sent to MDHHS.	4
Technical Assistants contacts	9
# of deaths/disenrollments (recertification forms reviewed & signed)	2 deceased 1 disenroll
# of recertification forms reviewed and signed	38
# of recertification forms pended	13

Historical Trend



Serious Emotional Disturbance Waiver (SEDW)

# of youth expected to serve in the SEDW for FY 21-22	65
# of active youth served in the SEDW, thus far for FY 21-22	64
# of youth currently active in the SEDW for the month of January	57
# of referrals received in January	12
# of youth approved/renewed for the SEDW in January	9
# of referrals currently awaiting approval at MDHHS	0
# of referrals currently at SEDW Contract Provider	9
# of youth terminated from the SEDW in January	0
# of youth transferred to another County, pursuing the SEDW	2
# of youth coming from another county, receiving the SEDW	0
# of youth moving from one SEDW provider in Wayne County to another SEDW provider in Wayne County	0

County of Financial Responsibility (COFR)

The COFR Committee continued to meet weekly for one (1) hour during the month of January. Weekly meetings are expected to continue ongoing. In December 2021, 62 cases were pending, January 2022 shows a 6% decrease.

	Adult COFR Case Reviews Requests	Children COFR Case Reviews Requests	Resolved	Pending*
January 2022	2	1	10	52

*This is a running total. Recommendations forwarded to Administration and pending determination

Note: Not all new cases referred are reviewed within the month they are received. All new cases are added to COFR Master List with date referral is received. Cases are reviewed by priority of the committee.

General Fund

There were 345 General Fund approvals during January 2022.

Denials and Appeals

For the month of January, there were zero denials, and two (2) medical necessity appeals to report. One of the appeals were upheld and the other was overturned.

	Oct. 21	Nov. 21	Dec. 21	Jan. 22	Feb. 22	Mar 22	Apr 22	May 22	Jun. 22	Jul. 22	Aug. 22	Sept 22
Denial	0	2	4	0								
Appeal	0	0	2	2								

Service Authorization Administrative Denials

During the month of January there were seventeen (17) service authorization administrative denials and three (3) administrative appeals that were upheld.

Timeliness of UM Decision Making

Timeliness of UM Decision Making-DWIHN-Autism Program

	Urgent Concurrent	Urgent Preservice	Non-Urgent Preservice	Post-Service
Numerator *	N/A	N/A	1268	N/A
Denominator#	N/A	N/A	1274	N/A
Rate	N/A	N/A	99.5%	N/A

Timeliness of UM Decision Making-DWIHN-MI Health Link Program

	Urgent Concurrent	Urgent Preservice	Non-Urgent Preservice	Post-Service
Numerator *	3	0	24	1
Denominator#	3	0	29	1
Rate	100%	0%	82.7%	100%

Timeliness of UM Decision Making-DWIHN- Substance Use Disorders

	Urgent Concurrent	Urgent Preservice	Non-Urgent Preservice	Post-Service
Numerator *	557	N/A	2830	N/A
Denominator#	566	N/A	3218	N/A
Rate	98.4%	N/A	87.9%	N/A

Timeliness of UM Decision Making- Children's Center

	Urgent Concurrent	Urgent Preservice	Non-Urgent Preservice	Post-Service
Numerator *	N/A		N/A	N/A
Denominator#	N/A		N/A	N/A
Rate	N/A	%	N/A	N/A

Timeliness of UM Notification- COPE

	Urgent Concurrent	Urgent Preservice	Non-Urgent Preservice	Post-Service
Numerator *	N/A		N/A	N/A
Denominator#	N/A		N/A	N/A
Rate	N/A	%	N/A	N/A

Timeliness of UM Decision Making- Guidance Center

	Urgent Concurrent	Urgent Preservice	Non-Urgent Preservice	Post Service
Numerator *	N/A		N/A	N/A
Denominator #	N/A		N/A	N/A
Rate	N/A	%	N/A	N/A

Timeliness of UM Decision Making- New Oakland

	Urgent Concurrent	Urgent Preservice	Non-Urgent Preservice	Post-Service
Numerator	N/A	170	N/A	N/A
Denominator	N/A	170	N/A	N/A
Rate	N/A	100%	N/A	N/A

State Hospital Liaison Activity Report

Hospital	Caro Center		Kalamazoo		Walter Reuther	
Census	Total	2	Total	6	Total	96
	NGRI	0	NGRI	1	NGRI	33
	Non-NGRI	2	Non-NGRI	5	Non-NGRI	63
Wait List	0		1		6	
Admissions	Total	0	Total	1	Total	3
	NGRI	0	NGRI	1	NGRI	1
	Non-NGRI	0	Non-NGRI	0	Non-NGRI	2
ALS Status	0		1		68	

- State hospital admissions continue to be restricted to forensic referrals. However, community referrals may be prioritized if hospital or residential placement options have been exhausted. The MDHHS Careflow Workgroup reviews these referrals and makes the determination for an expedited admission to the first available state hospital facility. This month 2 referrals were submitted for expedited review and are pending.
- Community referrals remain wait listed and monitored by DWIHN to ensure case coordination and assessment of consumer needs. DWIHN continues to coordinate with community hospitals to review state hospital referrals and facilitate alternative options to state hospital admission. Currently, 7 DWIHN members are awaiting state hospital admission.
- Liaison staff continue to monitor and provide consult to the CMH provider network serving the 69 DWIHN members under NGRI status. This month, two NGRI members were re-hospitalized in a state facility following treatment in the local ED. Liaison staff is working with the NGRI Committee to clarify protocols for NGRI community hospitalizations and state hospital returns as beds are limited across all hospital levels.

MI Health Link

Monthly ICO Authorization Report-January 2022

	Preservice Authorizations		Urgent Authorizations		Expedited Authorizations (Currently No DWIHN Authorizations labeled as Expedited)		Post Service Authorizations	
Total # of Auth's Received for the Month	Total Amount Preservice Auth's Received	Total Preservices processed ≤14 days	Total Amount Urgent Auth's Received	Total Urgent processed ≤24 hrs	Total Amount Expedited Auth's Received	Total Expedited processed ≤72 hrs	Total Amount Postservice Auth's Received	Total Post Service processed ≤14 days
35	1	1	15	15	0	0	19	19

The data for January 2022 delineates the total number of authorizations requests and the amount of each authorization type for the 5 ICOs. The table(s) account for the total number of authorizations by ICO, the type of authorization and the amount of time taken to process the request. Additionally, the data only includes those authorizations that required manual review and approval by UM Clinical Specialists. It does not include those authorizations that were auto-approved because the request fell within the UM Service Utilization Guidelines.

As of 1/28/22, there were 35 MI Health Link authorizations received compared to 47 authorizations the end of December 2021, a 25.5% decrease. By ICO, there were 10 authorizations for Aetna, 7 for AmeriHealth, 0 for Michigan Complete Health (Fidelis), 4 for HAP Midwest and 14 for Molina. Out of the 35 MI Health Link authorizations reported, 100% of the requests were processed within the appropriate timeframes.

**The number of MI Health Link admissions to inpatient, partial and CRU are included in the Provider Network data.

Provider Network

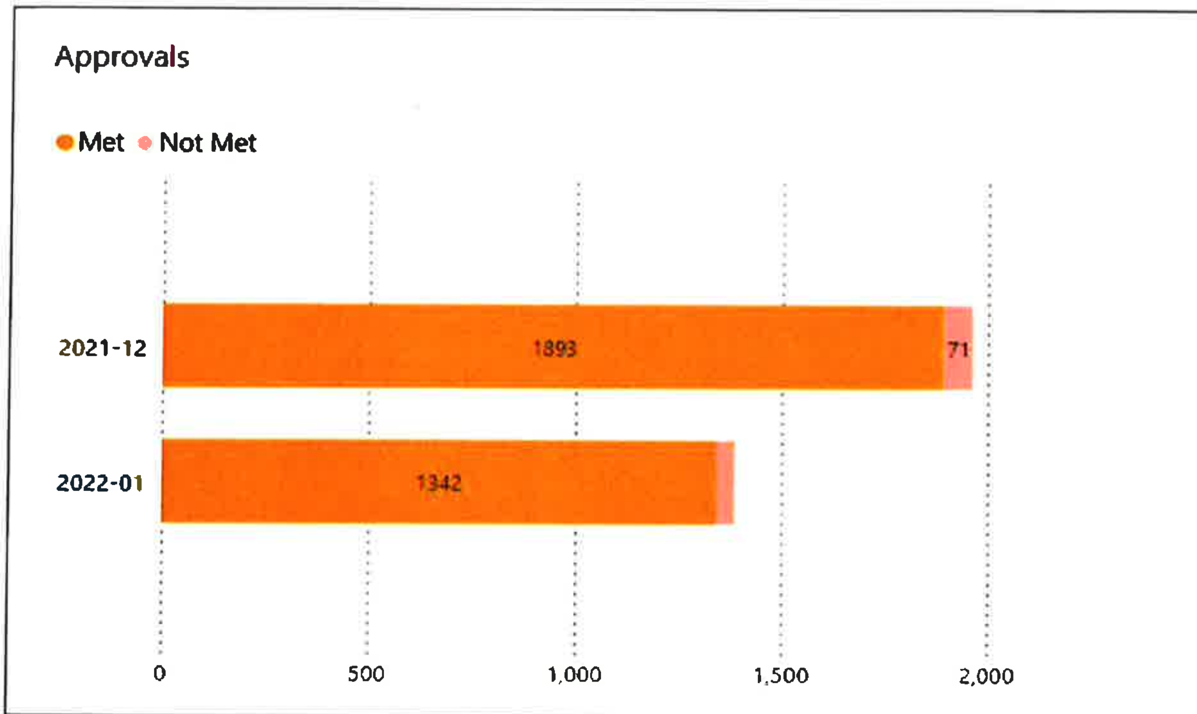
As of 1/28/22, the UM Team has managed a total of 504 members within the provider network. This includes Inpatient, MI Health Link, Partial Hospital and Crisis Residential. To date, there were 410 admissions for inpatient treatment reflecting a 33.5% decrease from the 617 inpatient admissions during December 2021. Per the preliminary recidivism data for the first month of Quarter 2, FY 22, 29 members (2 children and 27 adults) readmitted within 30 days of a prior hospitalization. There were 49 Partial Hospital and 43 Crisis Residential admissions for adults and children. The two Adult Crisis Residential Units at Boulevard and Oakdale House continue to operate with nine beds available at both CRU providers. Only one location (Warren) of Safehaus remains open. The Grand Rapids and Rose City locations have been permanently closed.

The data outlined below reflects the number of admissions as of 1/28/2022:

- Inpatient: 410
- MHL: 35
- Partial: 49
- Crisis Residential (adults-32 and children-11): 43
- Total Admissions: 537
- Average Length of Inpatient admissions: 12

<u>Outpatient Services</u> (Non-Urgent, Pre-Service Authorizations)

As of 1/28/22, there were 1388 approvals for non-urgent, pre-service authorizations. These are authorization requests that required manual review by UM Clinical Specialists. The chart below depicts the number of approvals (1388), those that were approved within 14 days of the request (1342) and the 46 authorizations that were approved beyond 14 days. For comparison, the number of approvals from December are also included. Out of the 1388 approvals, 96.69% were approved within 14 days of the request and 3.31% were approved 15 days or more after the submission. The UM Department continues to review and update the Service Utilization Guidelines to allow for auto approval of medically necessary services and decrease the number of authorizations requiring manual review.



****Data Source: Power-BI****

Substance Use Disorder

SUD Authorizations
There were 1815 SUD authorizations approved during the month of January compared to 1325 approved in December. This month's data was collected on 1/27/2021. UM reviewed 1185 authorizations in December, compared to 728 in December. Access and SUD Providers generated the remaining 629.

There were several issues with the FY 22 Modifier changes, but overall, have reduced significantly. Additionally, there were several organizations that reported issues with billing OHH. With assistance from the SUD Health Home Administrator, the contracts were corrected to reflect OHH instead of SUD. UM continues to collaborate with the Procedure Code Work Group, IT and the Claims Department to help troubleshoot other authorization issues.

SUD Administrative Denials
During the month of January, the SUD team issued 31 administrative denials compared to 9 in December.

Medical Necessity Denials
There were no SUD medical necessity denials this month.

SUD Appeal Requests and Appeal Determination Forms
There was one SUD administrative appeal received during the month and the decision is pending. Administrative appeals have a 30-day response time and will be responded to in a timely manner.

SUD Timeliness Dashboard
As of 1/27/2022, there were 198 urgent authorizations approved. Out of the 198, 196 (99%) were authorized within 72 hours. There were 655 non-urgent authorizations and 632 (97%) were approved within 14 days.

SUD Bi-Monthly Provider Meeting
The SUD Provider meeting was held on January 25th. The new UM Director was introduced to providers in attendance. UM presented an enhancement to the UM Guidelines for the 4 Levels of IOP (H0015). SUD UM staff attend when schedules permit.

MCG
As of 1/27/22, there were 764 individuals screened in Indica which is an average of 28 cases per day screened using the MCG Behavioral Health Guidelines. Projecting until the end of the month, the per day average is usually between 30-32 screenings each day. There is a quarterly meeting with the MCG account representative is scheduled for February. The Parity workgroup will also resume meeting in February and begin a quarterly meeting schedule as well.

IRR
IRR testing continues with new hires. Four new studies are published quarterly.

FY 21 Annual UM Evaluation
Work continues the FY 21 Annual UM Evaluation. Some enhancements were requested for hospitalization data from Power BI. The screening entities provided some clarification and additions to their reports. The evaluation is scheduled to be presented in February to QISC and later to PCC and full Board.

DETROIT WAYNE INTEGRATED HEALTH NETWORK
BOARD ACTION

Board Action Number: 21-36 R2 Revised: Y Requisition Number:

Presented to Full Board at its Meeting on: 2/16/2022

Name of Provider: Children's Center of Wayne County Inc., Sprout Evaluation Center, LLC

Contract Title: Independent Evaluator for ASD

Address where services are provided: See attached list__

Presented to Program Compliance Committee at its meeting on: 2/9/2022

Proposed Contract Term: 10/1/2020 to 9/30/2022

Amount of Contract: $ 1,400,000.00 Previous Fiscal Year: $

Program Type: Continuation

Projected Number Served- Year 1: 2,200 Persons Served (previous fiscal year): 1879

Date Contract First Initiated: 2/23/2022

Provider Impaneled (Y/N)? Y

Program Description Summary: Provide brief description of services provided and target population. If propose contract is a modification, state reason and impact of change (positive and/or negative).

DWIHN is requesting to add Sprout Inc. as an additional ASD evaluator to meet the demand for Autism screening for children in Wayne County. The request is a follow-up to a RFP 2020-003 Rebid 2. Adding Sprout has improved the backlog of assessments allowing DWIHN to remain in compliance with regard to MDHHS minimum timeframes for the completion of assessments.

DWIHN awarded Sprout Inc. a six (6)month provisional approval which expired January 31, 2022. **This amendment is a request to extend Sprout, Inc.'s contract to September 30, 2022.**

The board action was approved for a two-year term for an amount not to exceed $1,400,000. This board action does not change the dollar amount or the term of the two previously awarded providers.

Outstanding Quality Issues (Y/N)? N If yes, please describe:

Source of Funds: Medicaid

Fee for Service (Y/N): Y

Revenue	FY 21/22	Annualized
Medicaid	$ 1,400,000.00	$ 1,400,000.00
	$ 0.00	$ 0.00
Total Revenue	$ 1,400,000.00	$ 1,400,000.00

Recommendation for contract (Continue/Modify/Discontinue): Continue

Type of contract (Business/Clinical): Clinical

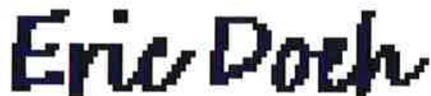
ACCOUNT NUMBER: 64940.827010.00000

In Budget (Y/N)? Y

Approved for Submittal to Board:

Eric Doeh, Chief Executive Officer

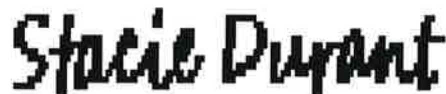
Signature/Date:



Signed: Thursday, February 3, 2022

Stacie Durant, Chief Financial Officer

Signature/Date:



Signed: Thursday, February 3, 2022

DETROIT WAYNE INTEGRATED HEALTH NETWORK
BOARD ACTION

Board Action Number: 22-47 Revised: N Requisition Number:

Presented to Full Board at its Meeting on: 2/16/2022

Name of Provider: DWIHN Provider Network - see attached list

Contract Title: Mental Health First Aid/QPR

Address where services are provided: 'None'__

Presented to Program Compliance Committee at its meeting on: 2/9/2022

Proposed Contract Term: 2/1/2022 to 9/30/2022

Amount of Contract: $ 550,000.00 Previous Fiscal Year: $ 550,000.00

Program Type: Continuation

Projected Number Served- Year 1: 1,000 Persons Served (previous fiscal year): 1320

Date Contract First Initiated: 2/1/2022

Provider Impaneled (Y/N)? N

Program Description Summary: Provide brief description of services provided and target population. If propose contract is a modification, state reason and impact of change (positive and/or negative).

The Detroit Wayne Integrated Health Network (DWIHN) is requesting approval to enter into a contract with various vendors (enclosed) for the continuation of Mental Health First Aid and QPR-Question, Persuade, Refer under BA 22-47. Each of the curricula support the efforts that DWIHN has worked toward for the past couple of years.

It is requested that the contracts utilizing General Fund begin February 1, 2022 and continue through September 30, 2022. The cost and fees for professional services to DWIHN will not exceed $550,000.00. Each of the entities has certified trainers and has met outcomes in alignment with DWIHN expectation were selected for contract continuation. These are Providers who will offer training and participate in training efforts for the county.

Outstanding Quality Issues (Y/N)? N If yes, please describe:

Source of Funds: General Fund

Fee for Service (Y/N): Y

Revenue	FY 21/22	Annualized
General Fund	$ 550,000.00	$ 550,000.00

	$ 0.00	$ 0.00
Total Revenue	$ 550,000.00	$ 550,000.00

Recommendation for contract (Continue/Modify/Discontinue): Continue

Type of contract (Business/Clinical): Clinical

ACCOUNT NUMBER: 64931.827206.05900

In Budget (Y/N)? Y

Approved for Submittal to Board:

Eric Doeh, Chief Executive Officer

Signature/Date:

Eric Doeh

Signed: Friday, February 4, 2022

Stacie Durant, Chief Financial Officer

Signature/Date:

Stacie Durant

Signed: Friday, February 4, 2022

DETROIT WAYNE INTEGRATED HEALTH NETWORK
BOARD ACTION

Board Action Number: 22-49 Revised: Requisition Number:

Presented to Full Board at its Meeting on: 2/16/2022

Name of Provider: DWIHN Provider Network - see attached list

Contract Title: Tri-County Strong Crisis Counseling Program (CCP)

Address where services are provided: 'None'__

Presented to Program Compliance Committee at its meeting on: 2/9/2022

Proposed Contract Term: 2/1/2022 to 9/30/2022

Amount of Contract: $ 3,725,575.00 Previous Fiscal Year: $ 0.00

Program Type: New

Projected Number Served- Year 1: 800 Persons Served (previous fiscal year): 0

Date Contract First Initiated: 2/1/2022

Provider Impaneled (Y/N)? Y

Program Description Summary: Provide brief description of services provided and target population. If propose contract is a modification, state reason and impact of change (positive and/or negative).

The Detroit Wayne Integrated Health Network (DWIHN) is requesting approval to enter into a contract with nine various vendors (enclosed) for an amount not to exceed $3,725,575 to implement a virtual and face to face crisis counseling program designed to serve victims of flooding in the tri-county area. Each of the partners are named and approved via the federal funder and the State of Michigan. Providers were selected based on the Governors declaration of disaster areas and their catchment areas; MDHHS will be providing the grant funds directly to DWIHN.

The state's partners in this grant pursuit are Detroit Wayne Integrated Health Network (DWIHN), Oakland Community Health Network (OCHN), and Macomb County Community Mental Health (MCCMH). DWIHN will be the grant's lead partner and will disburse all funding.

Outstanding Quality Issues (Y/N)? N If yes, please describe:

Source of Funds: Block Grant

Fee for Service (Y/N): Y

Revenue	FY 21/22	Annualized

Block Grant	$ 3,725,575.00	$ 3,725,575.00
	$ 0.00	$ 0.00
Total Revenue	$ 3,725,575.00	$ 3,725,575.00

Recommendation for contract (Continue/Modify/Discontinue): Continue

Type of contract (Business/Clinical): Clinical

ACCOUNT NUMBER: VARIOUS

In Budget (Y/N)? Y

Approved for Submittal to Board:

Eric Doeh, Chief Executive Officer

Signature/Date:

Eric Doeh

Signed: Friday, February 4, 2022

Stacie Durant, Chief Financial Officer

Signature/Date:

Stacie Durant

Signed: Friday, February 4, 2022

DETROIT WAYNE INTEGRATED HEALTH NETWORK
BOARD ACTION

Board Action Number: BA #22-53 Revised: Requisition Number:

Presented to Full Board at its Meeting on: 2/16/2022

Name of Provider: The Empowerment Plan

Contract Title: Sleeping Bags/Coats

Address where services are provided: 'None'__

Presented to Program Compliance Committee at its meeting on: 2/9/2002

Proposed Contract Term: 3/1/2022 to 9/30/2022

Amount of Contract: $ 88,100.00 Previous Fiscal Year: $ 50,000.00

Program Type: Continuation

Projected Number Served- Year 1: 199 Persons Served (previous fiscal year): 50

Date Contract First Initiated: 10/1/2021

Provider Impaneled (Y/N)?

Program Description Summary: Provide brief description of services provided and target population. If propose contract is a modification, state reason and impact of change (positive and/or negative).

The SUD Department is requesting $88,100.00 in PA 2 funding for 700 Sleeping Bag/Coats for our Co-Occurring Homeless consumers. The Sleeping Bag/Coats will allow providers to provide active outreach and support individuals who are experiencing homelessness and substance use disorder throughout Wayne County. In addition, the service will allow providers to maximize their outreach efforts and assist in supporting linkages to SSI assistance, housing, substance use disorder services, and mental health etc. The Empowerment Plan's durable and weather-resistant coat can be converted into a sleeping bag or an over-the-shoulder bag when not in use. The coats are intended to last for multiple seasons and materials used include upcycled fabric from companies such as General Motors and Patagonia. The Empowerment Plan will include 400 socks, hats and gloves.

Outstanding Quality Issues (Y/N)? N If yes, please describe:

Source of Funds: PA2

Fee for Service (Y/N): N

Revenue	FY 21/22	Annualized
PA2	$ 88,100.00	$ 88,100.00
	$ 0.00	$ 0.00

Total Revenue	$ 88,100.00	$ 88,100.00

Recommendation for contract (Continue/Modify/Discontinue): Continue

Type of contract (Business/Clinical): Clinical

ACCOUNT NUMBER: 64932.826606.00000

In Budget (Y/N)?

Approved for Submittal to Board:

Eric Doeh, Chief Executive Officer

Signature/Date:

Eric Doeh

Signed: Friday, February 4, 2022

Stacie Durant, Chief Financial Officer

Signature/Date:

Stacie Durant

Signed: Friday, February 4, 2022

DETROIT WAYNE INTEGRATED HEALTH NETWORK
BOARD ACTION

Board Action Number: BA 22-54 Revised: Requisition Number:

Presented to Full Board at its Meeting on: 2/16/2022

Name of Provider: DWIHN Provider Network - see attached list

Contract Title: Jail Plus

Address where services are provided: 'None'__

Presented to Program Compliance Committee at its meeting on: 2/9/2022

Proposed Contract Term: 10/1/2021 to 9/30/2022

Amount of Contract: $ 241,000.00 Previous Fiscal Year: $ 241,000.00

Program Type: Continuation

Projected Number Served- Year 1: 200 Persons Served (previous fiscal year): 50

Date Contract First Initiated: 10/1/2021

Provider Impaneled (Y/N)?

Program Description Summary: Provide brief description of services provided and target population. If propose contract is a modification, state reason and impact of change (positive and/or negative).

The Wayne County Department of Health , Human and Veterans Services (HHVS), Clinical Services Division, Adult Community Corrections, is requesting approval of a sub-recipient Intergovernmental Agreement (IGA) between the County of Wayne and Detroit Wayne Integrated Health Network (DWIHN).

DWIHN is the Prepaid Inpatient Health Plan (PIHP) for Wayne County and manages federal and state prevention treatment and recovery services in Wayne County, in addition to mental health services. The IGA with the DWIHN is based on DWIHN's ability to bring added value to our contracted services not funded via the Community Corrections grant, including, access to its network of providers for intensive wrap-around service, utilization of its Access Management System for immediate client placement.

The term of the agreement is from October 1, 2021 through September 20,2022. The total amount of this contract is $241,000.00, which includes Black Family Development ($85,000.00), Detroit Recovery Project ($116,000.00), Detroit Rescue Mission ($18,750.00), Elmhurst Home/Naomi's Nest ($18,750.00) and $7,500.00 DWIHN administrative fee allocation. This IGA is a locally funded, and does not include federal dollars, or any match requirements

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Outstanding Quality Issues (Y/N)? N If yes, please describe:

Source of Funds: Other

Fee for Service (Y/N): N

Revenue	FY 21/22	Annualized
Local grant	$ 241,000.00	$ 241,000.00
	$ 0.00	$ 0.00
Total Revenue	$ 241,000.00	$ 241,000.00

Recommendation for contract (Continue/Modify/Discontinue): Continue

Type of contract (Business/Clinical): Clinical

ACCOUNT NUMBER: VARIOUS

In Budget (Y/N)?

Approved for Submittal to Board:

Eric Doeh, Chief Executive Officer

Signature/Date:

Eric Doeh

Signed: Friday, February 4, 2022

Stacie Durant, Chief Financial Officer

Signature/Date:

Stacie Durant

Signed: Friday, February 4, 2022

DETROIT WAYNE INTEGRATED HEALTH NETWORK
BOARD ACTION

Board Action Number: 22-55 Revised: Requisition Number:

Presented to Full Board at its Meeting on: 2/16/2022

Name of Provider: DWIHN Provider Network - see attached list

Contract Title: American Rescue Plan Act (ARPA)

Address where services are provided: 'None'__

Presented to Program Compliance Committee at its meeting on: 2/9/2022

Proposed Contract Term: 10/1/2021 to 9/30/2022

Amount of Contract: $ 1,254,060.00 Previous Fiscal Year: $ 0.00

Program Type: New

Projected Number Served- Year 1: 1,200 Persons Served (previous fiscal year): 0

Date Contract First Initiated: 10/1/2021

Provider Impaneled (Y/N)?

Program Description Summary: Provide brief description of services provided and target population. If propose contract is a modification, state reason and impact of change (positive and/or negative).

The Michigan Department of Health and Human Services awarded the SUD Department $1,129,060 from the American Rescue Plan Act (ARPA) grant with an additional $125,000 for administrative cost and unmet needs. The funding will provide prevention, intervention, treatment, and recovery support continuum services to includes various evidence-based services and supports for individuals, families, and communities. These underserved and marginalized populations include, but are not limited to, pregnant women and women with dependent children; persons who inject drugs; persons using opioids and/or stimulant drugs associated with drug overdoses; persons at risk for HIV, TB, and Hepatitis; persons experiencing homelessness; persons involved in the justice system; persons involved in the child welfare system; Black, Indigenous, and People of Color (BIPOC); LGBTQ individuals; rural populations; and other underserved groups.

The award identifies 14 areas of services:

Recovery Housing, Recovery Community Organization, Recovery Support Services, Individualized Placement and Support, Youth Community Centers, Prosocial Activities, Telehealth Hubs, Telehealth Technology, Accessing Behavioral Health for African American, Staffing Support, Student Assistance Programming, and Evidence-Based Programming

The selected providers include: Elmhurst Home/Naomi's Nest, Personalized Nursing Lighthouse, SHAR, Sobriety House, Detroit Rescue Mission Ministries, Growth Works, Detroit Recovery Project, and Team Wellness Center.

The selected Prevention Providers include Beaumont, Leaders Advancing and Helping Communities, and the National Council on Alcoholism and Drug Dependence and Empowerment Zone.

The provider allocation is as follows:
Treatment
Elmhurst Home - Recovery Support $75,000
Recovery Housing $100,000
Personalized Nursing Lighthouse - SUD Health Home - $10,000
SHAR - Accessing behavioral health for African Americans - $50,000 Telehealth hubs $25,000
Development of recovery community organization $75,000
Sobriety House accessing behavioral health for African American - $50,000. Telehealth technology $75,000
Detroit Recovery Project Youth community centers $350,000
Collegiate Recovery Program $25,000
Growth Works Development of recovery community organization $75,000
Detroit Rescue Mission Ministries
Telehealth hubs $25,000
Team Wellness Center Individual Placement and Support $25,000

Prevention
Beaumont - Student Assistance Program - $50,000K
LAHC - Evidence Based Program - $40,000
NCADD - Evidence Based Program - $40,000
Empowerment Zone - Evidence Based $39,060

The Authority has the discretion to allocate the funds among the providers based upon utilization as long as the total amount of the board action (i.e. contract amount) does not increase. As a result, budget may be decreased/increased among sub-recipients as long as overall budget does not change.

Outstanding Quality Issues (Y/N)? N If yes, please describe:

Source of Funds: Block Grant

Fee for Service (Y/N): N

Revenue	FY 21/22	Annualized
Federal grant	$ 1,254,060.00	$ 1,254,060.00
	$ 0.00	$ 0.00
Total Revenue	$ 1,254,060.00	$ 1,254,060.00

Recommendation for contract (Continue/Modify/Discontinue): Continue

Type of contract (Business/Clinical):

ACCOUNT NUMBER: VARIOUS

In Budget (Y/N)?

Approved for Submittal to Board:

Eric Doeh, Chief Executive Officer

Signature/Date:

Eric Doeh

Signed: Friday, February 4, 2022

Stacie Durant, Chief Financial Officer

Signature/Date:

Stacie Durant

Signed: Friday, February 4, 2022