Quality Operations Technical Assistance Workgroup Meeting Agenda

Wednesday, September 29, 2021

Via Zoom Platform

9:30 a.m. – 11:00 a.m.

I.	Announcements	April Siebert/Tania Greason
II.	SUD Updates	Judy Davis
III.	Crisis Service Update PI #1	Jacqueline Davis
IV.	DWIHN Clinical Practice Guidelines: • Diabetic Guidelines • Multi Medication Guidelines	Dr. S. Faheem
V.	Over and Under Utilization Reports	Rhianna Pitts
VI.	DWIHN Policies/Procedures • Wraparound • Use of Behavior Treatment in CHM Setting	 Monica Hampton Fareeha Nadeem
VII.	Documentation of Clinical Service	Dana Stevens
VIII.	HSAG (PMV) Preliminary Report	Tania Greason
IX.	Mission Based Performance Indicator DWIHN • Quarter 3 (Due to MDHHS 9/30/2021)	Justin Zeller/Tania Greaon
X.	Critical Events/Sentinels Events Processing	Carla Spight-Mackey
XI.	Provider Feedback	Group
XII.	Adjournment	

Quality Operations Technical Assistance Workgroup Meeting

Wednesday, September 29, 2021

Via Zoom Platform

9:30 a.m. – 11:00 a.m.

Note Taker: Aline Hedwood

1) Item: Announcements – April Siebert & Tania Greason

Goal:

Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems ☐ Quality ☐ Workforce

NCQA Standard(s)/Element #: ☐ QI #___ ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

<Notes on discussion>

Discussion/Decisions Made		
The Support Coordinator & Case Management initial meeting will be held on September 30, 2021 from 10am – 12 pm via zoom link. Tania asked providers to register and inform their SC & CM of the scheduled meeting. The meetings are intended for SC and CM to review their everyday activities and MDHHS/DWIHN's requirements.		
Action Items	**Assigned To**	**Deadline**
Providers will inform their SC and CM staff of the meeting for registration.	Provider	September 30, 2021

2) Item: SUD Updates – Judy Davis
Goal:
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems ☐ Quality ☐ Workforce
NCQA Standard(s)/Element #: ☐ QI #___ ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___
<Notes on discussion>

Discussion/Decisions Made		
Judy Davis informed the workgroup that on 10/1/202, DWIHN will continue the SUD assessment process for adults only. All SUD staff members must be trained. Staff that are not trained, will not be able to complete an assessment or billing through MH-WIN. Providers are required to use the assessment tool when providing services for children. Please reach out to Judy Davis if you have not received communication from SUD or if you have additional questions. • All SUD modifiers have changed; SUD has scheduled a meeting/training for September 30, 2021 at 1pm. The modifier will indicate the level of education an individual has when providing services. • DWIHN Opiate Health Home services will continue and SUD has hired a new administrator Stacy Sharp to oversee the Opiate Health Home project. A meeting is scheduled for September 30, 2021 with SUD providers. These services are paid through Medicaid grants. • SUD is finalizing and uploading all the SUD contracts into Cobblestone, if you need your information regarding funding and allocation reach out to your contract manager. • The next SUD providers meeting will be held on October 20, 2021.		
Action Items	**Assigned To**	**Deadline**
None Required.		

3) Item: Crisis Services Update (MMBPI) PI #1 – Jaqueline Davis
Goal: Review of MMPI # 1 Crisis Service ACT Memo
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems **X Quality** ☐ Workforce
NCQA Standard(s)/Element #: X QI #4 ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___
<Notes on discussion>

Discussion/Decisions Made		
Jacqueline Davis shared with the committee that on September 14th, 2021, the Clinical Practice Improvement (CPI) team at DWIHN reminded the provider network of the requirements for Preadmission Screenings(PAR) as it relates to the MMBPI PI# 1 requirement. Currently, DWIHN is requiring that the disposition for admission be made within a two hour period. If there are instances in which cases exceed the 2-hour requirement, the reason will need to be clearly documented in the PAR located in MH-WIN. DWIHN has worked with PCE to revise the PAR, enabling staff to document the reason for exceeding the 2-hours prior to signing the PAR. Beginning with August data, providers must submit monthly reports for those cases exceeding 2 hours (including the reason). This will enable providers to ensure monitoring of the time requirement, along with correcting any errors prior to data being submitted to the Michigan Department of Health and Human Services (MDHHS). DWIHN continues to monitor the data to ensure the screening is completed timely. DWIHN will offer training to address completing PARS within the 2-hour time frame with the appropriate documentation. If providers have questions, please reach out to Sherry Scott, sscott@dwihn.org.		
Action Items	**Assigned To**	**Deadline**
ACT and Crisis providers to submit cases to DWIHN's CPI unit that exceed the two hour required period.	ACT and Crisis Providers	Ongoing

4a) Item: Clinical Practice Guideline: Diabetic Guidelines – Dr. Shama Faheem
Goal: Review of Diabetic Clinical Practice Guidelines
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems **X Quality** ☐ Workforce
NCQA Standard(s)/Element #: X QI #9 ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___
<Notes on discussion>

Discussion/Decisions Made		
Dr. Faheem provided an overview of the use of diabetic and multiple antipsychotics guidelines and discussed the following highlighted areas below: • Educate members and support staff on treatment options. • Treatment must be person-centered planning and individualized. • For atypical antipsychotic medications within fourteen (14) days of labs being ordered a follow up should be completed. • HEDIS measure diabetes screening for people with schizophrenia or bipolar disorder who are using multiple antipsychotic medications. • Please document changes to target symptoms. Clinical guidelines based on the following articles: 1. American Heart Association article, "Symptoms and Diagnosis of Metabolic Syndrome," September 15, 2016. 2. American Diabetes Association article, "Metabolic Screening after the American Diabetes Association's Consensus Statement on Antipsychotic Drugs and Diabetes," June 2009. 3. International Journal of Endocrinology article, "An Overview of Diabetes Management in Schizophrenia Patients: Office Based Strategies for Primary Care Practitioners and Endocrinologists," For additional information please review handout **"Screening members with schizophrenia and bipolar disorder on atypical antipsychotic medications for diabetes"** for the following highlighted areas: • Screening for diabetes • Treatment and Follow-up • Monitoring		
Action Items	**Assigned To**	**Deadline**
None Required		

4b) Item: Clinical Practice Guidelines: Multi Medication Guidelines – Dr. Shama Faheem
Goal: Review of Multi Medication Clinical Practice Guidelines
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems ☐ Quality ☐ Workforce
NCQA Standard(s)/Element #: X QI #9 ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___
<Notes on discussion>

Discussion/Decisions Made		
Dr. Faheem provided an overview of DWIHN's clinical practice guidelines for use of multi antipsychotic with the group. Detroit Wayne Integrated Health Network (DWIHN) has focused on decreasing the use of multiple antipsychotics. This measure has the potential to improve the health of members with mental illness by reducing side effects associated with antipsychotic medication and possibly increasing medication adherence. According to the American Psychiatric Association, second generation antipsychotics are preferred due to fewer extrapyramidal symptoms. Second generation antipsychotic medications, though, as a class, are more likely to cause metabolic abnormalities than first generation agents, and cause other side effects as well. These include obesity, hypertension, hyperlipidemia, and diabetes mellitus – which increase the risk for cardiovascular disease Please review Memo sent out to providers from Dr. Shama Faheem, DWIHN Chief Medical Officer dated September 17, 2021 for additional information on the following: • APA's Choosing Wisely Program recommendations on inappropriate use of antipsychotics • Common side effects		
Action Items	**Assigned To**	**Deadline**
None Required		

5) Item: Over and Under Utilization Report - Rhianna. Pitts
Goal: Review of Over and Under Utilization Reports
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems ☐ Quality ☐ Workforce
NCQA Standard(s)/Element #: ☐ QI #___ ☐ CC# ___ **x UM #5** ☐CR # ___ ☐ RR # ___
<Notes on discussion>

Discussion/Decisions Made		
Rhianna Pitts provided an overview of the UM Over and Under Utilization Report for Quarters 1-3 FY2021. The summary for HOO39 and T107 include the following: • SUG for code H0039 is 40 units per month/120 units per quarter/480 units per year. Across the network for FY21, H0039 is utilized above the SUG approximately 14%. The average amount utilized above the SUG is 54 units per month; 14 units above the monthly SUG. Conversely, H0039 is utilized below the SUG approximately 84% across the network for FY21. The average amount utilized/received per ACT member is 10 units per month; which is 30 units below the monthly allotted SUG. There are five (5) providers consistently underutilizing H0039 for FY21, Quarters 1-3. • SUG for code T1017 is 8 units per month/24 units per quarter/96 units per year. Across the network for FY21, T1017 is utilized above the SUG approximately 24%. The average amount utilized above the SUG is 13 units per month; 5 units above the monthly SUG. Conversely, T1017 is utilized below the SUG approximately 71% across the network for FY21. The average amount received/utilized is 2 units per month per member, which is 6 units below the allotted monthly SUG. Across the Network, T1017 is utilized 1% of the time within the allotted SUG; 8 units per month/24 units per quarter/96 units per year. There are four (4) providers consistently underutilizing T1017 for FY21, Quarters 1-3 • CPT Code 80039 ACT services for FY 2020-21 Quarter1-3 the total numbers of the units above the SUG for quarter 1-3. The allotted units for 80039 is 40 units per month, 120 units per quarter and 480 units per year. This code is utilized above SUG 14% of the time the average amount utilized above the SUG is 54 units per month, 14 units above the monthly SUG. There Five(5) providers that are underutilizing 80039 for FY 2021 quarters 1-3.		

Action Items	Assigned To	Deadline
• DWIHN will review the fidelity standards from the state of Michigan specific individual members. • DWIHN's UM unit will continue to review Over and Under Reporting with the workgroup and discuss outcomes with individual providers.	DWIHN UM Unit Providers	Ongoing

6a) Item: DWIHN Policies/Procedures: Wraparounds – Monica Hampton
Goal: Review of Wraparound Policy and Procedure
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems ☐ Quality ☐ Workforce
NCQA Standard(s)/Element #: ☐ QI #___ ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___
<Notes on discussion>

Discussion/Decisions Made		
Monica Hampton provided overview of the wraparound policy and procedure. It is the policy of the DWIHN to provide Wraparound services that promote and support youth, under the age of 21 to live in the community with their families and achieve improved functioning in their homes, schools and communities, using a strength-based model. The purpose of the Wraparound policy is to ensure that DWIHN's contractors and subcontractors provide promising practices within the continuum of services in order to promote the best interest of the youth receiving services. For additional updates and revisions in please review DWIN Wraparounds Policy on the following highlighted areas: • Keywords • Standards 1. Responsibility of DWIHN 2. Responsibility of the Service Provider 3. Responsibility of the Community Team 4. Qualified Staff 5. Provisional Status Wraparound Approval 6. Wraparound Facilitators must 7. The Wraparound Supervisor must 8. Services Delivery Procedure 9. Scope of Services and Treatment Modalities If providers have additional questions, please contact Monica Hampton via email at mhampton@dwihn.org.		
Action Items	**Assigned To**	**Deadline**
None Required		

6b) Item: DWIHN Policies/Procedures: Use of Behavior Treatment in CMH Settings – Fareeha Nadeem
Goal: Review of Use of Behavior Treatment in CMH Settings Policy and Procedure
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems X Quality ☐ Workforce
NCQA Standard(s)/Element #: X QI #1 ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___
<Notes on discussion>

Discussion/Decisions Made		
Fareeha Nadeem provided an overview of DWIHN the use of behavior treatment (BT) in community mental health setting policy. It is the policy of DWIHN that the use of Behavior Treatment Interventions complies with State and Federal requirements. The purpose of this policy is to give direction to the contracted BTPRC to oversee, access and implement BTP procedures and to ensure that standards and procedures are established and applied as required by MDHHS. For information please review this policy on the following areas below: • Composition of BTPRC of DWIHN service providers • Purpose • Keyword • Standards If provider have additional questions please contact Fareeha Nadeem via email at fnadeem@dwihn.org		
Action Item	**Assigned To**	**Deadline**
None Required		

7) Item: Documentation of Clinical Services – Dayna Stevens
Goal: Review of required documentation of Clinical Services
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems **X Quality** ☐ Workforce

NCQA Standard(s)/Element #: X QI #1 ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___
<Notes on discussion>

Discussion/Decisions Made		
Dayna Stevens shared with the workgroup the importance of complete documentation. The QI team has noticed a trend of lack for supporting documentation. The information is being shared with this workgroup in order to workgroup members (providers) to share information with their teams. Medicaid requires that CLS providers keep records to document services. Progress notes are evidence that the service was provided. They are important for payment of service claims. For additional information please review PowerPoint "DWIHN Documentation of Clinical Services" on the following areas below: • Why are CLS progress notes important: a) Billing b) Legal records c) Monitoring d) It tells the individual story • Key words to include in your documentation • Progress Notes • Example of progress notes		
Action Items	**Assigned To**	**Deadline**
QI will ensure the QOTAW members receive a copy of this presentation to share with their team members.	QI	October 1, 2021

8) Item: HSAG (PMV) Preliminary Report – Tania Greason
Goal: Review of the HSAG PMV Preliminary Results
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems **X Quality** ☐ Workforce
NCQA Standard(s)/Element #: X QI #4 ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___
<Notes on discussion>

Discussion/Decisions Made		
Tania Greason informed the workgroup that DWIHN has received the preliminary findings from the Performance Measurement Validation (PMV) review from MDHHS. MDHHS contracts with HSAG to review three areas for EQR requirements which include Compliance, Performance Improvement Project (PIP), and Performance Measurement Validations. The PMV review is a review of DWIHN's MMBPI, BH-Teds and Claims submission to MDHHS. The preliminary report demonstrates that DWIHN is following the guidelines and accurately reporting data. A POC is not required with a preliminary compliance score of 100%. Results from the final report will be shared with the QOTAW once received from HSAG.		
Action Item	**Assigned To**	**Deadline**
Final HSAG Compliance report/results will be shared with the QOTAW once received.	QI	October 30, 2021

9) Item: Mission Based Performance Indicator Quarter 3 (due to MDHHS 9/30/2021) – Justin Zeller
Goal: Review of MMBPI data due to MDHHS
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems **X Quality** ☐ Workforce
NCQA Standard(s)/Element #: X QI #4 ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___
<Notes on discussion>

Discussion/Decisions Made		
Justin Zeller provided an overview to the workgroup regarding the MMBPI data (Q3) that is due to MDHHS on 9.30.2021. • DWIHN continues to review PI 2a for barriers/improvements. DWIHN's QI, MCO and Access Units continue to meeting with each assigned CRSP on a monthly basis • PI #4a, DWIHN's QI unit has reached out to all the providers in August 2021 for required documentation of exceptions (Member no show, Member cancelled). Providers are required to make exceptions prior to the submission of the data to MDHHS. • PI #1, DWIHN's QI unit met with COPE to discuss identified barriers and interventions. The PI# 1 numbers are improving for 4th quarter. • PI #3 continues to remain at over 80% compliance. DWIHN's compliance scores for PI# 3 are amongst the highest in the State. MDHHS has not yet set a benchmark. • PI #10 (Adults) continues to trend in the right direction. The current standard is below 15% currently compliance scores are at 15.01% (Adults).		
Action Items	**Assigned To**	**Deadline**
CRSP's are required to make exceptions to PI# 4a prior to submission to MDHHS. Providers have the capability to make exceptions ongoing through the MMPI "View Only" module.	Clinically Responsible Providers	Ongoing

10) Item: PI #2a Review/Requirement – Tania Greason
Goal: Review of PI# 2a Requirements and Barriers
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems X Quality ☐ Workforce
NCQA Standard(s)/Element #: X QI #4 ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___
<Notes on discussion>

Discussion/Decisions Made		
Tania Greason discussed with the workgroup the importance of PI #2a. PI# 2a *The percentage of new persons during the Period receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service* demonstrates the ability for new members to access services once they contact DWIHN's access center to the time of the assigned provider completing their biopsychosocial screening. The standard for PI# 2a is for the completion of the IBPS to occur within 14 days of the initial request. As a system, our compliance score is currently at 47.42% for this indicator, however the overall average for PHIP's in Michigan is 68%. DWIHN has had several meetings internally and externally on how to increase the scores ensuring that members are accessing and receiving services timely within the 14 day requirement. DWIHN is aware of the providers staffing issues and are working with providers to discuss resolutions, however providers must continue to make certain to complete the IBPS within 14 days of the new member referral. There are no excluded exceptions or set benchmarks for PI 2a. All CRSP's should have access the MMBPI View Only module where you all can review your data for internal discussions and ongoing monitoring.		
Action Items	**Assigned To**	**Deadline**
Clinically Responsible Providers to review PI# 2a data for compliance and ongoing monitoring. DWIHN's QI, MCO and Access Units will continue to meet with providers each month to review open calendar appointment slots and discuss identified barriers/interventions.	CRSP's and DWIHN's QI, MCO and Access Units	Ongoing

11) Item: Critical Event and Sentinel Event – Carla Spight-Mackey
Goal: Review of CE/SE Processing
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems X Quality ☐ Workforce
NCQA Standard(s)/Element #: X QI #1 ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___
<Notes on discussion>

Discussion/Decisions Made		
Carla Spight-Mackey provided an overview of the requirements for CE/SE processing. DWIHN's QI unit is preparing for the CE/SE year end data collection and report analysis. During last FY, QI received and processed a total of 3,183 events, not receiving documentation for 118 events, 95% of those critical events have been closed. During FY2021, DWIHN received a total of 681 events that were not required to be reported (did not meet the reporting requirement). If a member has tested positive for Covid-19 documentation must be noted in the member chart under the health and safety warning, there is no need to enter a critical event unless the member dies from Covid-19. QI will be generating data reports for FY 2020-21 on October15, please ensure your events for this FY is entered in the MH-WIN into critical event module prior to October 15, 2021. Also, for members that are on a BTP, there are four categories under the critical & sentential events module that are required to be reported for serious challenges and behavior. Please make certain that staff are documenting correctly within the CE/SE reporting module If you have additional questions, please reach out to Fareeha Nadeem at fnadeem@dwihn.org.		
Action Items	**Assigned To**	**Deadline**
CRSP's to upload and complete CE/SE processing for FY2021 before October 15th, 2021 to include submitting requested documentation. Providers are also required to report for members that are on a BTP.	Clinically Responsible Providers (CRSP)	October 15, 2021

12) Item: Providers Feedback
Goal:
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems ☐ Quality ☐ Workforce
NCQA Standard(s)/Element #: ☐ QI #___ ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___
<Notes on discussion>

Discussion/Decisions Made		
None		
Action Items	**Assigned To**	**Deadline**

NEXT MEETING: Wednesday, October 27, 2021 @ 9:30 a.m. – 11:00 a.m. via Zoom Link Platform

ADJOURMENT: 11:30 a.m.

ah_10.14.2021

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Date: September 14, 2021
To: ACT Providers
From: Sherry Scott, Clinical Practice Improvement Manager
CC: Ebony Reynolds, Melissa Moody, Dr. Shama Faheem, Jacquelyn Davis, April Siebert, Tania Greason
Re: Pre-Admission Review Screening (PARS)

This memo is to inform ACT Providers of Detroit Wayne Integrated Health Network's (DWIHN) effort to provide clarification of conducting the Pre-Admission Review Screening (PARS) telephonically or face to face.

The PARS may be conducted telephonically or face- to- face in the emergency department. The Clinically Responsible Service Provider (CRSP) will determine how the PARS will be performed based on each individual member clinical presentation. When PARS are conducted, a place of service code will need to be added when billing telephonically or face-to-face. Once the member has been medically cleared, the medical health professional must contact the appropriate agency prior to any further mental health services. With conducting telephonic PARS, it is still a continued responsibility to conduct the PARS within the 2-hour time frame.

We understand that there may be instances where cases exceed the 2-hour requirement. In these cases, the reason will need to be documented in the PAR located in MH-WIN. DWIHN has worked with PCE to revise the PAR, enabling staff to document the reason for exceeding the 2-hours prior to signing the PAR. Beginning with August data, providers must submit monthly reports for those cases exceeding 2 hours (including the reason). This will enable providers to ensure monitoring of the time requirement, along with correcting any errors prior to data being submitted to the Michigan Department of Health and Human Services (MDHHS). This also enables DWIHN to work with providers to identify and address any barriers.

DWIHN will offer training to address completing PARS within the 2-hour time frame with the appropriate documentation.

If you have questions, please reach out to Sherry Scott, sscott@dwihn.org.

Thank you for the work that you do and your commitment to the members we serve.

SCREENING MEMBERS WITH SCHIZOPHRENIA AND BIPOLAR DISORDER ON ATYPICAL ANTIPSYCHOTIC MEDICATIONS FOR DIABETES

1. Screening for diabetes:
    a. HbA1c or fasting blood sugar(FBS) should be ordered or performed prior to the first prescription of atypical antipsychotic medication(s) for new patients not currently on atypical antipsychotic medication(s);
    b. For enrollee/members currently on atypical antipsychotic medications who have never been screened, HbA1c or FBS will be ordered or drawn at next medication review appointment.
2. Treatment and Follow-up:
    a. Educate the enrollee/member and supports about treatment options, self-management and supports, lifestyle changes including nutrition and exercise, coping skills and spiritual support;
    b. Treatment planning must be individualized and person-centered;
    c. Follow up will be done with enrollee/member within fourteen (14) days of labs being ordered to ensure enrollee/member has had it drawn. If no, discuss importance and address any barriers.
    d. If initiating atypical antipsychotic medications, ensure that informed consent has been documented.
        i. Make efforts to draw baseline laboratory studies and follow-up as clinically appropriate.
        ii. Educate enrollee/members about side effects, including those following abrupt discontinuation.
        iii. Address any side effects at each appointment and adjust or change medications as needed to ensure compliance.
    e. Ensure the appropriate frequency of follow-up contacts, which should be more frequent during the initiation of treatment, or following increases or tapering of medications.
    f. Enrollee/members on atypical antipsychotics will be weighed prior to starting atypical antipsychotics and at all subsequent medication review appointments.
    g. For enrollee/members with HbA1c greater than 5.7% provide referral to a primary care provider if enrollee/member does not have one and assist in obtaining an appointment with primary care provider for follow up and sharing of lab results;
    h. For enrollee/member with fasting blood sugar (FBS) greater than or equal to 100 mg/DL provide referral to a primary care provider if enrollee/member does not have one and assist in obtaining an appointment with primary care provider for follow up and sharing of lab results;
    i. For enrollee/member who gains 5% or more of their initial weight at any time during therapy, consider switching to a different antipsychotic medication;
    j. Ensure enrollee member has an assigned primary care provider and is obtaining regular medical care;
    k. Follow up with enrollee/member to ensure that they kept appointment with primary care provider. If no, educate on importance and address any barriers;

    l. For enrollee/members with normal baseline tests, it is recommended that HbA1c or FBS are repeated at 12 weeks after initiation of treatment; and annually thereafter.
3. Monitoring
    a. HEDIS measure diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications to monitor compliance with lab draws will be run at least annually.
    b. Clinicians should Document changes to target symptoms
    c. Lack of significant response to treatment should result in an adjustment to treatment.

Clinical guidelines based on the following articles:

1. American Heart Association article, “Symptoms and Diagnosis of Metabolic Syndrome,” September 15, 2016.
2. American Diabetes Association article, “Metabolic Screening after the American Diabetes Association’s Consensus Statement on Antipsychotic Drugs and Diabetes,” June 2009.
3. International Journal of Endocrinology article, “An Overview of Diabetes Management in Schizophrenia Patients: Office Based Strategies for Primary Care Practitioners and Endocrinologists,”

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Memorandum

Date: September 17, 2021

To: Chief Medical Officer/CEO

From: Dr. Shama Faheem (Chief Medical Officer), Detroit Wayne Integrated Health

RE: Use of multiple antipsychotics

Detroit Wayne Integrated Health Network (DWIHN) has focused on decreasing the use of multiple antipsychotics. This measure has the potential to improve the health of members with mental illness by reducing side effects associated with antipsychotic medication and possibly increasing medication adherence.

According to the American Psychiatric Association, second generation antipsychotics are preferred due to fewer extrapyramidal symptoms. Second generation antipsychotic medications, though, as a class, are more likely to cause metabolic abnormalities than first generation agents, and cause other side effects as well. These include obesity, hypertension, hyperlipidemia, and diabetes mellitus – which increase the risk for cardiovascular disease.

There is general consensus regarding monotherapy in the first several treatment tiers for the treatment of schizophrenia across well-known algorithms: the Texas Medication Algorithm Project (TMAP), the International Psychopharmacology Algorithm Project (IPAP), and the Psychopharmacology Algorithm Project at the Harvard Medical School. The treatment algorithms for Bipolar Disorder, while arriving at polypharmacy more rapidly than for schizophrenia, do not include antipsychotic polypharmacy.

Despite recommendations against it, there continue to be many individuals being prescribed more than one antipsychotic, of both the traditional and atypical variety. Research shows that use of two or more antipsychotic medications occurs in 4% to 35% of outpatients and 30% to 50% of inpatients. However, evidence for the efficacy and safety of using multiple antipsychotic medications is limited, and risk for drug interactions, noncompliance, and medication errors is increased. Generally, the use of two or more antipsychotic medications concurrently should be avoided except in cases of three failed trials of monotherapy, which included one failed trial of clozapine where possible, or where a second antipsychotic medication is added with a plan to cross-taper to monotherapy.

APA's ***Choosing Wisely*** Program has following recommendations regarding possible inappropriate use of antipsychotics:

1. Don't prescribe antipsychotic medications to patients for any indication without appropriate initial evaluation and appropriate ongoing monitoring.
2. Don't routinely prescribe two or more antipsychotic medications concurrently.
3. Don't routinely use antipsychotics as first choice to treat behavioral and psychological symptoms of dementia.
4. Don't routinely prescribe antipsychotic medications as a first-line intervention for insomnia in adults.
5. Don't routinely prescribe antipsychotic medications as a first-line intervention for children and adolescents for any diagnosis other than psychotic disorders.

While sometimes appropriate, individuals prescribed 2 or more antipsychotics concurrently are at higher risk for complications and side effects.

Common side effects include:

- Sedation
- Weight gain
- Increased risk for diabetes mellitus
- Increase risk of hyperlipidemia
- Prolongation of QTc interval
- Increased risk of Myocarditis
- Sexual side effects
- Increased risk for cataracts
- Extrapyramidal side effects

It should also be noted that a complicated medication regimen increases the likelihood of nonadherence to treatment and medications as well.

The Detroit Wayne Integrated Health Network (DWIHN) will use population health metrics to identify individuals currently on 2 or more antipsychotics for longer than 60 days. Particular focus will be on individuals prescribed 3 or more antipsychotics. The overall goal of this project is to reduce the use of polypharmacy throughout the network.

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https://psychiatryonline.org/doi/pdf/10.1176/appi.books.9780890424841
https://www.psychiatry.org/psychiatrists/practice/quality-improvement/choosing-wisely
https://jpshealthnet.org/sites/default/files/inline-files/tmapalgorithmforschizophrenia.pdf
https://manual.jointcommission.org/releases/TJC2018A/DataElem0137.html

DETROIT WAYNE INTEGRATED HEALTH NETWORK

Service Documentation

With a Focus on the Documentation of Community Living Supports

September 29, 2021

Virtual Presentation

Why are CLS progress notes important?

Billing:
Medicaid requires that CLS providers keep records to document services. Progress notes are evidence that the service was provided. They are important for payment of service claims.

Why are CLS progress notes important?

Legal Record:
Progress notes become part of the persons permanent legal record. They may be used in legal proceedings, audits, or investigations. They can also provide a paper trail in case of conflict or difficult situations.

Why are CLS progress notes important?

Monitoring:
Case Managers review progress notes to see how supports and services are working. They document progress towards an individual's progress toward IPOS goals and desired outcomes. They are a valuable source of information

Why are CLS progress notes important?

A person's story:

Progress notes help map out a person's progress. Notes are a part of that story.

Key words to be included

Achieved Assisted Explained Guided

Helped Participated Prompted Reminded Socialized

Supported Trained

Progress Notes

Should include:

- Actions staff took and specific **support** provided.

Progress Notes

Should include:

What staff did to help meet the individual's **health and safety needs.**

Progress Notes

Should include:

What staff did to help meet the individual's other **support needs**.

Progress Notes

Should include:

Any progress towards the person's **goals**.

Example of Progress notes:

Good:
Assisted Frank with shopping.

Example of Progress notes:

Better:
Assisted Frank with grocery shopping, budgeting, making change, talking with people and transportation

Example of Progress notes:

Best:
Assisted Frank at the grocery store with selecting needed items, staying within budgeted amount, counting correct change, and communicating with the cashier. Provided transportation to and from the grocery store.

Example of Progress notes:

Good:

Supported Sally at the bowling alley.

Example of Progress notes:

Better:

Provided social and communication support to Sally while at the bowling alley

Example of Progress notes:

Best:
Provided social and communication support to Sally while at the bowling alley:

- Prepped for conversation with cashier before going in
- Reminded of social rules at the bowling alley
- Reminded of safety rules when talking with people she met at the bowling alley

Last minute thoughts thoughts

- Use details.
- Be specific.
- Avoid personal opinions.
- Use respectful language.
- Avoid slang or abbreviations.
- Avoid copied or “cookie cutter” notes
    - Even if two people have similar needs, their notes should be personalized.

THANK YOU!