**Detroit- Wayne Integrated Health Network**

**Quarterly Contract Status Report**

**Report Period:**

1st Quarter (Oct. 1- Dec.31)  2nd Quarter (Jan. 1- Mar 31)  3rd Quarter (April 1- June 30)   4th Quarter (July 1- Sept. 30)

**Directions:**

Quarterly Contract Status Report must be submitted on the 10th business day following the end of the quarter as required per contract. Submit this report to Provider Network Manager via email. **(Word only—no PDF)** Complete all sections and be sure that the report is signed by the President/CEO or designee.

**Organization Name:** Click or tap here to enter text.

President & CEO: Click or tap here to enter text.

Phone Number: Click or tap here to enter text. Email: Click or tap here to enter text.

Administrative Address: Click or tap here to enter text.

Additional Contact Person: Click or tap here to enter text.

Phone: Click or tap here to enter text. Email: Click or tap here to enter text.

Signed Executed Contract Date: Click or tap here to enter text. FY: Click or tap here to enter text.

Budget Amount:Click or tap here to enter text.

SAM Organization Registration Date: Click or tap here to enter text.DWIHN Impanel Certificate Date:Click or tap here to enter text.

# of employees: Click or tap here to enter text.# of Licensed Homes: Click or tap here to enter text.# of Unlicensed Homes: Click or tap here to enter text. # of People Supported: Click or tap here to enter text.

Population Served: Click or tap here to enter text.

Contracted Services: Click or tap here to enter text.

**Provider Goals**

1. State the goal(s) accomplished during the reporting period:Click or tap here to enter text.
2. Summarize the activities that have occurred towards achievement of goal(s): Click or tap here to enter text.
3. Identify any challenges/barriers that impacted achievement of goal(s) and describe actions to address them. Click or tap here to enter text.
4. Describe any new program goals and activities for the next quarter: Click or tap here to enter text.

**NCQA Standards**

1. How does your organization self-monitor the maintenance of records that all the staff have evidence of completed current required trainings and credentials? Click or tap here to enter text.
2. Do you have a Behavior Treatment Plan Policy? Yes  No  Effective Date: Click or tap here to enter text.
3. CRSPs ONLY – Are the responsibilities in coordination of the person-centered and treatment planning process being followed including timeliness? Yes  No  Identify any issues:Click or tap here to enter text.

**DWIHN Contract Monitoring:**

1. Has there been any program, ownership or administrative changes within the organization? Yes  No  If yes, submit a revised Service Agency Profile (SAP), Provider Information Change Form, and/or disclosure of ownership form to your contract manager.
2. Have there been any staff changes (new hire, terminations)? Yes  No  If yes, has the staff profile in MHWIN been updated? Yes  No
3. Are there any Lara Licensing changes/updates? Click or tap here to enter text.

**Contract Performance Monitoring:**

1. Is the organization achieving the performance outcomes(s) according to the DWIHN contract? Yes  No
2. Indicate any barriers to achieving performance outcomes. Click or tap here to enter text.
3. **If you are CRSP**, does your organization utilize subcontractors to service DWIHN members Yes  No  If yes, have you provided DWIHN with a copy of the subcontractor contracts Yes  No  If no, please attach

Subcontract (Please refer to Subcontracting Section in DWIHN contract for subcontractor requirements)

1. Has the organization been placed on a Plan of Correction (by LARA, ORR, QI, MCO)? Yes  No  If yes, attach an explanation to this report along with supporting documents.
2. Is your organization currently being sued? (named, involved in any lawsuit): Yes  No  If yes, attach an explanation to this report on your organization’s letterhead, signed and dated by your CEO.

**Finance**:

1. Are there any authorization, claim, or payment issues that have not been resolved? Yes  No  If yes, provide a brief explanation: Click or tap here to enter text.

**MHWIN**

1. Ensure the information is accurate in the DWIHN (searchable) Provider Directory. Date verifiedClick or tap here to enter text.
2. Ensure the information is accurate and complete under section titles: Provider List, Primary Address, Primary Contact Person, Federal and State Information and Identifiers. Date Verified Click or tap here to enter text.
3. Residential Contracts ONLY – Ensure the information is accurate and complete under section titled: Home/Contracted Site Information. Date Verified Click or tap here to enter text.
4. Outpatient Contracts ONLY – Ensure Information is accurate and complete under section titled: Other Information. Date Verified Click or tap here to enter text.

**Bulletins:**

1. Please refer to our website at <https://www.dwihn.org/billig-coding-bulletins>

**Residential Providers ONLY:**

1. Are there any unresolved CRSP concerns (Case Management/IPOS)? Yes  No

If yes, briefly describe: Click or tap here to enter text.

1. Does each **licensed** home have a dedicated phone landline Yes  No  Do members have access to the phone landline Yes  No  If no, for any home provide name of home (s) and date of correction Click or tap here to enter text.

|  |  |  |
| --- | --- | --- |
| Licensed Home Name | Site Location Address | Landline Phone Number |
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\*Note: phone numbers should be in MHWIN for each site. Please check the phone number and ensure it is correct.

**Home and Community Based Services (Final Rule)**

1. Have your homes been deemed Home and Community Based Services (HCBS) compliant by DWIHN Quality department? Yes  No  If not, were you granted an extension? Yes  No

\* Does the setting look similar to other buildings/businesses in the neighborhood? Yes  No

If no, please provide name of home(s): Click or tap here to enter text.

\* Can the individual(s) close and lock the bathroom door?  Yes  No

 If no, please provide name of home(s): Click or tap here to enter text.

\* Can the individual(s) choose to come and go from the setting when they want?  Yes  No

If no, please provide name of home(s): Click or tap here to enter text.

\* Is the individual(s) encouraged to have full access to the community?  Yes  No

If no, please provide name of home(s): Click or tap here to enter text.

**Provider Network Policies (**These policies address oversight by MCO and can be found on <https://www.dwihn.org/policies>).

The purpose of reviewing our policies is to keep the network informed of any changes that may occur. Please provide the date that you reviewed the policies listed below:

1. Credentialing/Re-Credentialing - Date reviewed: Click or tap here to enter text.
2. MI Health Link Non-Contracted Provider Procedure – Date Reviewed: Click or tap here to enter text.
3. Network Monitoring and Management (Termination of Contract Sites): Click or tap here to enter text.
4. Work Force a Provider Background Check – Date reviewed: Click or tap here to enter text.
5. Self-Determination – Date Reviewed: Click or tap here to enter text.
6. Out of Network Procedures for Behavioral Health Services (Non-MI Health Link) – Date Reviewed: Click or tap here to enter text.
7. MI Health Link Non-Contract Provider Procedure – Date Reviewed: Click or tap here to enter text.
8. Out of Network Policy – Date Reviewed: Click or tap here to enter text.

**Litigation:**

1. In the event your organization is a party to any type of litigation **even if DWIHN is not involved** the following information should be provided along with a copy of the compliant:

*1.           Provider Name*

*2.           A copy of the Complaint*

*3.           Case Name*

*4.           Case Number*

*5.           The Nature of the Claim*

*6.           Status of the Claim*

*7.           Names and Addresses of All Appearing Counsel.*

8.          *Copy of the complaint (please attach)*

Click or tap here to enter text.Click or tap here to enter text.

**Name and Title Date**

**DWIHN STAFF ONLY**

This report has been reviewed by*:*

Click or tap here to enter text. Click or tap here to enter text.

**Name and Title Date**

\* Does this report have all requested attachments? Yes  No  NA

\* Are fee schedules in MHWIN correct Yes  No

\* Is there a current copy of General Liability on file and uploaded in MHWIN for the provider? Yes  No

\* Is this report saved in MCO Drive under “*Provider Quarterly Report Folder”?*  Yes  No

Next Review Meeting Date: Click or tap here to enter text.

Comments: Click or tap here to enter text.