Quality Operations Technical Assistance Workgroup Meeting Agenda
Wednesday, February 22, 2023
Via Zoom Link Platform
9:30 a.m. – 11:30 a.m.

I.	Announcements	A. Siebert
II.	Substance Use Disorder (SUD)	J. Davis/G. Lindsey
III.	Recipient Rights	C. Witcher
IV.	QAPIP Effectiveness	
	a. HCBS Transition	W. Sabado
	b. CE/SE Reporting	
	○ CRM (MDHHS) Reporting System	C. Mackey/S. Applewhite
	○ RCA (Electronic MH-WIN)	M. Lindsey
	c. Annual QAPIP 2022 Evaluation	A. Siebert/T. Greason
	d. Annual QAPIP 2023 Work Plan	A.Siebert/T. Greason
	e. BTAC Annual 2022 Analysis	F. Nadeem
	f. CE/SE BTP Under Reporting	F. Nadeem
	g. Over and Under Utilization Reporting	L. Wayna
V.	Adjournment	

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Wednesday, February 22, 2023
Via Zoom Link Platform
9:30 a.m. – 11:30 a.m.
Note Taker: DeJa Jackson

1) Item: Announcements:

- April Siebert shared with the group that DWIHN has hired new staff. The new Director of Contract Management is Brandon Taylor, who has replaced June White in the position. The group as also reminded to utilize the new DWIHN mobile App that's now available on our Website.

2) Item: Substance Use Disorder (SUD) – Gregory Lindsey
Goal: Updates from SUD

Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems ☐ Quality ☐ Workforce
NCQA Standard(s)/Element #: QI ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Discussion		
Gregory Lindsey provided the workgroup with the following SUD updates: • MDHHS has set a mandate starting January 1, 2023 for continuing education and recertification requirements for all Certified Peer Support Specialists and Certified Peer Recovery Coaches. They must complete a minimum of 32 CEU's of approved training, which can include workshops or conferences, during a two year period in order to renew their certification. CEU's taken before January 1, 2023 will not be included. • DWIHN will be initiating a Naloxone Emergency Plan. It's for all provider sites, just like one would have an emergency box for a fire alarm, we're going to have emergency Naloxone kits put at every provider site so they will be on hand in case of an overdose. They'll be prepared to address any overdoses. • New staff person Davion Jones, who is our complex case manager for the MDOC population, but he is also in charge of our Naloxone trainings so any provider or community group that would like to be scheduled for that training may get in contact with him.		

Provider Feedback	Assigned To	Deadline
Providers Questions/ Concerns: 1. Does the ongoing training requirement include Peer Mentors? 2. Is this specific to SUD Peers? Answers: 1. Yes, this applies to all those who have a certification from MDHHS. 2. Yes, this is specific to SUD Peers.		
Action Items	**Assigned To**	**Deadline**
None Required.		

3) Item: Recipient Rights – Chad Witcher
Goal: Updates from Office of Recipient Rights (ORR)

Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems ☐ Quality ☐ Workforce
NCQA Standard(s)/Element #: QI ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Discussion		
Chad Witcher provided the workgroup with the following ORR updates: • Chapter 7 of the Mental Health Code and the HIPAA law states that we are not allowed to use confidentiality as an excuse to not share health care information when it's necessary to coordinate care or provide treatment or services to the individual. Consent is not required in those circumstances. • Recipient Rights new hire training has been updated to implement the latest HIPAA provisions as and other required trainings.		
Provider Feedback	**Assigned To**	**Deadline**
Providers Questions/ Concerns: 1. In reporting the death process, we're still sometimes being asked for more information than we would normally be required to report, could you, with your team cover that again? ORR's Reply/Answers: 1. Please contact Chad Witcher at cwitcher@dwihn.org for more information regarding the death reporting process		
Action Items	**Assigned To**	**Deadline**
None Required.		

4) Item: **HCBS Transition**

Goal: Updates on HCBS Transition

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

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

Discussion		
William Sabado shared with the group the following updates for the Home and Community Base Services (HCBS): • There are currently fifty six (56) members identified on the nonresponders list, which was published back in September 2022. DWIHN's Quality team has been working in collaboration with the identified CRSP's as well as the affected 27 providers and 38 sites regarding the identified members. Our efforts include utilizing the person centered planning process to assure that members are able to exercise their choice to continue their Home Community Based Services. For members that choose to stay at their current residence, DWIHN is working with the CRSP's to develop strategies and planning to supplement and address the loss their Home Community Based Services after March 17th. DWIHN will be sending out letters to each of the identified CRSP leadership teams. We are working collaborate with this project, which includes the importance of getting the documentation, such as attestations, risk assessments, updated IPOS's making certain that all documents are in place prior to the March 17th requirement for submission to MDHHS. • DWIHN continues collaborative efforts with leadership executive team as well as the clinical and quality departments to review the "non-responders" homes and assess their current status, in order to review status updates for achieving the HCBS compliance and readiness requirements. • DWIHN's Quality unit will be hosting monthly meetings, the first meeting was held on February 14th. The meetings will be inclusive of our CRSP and Residential provider network for discussions and assistance with resources. • DWIHN is also continue collaborative efforts with MDHHS to address challenges with the surveys and updating the WSA database, opened discussions are occurring on how to improve the process.		

Provider Feedback	Assigned To	Deadline
Provider Questions/ Concerns: 1. Where does someone access the portal where questions regarding the HCBS process can be asked? Answers: 1. For HCBS Questions please E-Mail to Quality@dwihn.org and HCBSInforPIHP@dwihn.org.		

Action Items	Assigned To	Deadline
None Required		

5) Item: CE/SE Reporting

Goal: Updates for Critical/Sentinel Events processing.

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

NCQA Standard(s)/Element #: QI 1 CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Discussion		
Carla Spight-Mackey provided the following updates: • DWIHN's Quality team has developed and completed the first updated training to include the newly developed MDHHS process for reporting. The training went well and we continue to work on the quiz process. There are currently some barriers, as this was the first time that our team collaborated with DWIHN's workforce development. One of the identified barriers was that we had providers forwarding the link to other staff. If the staff were not registered for the training, they were not able to receive the quiz. The quiz was sent to everyone that was verified as taking the training. A link to the quiz will also be forwarded to the staff on the verified list and did not receive the link. • The updated manual will be added to the DWIHN's website under the 2023 Critical Events, Provider section. The manual will contain all of the new training dates for the rest of the fiscal year. The training manual and other information will be added and updated monthly as well as a fact sheet for any questions to be answered. • We have implemented a quality performance improvement steps to resolution. We are required by MDHHS to have documentation to close a critical/ sentinel event which includes root cause analysis, hospital discharge information, information around arrests and convictions. The steps resolution will help us resolve critical and sentinel events in a timelier manner by notifying the leadership teams for requested documents. • As a reminder from the last QOTAW meeting, please, identify two (2) leads for your organization responsible for oversight and communication for Critical/Sentinel Events. • We are also establishing a Train-the-Trainer type model for Critical/Sentinel events. Identify what staff at your organization you would want to be included for the Train-the-Trainer workshop.		

Sinitra Applewhite provided the following updates: • An additional CE/SE training will be held Thursday, February 23, 2023. All trainings will require you to be registered through Detroit Wayne Connect (DWC). No one will be registered via email anymore, everything is done through DWC. • The Guidance Manual along with the quality performance improvement progressive steps will be located on our website. • Please reach out to the QI team if you have additional questions.		
Provider Feedback	**Assigned To**	**Deadline**
None.		
Action Items	**Assigned To**	**Deadline**
None.		

6) Item: Annual QAPIP Evaluation 2022/ Annual QAPIP 2023 Workplan
Goal: Update and information for the QAPIP Evaluation and 2023 Workplan

Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems ☐ Quality ☐ Workforce
NCQA Standard(s)/Element #: QI ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Discussion		
April Siebert provided the following updates to the work group: • The 2022 QAPIP Evaluation and the 2023 QAPIP Workplan has been approved by the Governing Board. • Both the QAPIP 2022 Evaluation and the QAPIP 2023 Workplan can be reviewed in greater detail on DWIHN's Website. • The goals for our 2023 Workplan is to improve our system, to improve outcomes and include goals as established the previous year that were not met. The workplan is designed to improve outcomes and service delivery for the people that we serve.		
Provider Feedback	**Assigned To**	**Deadline**
No provider feedback.		
Action Items	**Assigned To**	**Deadline**
None Required.		

7) Item: BTAC Annual 2022 Analysis/ CE/SE BTP Under Reporting

Goal: Updates

Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems ☐ Quality ☐ Workforce
NCQA Standard(s)/Element #: QI ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Discussion		
Fareeha Nadeem discussed the following: • The Background information for BTAC Analysis. • Some of the major challenges over the past few years. • Some of the major accomplishments. • An overview of FY 2021-2022 as well as data for fiscal year 2022 including: Total Behavior Treatment Plans Reviewed, Reported 911 calls and Critical/Sentinel Events, Reported Number of Medications, and Restrictive and Intrusive Interventions. • The document for CE/SE Reporting Requirements for member behavior treatment plans is available on our DWIHN website.		
Provider Feedback	**Assigned To**	**Deadline**
Providers Questions/ Concerns: 1. Isn't an arrest a critical event, not a 911 call? Answers: 1. This review is inclusive of the BTP analysis. When law enforcement announces a member is under arrest it should be reported as an event.		
Action Items	**Assigned To**	**Deadline**
None Required.		

8) Item: Over and Under Utilization Reporting
Goal: Updates for reporting of Over and Under Utilization

Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems ☐ Quality ☐ Workforce
NCQA Standard(s)/Element #: QI ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Discussion		
Leigh Wayna, Director of UM shared the following: • DWIHN's Utilization Management (UM) team will be tracking the same data that we tracked during last Fiscal Year. Last year we looked at the T. 1017 code and the H. 0039 codes targeted case management. We compared those two codes with the claims and encounters that had been entered vs the SUG data for those two codes. This year we will be doing another drill down of that same information to be able to compare the two different time periods. What we are looking at is authorizations and claims that have fallen within the SUG number, looking at a parameter of anywhere from five units below to five units above whatever that SUG is noted for. We will also look at the bucket of claims and encounters that are below that SUG parameter and then the bucket of claims that are above the SUG parameter allowing for a review of over utilization and underutilization of services to determine if there's a need change/update the SUG criteria.		
Provider Feedback	**Assigned To**	**Deadline**
Providers Questions/Concerns: 1. When will the SUG's be back on the website? Answers: 1. It has been resubmitted to the communications team, so very soon.		
Action Items	**Assigned To**	**Deadline**
Over and Under Utilization reporting will be reported to the workgroup no less than quarterly.	Leigh Wayna	Ongoing (Quarterly)

New Business Next Meeting: 03/29/23
Adjournment: 02/22/2023

CE/SE REPORTING REQUIREMENTS FOR MEMBERS ON BEHAVIOR TREATMENT PLANS

DWIHN Performance Improvement staff has reviewed the four reportable sub- categories for the members on Behavior Treatment Plans(BTP).....(Death, Emergency Hospitalizations – including Emergency Medical Treatment; and Use of Physical Management). We have discovered numerous reporting errors for members on BTP are being reported under "Serious Challenging Behaviors" instead of the required "Behavior Treatment" Category.

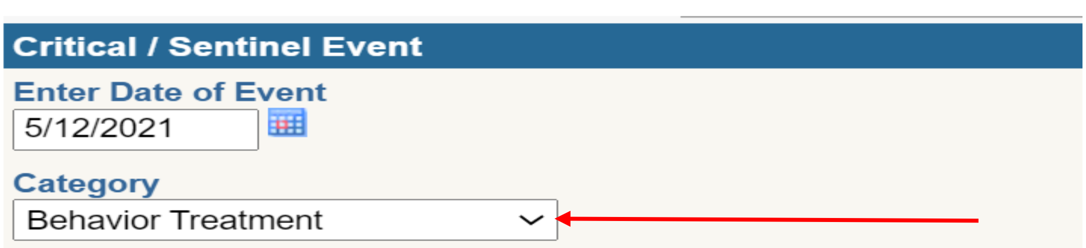
PLEASE ENSURE that you are reporting events in accordance with these training guidelines:

For the **members who have a BTP as indicated on the face of the MH-WIN record**, as stated in the Guidance Manual of Critical and Sentinel Events, **Behavior Treatment areas must be completed in: (1) Intervention Information (This section is for members with Behavior Treatment Plans Only) and (2) The Radio Button after the "Action Taken" section must be changed to indicate "Yes" the member is on a Behavior Treatment Plan.**

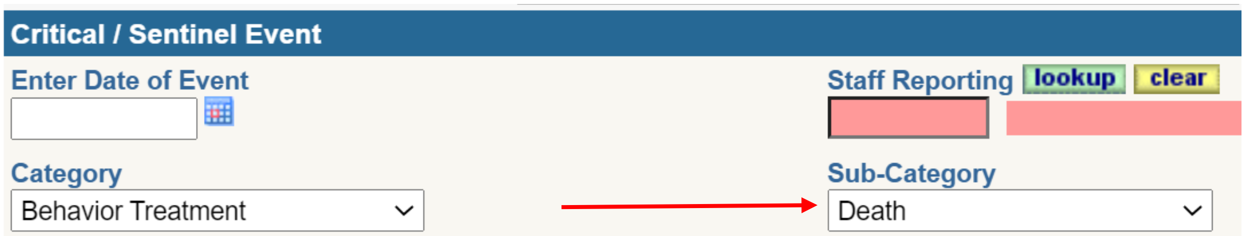
This process is required for every member on a BTP for all categories in the Critical/Sentinel Event module. The data required by MDHHS is queried through the CE/SE Module and used to verify reports submitted by the organization for the members on BTP. **For questions on Behavior Treatment Reporting Requirements, please contact QI staff Fareeha Nadeem at fnadeem@dwihn.org**

BEHAVIOR TREATMENT ONLY Categories and Sub-Categories include:

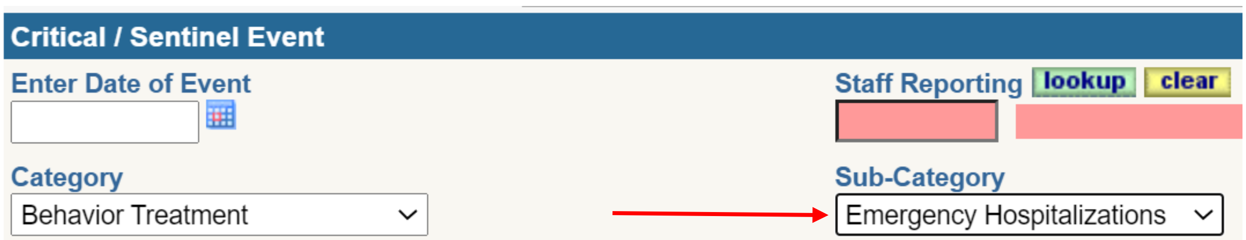
i. **Behavior Treatment * - a** NEW category used to **report four events** that occur with members on an approved Behavior Treatment Plan



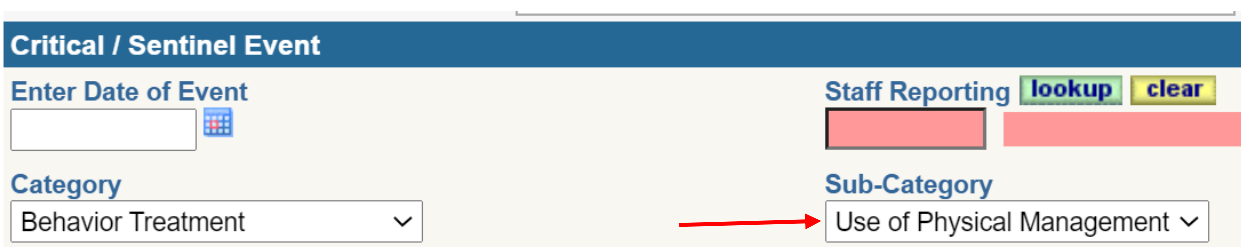
ii. **Death** Suicide – Homicide – Natural Deaths



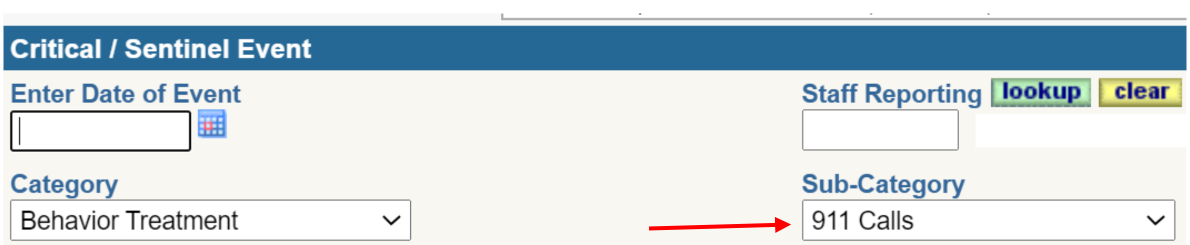
iii. **Emergency Hospitalizations** related to injury, medication error, and **unexpected** physical health (NOT ongoing regular chronic health issues); and **Emergency medical treatment** related to **injury** (as defined by discharge paperwork from a physician), **medication error**, and unexpected physical health (NOT ongoing regular chronic health issues)



iv. **Use of Physical Management –** applies **all staff of Behavioral/Physical Health organizations and their volunteers, interns, and contractors**. This does not apply to reporting for persons living on their own or in their own home and are physical managed in their own environment. If physical management is used by any person employed by Behavior/Physical Health toward/on a member - this is a reportable event.



v. **911 Calls** – all events that require a call to 911 as a result of behaviors are reported in this sub-category



DWIHN
Your Link to Holistic Healthcare
Detroit Wayne Integrated Health Network

QUALITY PERFORMANCE IMPROVEMENT
PROGRESSIVE STEPS TO RESOLUTION

1. Receive and review Critical/Sentinel Events and all pertaining documentation (documentation not later than **7 days**);
2. Upon the review notify CRSP; DWIHN Quality Performance Team; and, Quality Performance System Administrator of missing required documents and due date for missing documentation;
3. Second (2nd) notification sent when first request is not submitted by due date. Notifications sent to CRSP Management; Quality System Administrator, Quality Director;
4. If response is not received in **5 days** after second notification; Notification and request for documents for closure are forwarded to CRSP Executive leadership, Quality Director, Quality Performance Improvement Administrator, Medical Director, and Compliance.
5. If there is no response within **3 days** at this step – request for DWIHN progressive remediation will be forwarded internally.

Quality Performance Improvement Clinical Specialists will track and monitor the reporting of non-compliance to be added to the Trends and Patterns Quarterly Report published to Executive Leadership to highlight systemic weaknesses for focused improvement activities.

UPDATES IN CRITICAL/SENTINEL EVENTS

- Root Cause Analysis – INBEDDED in MH-WIN CE/SE Module
- Quality Performance Improvement Steps to Resolution
- Identifying two (2) leads for your organization responsible for oversight and communication of CE/SE
- CRSP Train-the-Trainer for CE/SE – Identify management staff responsible
- CRM/CIS aka MiCal – MDHHS Reporting System

DETROIT WAYNE INTEGRATED HEALTH NETWORK

QAPIP Annual Evaluation

Fiscal Year 2022

QAPIP Annual Evaluation

- The QAPIP Evaluation is based on six (6) pillars that are identified in DWIHN's Strategic Plan.
  - Customer
  - Access
  - Quality
  - Advocacy
  - Finance
  - Workforce Development
- The QAPIP Annual Evaluation reflects ongoing activities throughout the year and addresses areas of timeliness, accessibility, quality and safety of clinical care, quality of services, performance monitoring, member satisfaction and performance improvement projects.
- The data collected analyzes and evaluates the year to year trends of the overall effectiveness of the QAPIP plan, indicating progress for decision making to improve services and the quality of care for members served.
- Not all goals will be address. The Next Slides Highlight Goal Accomplishments, Goals Partially Met or Not Met, and plans for achieving goals in FY2023.

QAPIP Annual Evaluation

The goal of the **Customer Pillar** is to focus on DWIHN's commitment to providing an Excellent Member Experience and Services to Members. Several departments contribute to the makeup of this Pillar.

- There are six (6) objectives under the Customer Pillar. 3 of the 6 objectives were Met, 2 Not Met and 1 Partially Met (Practitioner Survey)
- ECHO Survey - *Goal not Met*
  - The 2022 (look back) ECHO® survey, is underway, a preliminary report will be available in late April and a final report will be available in June 2023.
- National Core Indicator Survey - *Goal not Met*
  - The 2022 NCI survey is underway with the pre-survey background being completed for selected members, results will not be available until August or September of 2023.

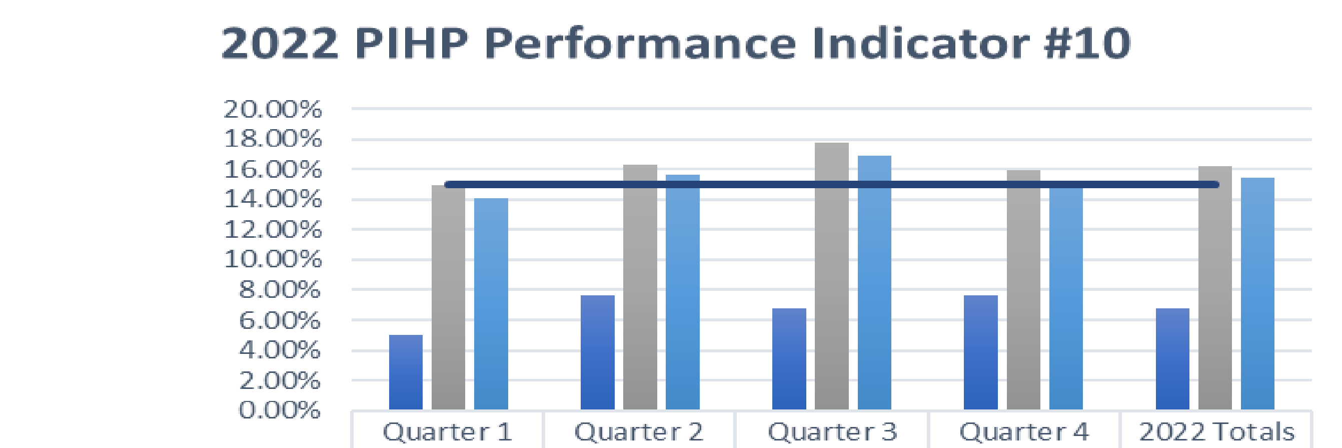
QAPIP Annual Evaluation

The goal of the **<u>Access Pillar</u>** is to monitor access to service using the Michigan Mission Based Performance Indicators (MMBPI) data. There are five (5) indicators that have been established by MDHHS that are the responsibility of the PIHP to collect data and submit on a quarterly basis.

- There are (6) objectives under the Access Pillar. 5 of the 6 objectives were met and 1 not met.
  - PI#10 (Recidivism or Readmission within 30 days) from Q2 (16.31%), Q3 17.79%, Q4 15.89% for Adults, with an total population rate 15.43%. The standard is 15% or less. This remains an opportunity for ongoing improvement. We will continue with the efforts to meet the standard and will continue to evaluate the effectiveness of the interventions

QAPIP Annual Evaluation

The percentage of readmissions of children and adults during FY 2022 to an inpatient psychiatric unit within 30 calendar days of discharge from a psychiatric inpatient unit. **Goal**: The goal is to attain and maintain performance standards as set by the MDHHS contract. Standard 15% or below. **Results:** FY2022 standard met for the children population. Standard not met for the adult population for three out of four quarters Q2 (16.31%), Q3 (17.79%), Q4 (15.89%). Total population rate (15.43%).



	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2022 Totals
Child	5.06%	7.69%	6.76%	7.64%	6.75%
Adult	14.93%	16.31%	17.79%	15.89%	16.23%
All Populations	14.05%	15.63%	16.86%	15.19%	15.43%
Standard	15.00%	15.00%	15.00%	15.00%	15.00%

QAPIP Annual Evaluation

DWIHN met the standards for PI#1 (Children & Adults), PI#4a (Adult), 4b (SUD) and PI#10 (Children) during FY22. DWIHN provided access to treatment/services for 95% or more members receiving a pre-admission screening for psychiatric inpatient care within 3 hours of a request for service. DWIHN demonstrated an 6.75% performance rate for Children who were re-admitted within 30 days of being discharged from a psychiatric hospitalization. This was a significant improvement in performance from the previous reporting period.

Performance Indicators	Population	1st Quarter 21/22	2nd Quarter 21/22	3rd Quarter 21/22	4th Quarter 21/22
Indicator 1: Percentage who Received a Prescreen within 3 Hours of Request (95% Standard)	Children	97.78%	98.14%	98.91%	98.80%
	Adults	97.14%	98.81%	97.83%	97.69%
	Total	97.29%	98.65%	98.06%	97.89%
Indicator 4a & 4b: Percentage who had a Follow-Up within 7 Days of Discharge from a Psychiatric Unit/SUD Detox Unit (95% Standard)	Children	98.15%	93.75%	86.44%	100.00%
	Adults	94.80%	95.94%	96.81%	97.90%
	Total	95.09%	95.71%	95.83%	98.10%
	SUD	100%	99.37%	99.81%	98.97%
Indicator 10: Percentage who had a Re-Admission to Psychiatric Unit within 30 Days (<15% Standard)	Children	5.06%	7.69%	6.76%	6.80%
	Adults	14.93%	16.31%	17.79%	15.85%
	Total	14.05%	15.63%	16.86%	15.15%

QAPIP Annual Evaluation

- The goal of the **Quality Pillar** is to monitor clinical performance of provider services and programs to ensure system wide compliance with State, Federal regulations and the safety and wellness of the people we serve.
- There are (6) objectives under the quality pillar. 6 of the 6 objectives were met.
- Goals were to increase performance monitoring with CRSP, Residential, B3 Service, Autism, Waiver Programs SUD and Inpatient Hospital Settings by 25% or greater during FY2022. (Goal Met)
- Increase CRSP self-monitoring reviews were increased by 10% during FY2022. (Goal Met)
- MDHHS reporting requirements for CE/SE (Goal Met)
- BTAC reporting requirements (Goal Met)

Year End Monitoring Data FY 2022

Provider Monitoring Reviews
Total Number Reviews Conducted = 107
CRSP, SUD, Autism, B3, Waivers and Inpatient Hospital Settings

Staff Record Reviews
Total Number of Staff Records Audited = 114
Overall Score = 96%

Provider Self-Monitoring
22 CRSP
1st Q Case Records
Overall Score = 93%

Provider Self-Monitoring
25 CRSP
2nd Q Case Records
Overall Score
= 92%

Provider Self-Monitoring
24 CRSP
3rd Q Case Records
Overall Score = 90%

Provider Self-Monitoring
14 CRSP
4th Q Case Records
Overall Score = 92%

Staff Qualification Reviews
Total Number of Staff Qualifications Audited = 114
Overall Score = 96%

Provider Network Trainings
Total Number Hosted = 6
Attendees = 800+

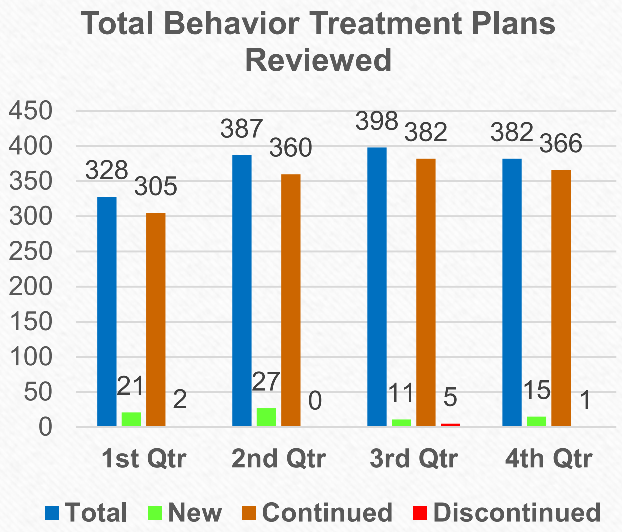
Critical/Sentinel, Unexpected Deaths and Risk Reporting

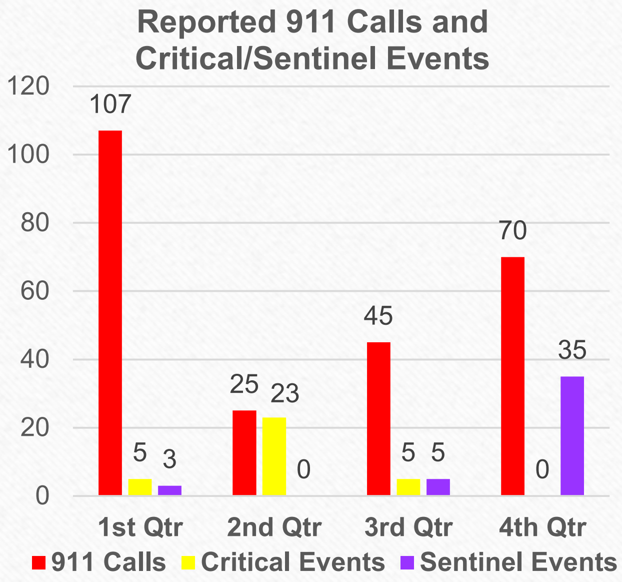
In FY2022, the Quality Performance Improvement Team processed 1,915 Critical/Sentinel Events, which is a decrease of (39.3%) from FY2021. This decrease is attributed ongoing training with the Provider Network on correct and accurate reporting. Of those incidents, the SERC reviewed and analyzed over eight-hundred and thirty (830) critical incidents. Critical Incidents include arrests, deaths, emergency medical treatment due to injuries or medication errors, and hospitalizations due to injuries or medication errors.

CATEGORY	FY 2021/2022	FY 2020/2021	FY 2019/2020	FY 2018/2019	FY 2017/2018
ARREST	64	72	83	161	153
BEHAVIOR TREATMENT (New 2020/2021)	88	61	0	0	0
DEATHS	492	551	731	480	444
ENVIRONMENTAL EMERGENCIES	57	79	38	65	205
Injuries Requiring ER	177	227	259	498	673
Injuries Requiring Hospitalization	35	47	203	88	83
Medication Errors	14	16	27	123	172
Physical Illness Requiring ER	216	975	634	1039	2188
Physical Illness Requiring Hospitalization	239	445	400	763	1107
Serious Challenging Behavior	437	609	815	1322	2199
OTHER/ADMINISTRATIVE	96	77	166	409	361
TOTAL	1915	3159	3356	4948	7585

Behavior Treatment Review

In FY22, through DWIHN's BTPRC provider network there were 1,495 member cases on Behavior Treatment Plans which is an increase of 334 (28.76%) from the previous year. The data below depicts all the use of intrusive and restrictive techniques, 911 calls/critical events and use of medication per Individual receiving the intervention. The charts below illustrate the BTAC Summary of Data Analysis FY22. During FY 2021-20222, DWIHN BTAC staff provided three system-wide trainings on Technical Requirements of Behavior Treatment Plan Review Committee (BTPRC) Processes with a total of 1,215 staff trained within our provider network.





QAPIP Annual Evaluation

DWIHN departments have been engaged in continuous process improvement (Performance Improvement Projects). The guidance for all projects include improving the identification of both outcome and process measurements.

- There are (9) PIP's under the quality pillar. 8 of the 9 PIP's did not meet the target goal.
  - *Improving the availability of a follow up appointment with a Mental Health Professional after Hospitalization for Mental Illness -* ***Adult***
    - *(7 Day Follow-Up: Goal Not Met – 28.33%, Goal at 45% or higher).*
    - *(30 Day Follow-Up: Goal Not Met – 46.67%, Goal at 58% or higher).*
  - *Adherence to Antipsychotic Medications for Individuals with Schizophrenia (Goal Not Met – 46.92%, Goal at 68.00% or higher)*
  - *Antidepressant Medication Management for People with a New Episode of Major Depression (Goal not Met – 13.36%, Goal at 46.42%)*
  - *Improving Diabetes Monitoring for People with Schizophrenia and Bipolar Disorder (Goal not Met – 64.86%; Goal at 78.01%)*
  - *Coordination of Care (Goal Not Met – 68.86%, Goal at 95% or higher)*
  - *Case Finding for Opiate Treatment (Goal not Met –,60% Goal at 79% or higher)*
  - ***PHQ-9 Implementation (Goal Met – 99.1%,Goal at 95%)***
  - *PHQ-A Implementation (Goal Not Met – 99.2%, Goal at 100%)*
  - *Decreasing Wait for Autism Services (Goal Not Met – 67.5%, Goal at 100%)*

QAPIP Annual Evaluation

- The goal of the **Workforce Pillar** is to continue to focus on maintaining and expanding a centralized training program for health professionals.
- There was (1) objective under the workforce pillar. The target goal was met.
    - DWIHN met the objective by continuous quality monitoring of our workforce through credentialing and through Provider trainings on Detroit Wayne Connect, a continuing education platform for stakeholders of the behavioral health workforce. We strive to provide a variety of live and online courses. Log on at dwctraining.com. SUD Trainings are also available on Improving MI Practices posted at www.dwihn.org.

QAPIP Annual Evaluation

HSAG conducted three (3) mandatory External Quality Reviews (EQR) as required to ensure compliance with regulatory requirements.

- Performance Improvement Project
  - Goal met/outcome (100%) Target goal (80%)
- Performance Measurement Validation
  - Goal met received (100%) with no POC required.
- Compliance Review
  - Goal partially met received a score of 83% with a corrective action plan.

QAPIP Annual Evaluation

The goal of the **Finance Pillar** is to ensure financial stewardship and provide monitoring and oversight of claims/encounters submitted within the Provider Network. DWIHN verifies the delivery of services billed through our Medicaid Claims Process.

- There was (1) objective under the finance pillar. The objective was met.
  - In FY2022, a total of 3,598 claims were randomly selected for verification. Of those claims, 3,524 were reviewed and validated for 98.03%, which is a 35.75% increase from the previous fiscal year 2021 (1260). 3,210 of the claims reviewed were compliant, having received scores of at least 95%, and 215 of the claims reviewed had scores ≤ 95%, of which 124 required a Plan of Correction during FY2022.

QAPIP Annual Evaluation

The goal of the **Advocacy Pillar** is to promote full integration in the community.

- There was (1) objective under the advocacy pillar. The targeted goal not met.
    - Ensure full compliance in the network with the Home and Community Based Setting requirements.

QAPIP Annual Evaluation

- Overall, most activities planned in the Work Plan FY22 2021-2022 is at approximately (70%) completion.

- The activities that were Not Met, Partially Met or opportunities for Continuous Quality Improvement will be continued during FY2022-2023.

Behavior Treatment Advisory Committee

Summary of Data Analysis

FY 2021-2022

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Clinical Specialist, Quality Improvement

BACKGROUND

- Detroit Wayne Integrated Health Network (DWIHN) started Behavior Treatment Advisory Committee (BTAC) in 2017;
- The Committee is comprised of DWIHN network providers, members, DWIHN staff, including Psychiatrist, Psychologist, and the Office of Recipient Rights;
- To review the implementation of network Behavior Treatment Plan Review Committees and evaluate each Committee's overall effectiveness;

BACKGROUND Continued…

- To review system-wide Behavior Treatment Plan Review Committee processes issues, including trends, approvals, disapprovals, and terminations of Behavior Treatment Plans;
- To reviews system-wide performance indicators for the open Behavior Treatment Plans such as emergency psychiatric hospitalization, use of law enforcement, 911 calls, Critical and Sentinel Events;

CHALLENGES

- Need for the structure of formal review process at the systemic level;
- Expediated Review Process for Emergent Reviews;
- Adherence to MDHHS requirements for Restrictive and Intrusive interventions;
- System-wide Technical assistance and training on Behavior Treatment Procedure ;
- H 2000 authorization/approval guidelines;
- Under reporting of the five reportable categories for the members on Behavior Treatment Plans; *(Suicide, Non-suicide death, Emergency Medical Treatment due to Injury, Medication Error; and Arrest of Consumer when law enforcement states person is being arrested)*

CHALLENGES Continued…

- ❖Adherence to MDHHS requirements to document Behavior Treatment Plan Review Committee meetings;
- ❖Compliance with In-service training requirements for Restrictive and Intrusive interventions;
- ❖Accuracy of required information on MDHHS data spreadsheets;
- ❖Revisions in the Behavior Treatment section of the Case Record Review Tool/Policy.

ACCOMPLISHMENTS

- ❖DWIHN offered three trainings on Behavior Treatment Procedures with MDHHS;
- ❖DWIHN started submitting quarterly data analysis reports on system-wide trends of Behavior Treatment Plans to MDHHS;
- ❖During the COVID pandemic, DWIHN issued HIPPA compliant virtual review and approval guidelines;
- ❖Behavior Treatment notification banner for each member on the Behavior Treatment Plan has been added to DWIHN's MH-WIN for effective monitoring;

ACCOMPLISHMENTS Continued…

❖MDHHS Technical Requirements have been incorporated into DWIHN Policy and Case Record Review Tool (Periodic revisions are conducted);

❖With effect from October 1, 2020, DWIHN has delegated the responsibility of Behavior Treatment reviews to DWIHN's Clinically Responsible Service Providers (CRSP);

❖Twenty Mental Health CRSP have established BTPRC and three have joint BTPRC;

ACCOMPLISHMENTS Continued….

- Behavior Treatment Category is now live in MH-WIN Critical and Sentinel Reporting Module to improve under-reporting the five reportable categories. *(Suicide, Non-suicide death, Emergency Medical Treatment due to Injury, Medication Error; and Arrest of Consumer when law enforcement states person is being arrested)*

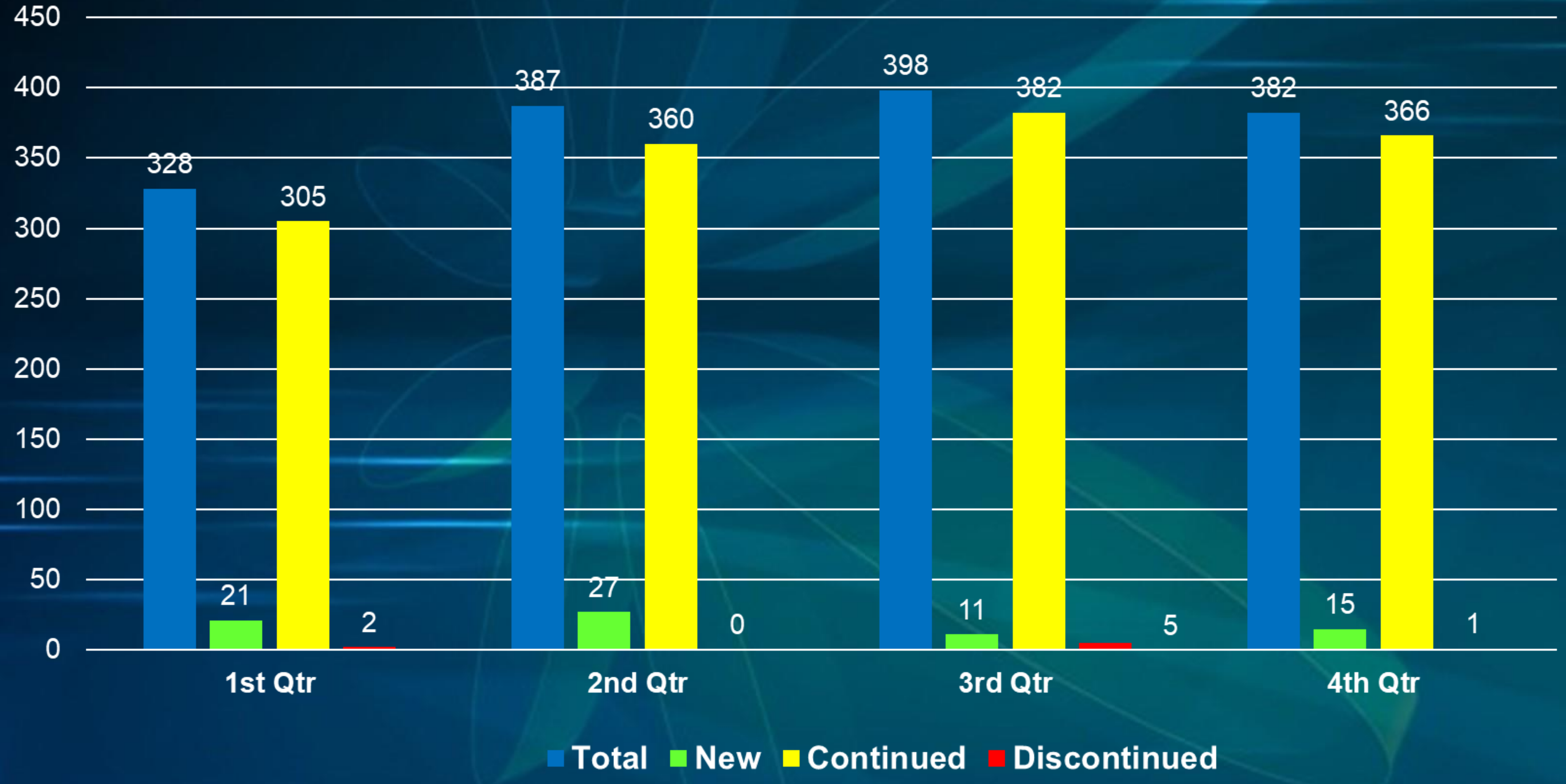
FY2021-2022

- During FY 2021-20222, DWIHN BTAC staff provided three system-wide trainings on Technical Requirements of Behavior Treatment Plan Review Committee (BTPRC) Processes. A total of 1215 staff throughout the provider network participated in these trainings. All trainings were conducted via the Zoom platform. The first training was focused solely on MDHHS requirements for Behavior Treatment whereas the second and the third training focused on the Behavior Treatment requirements as part of IPOS writing.

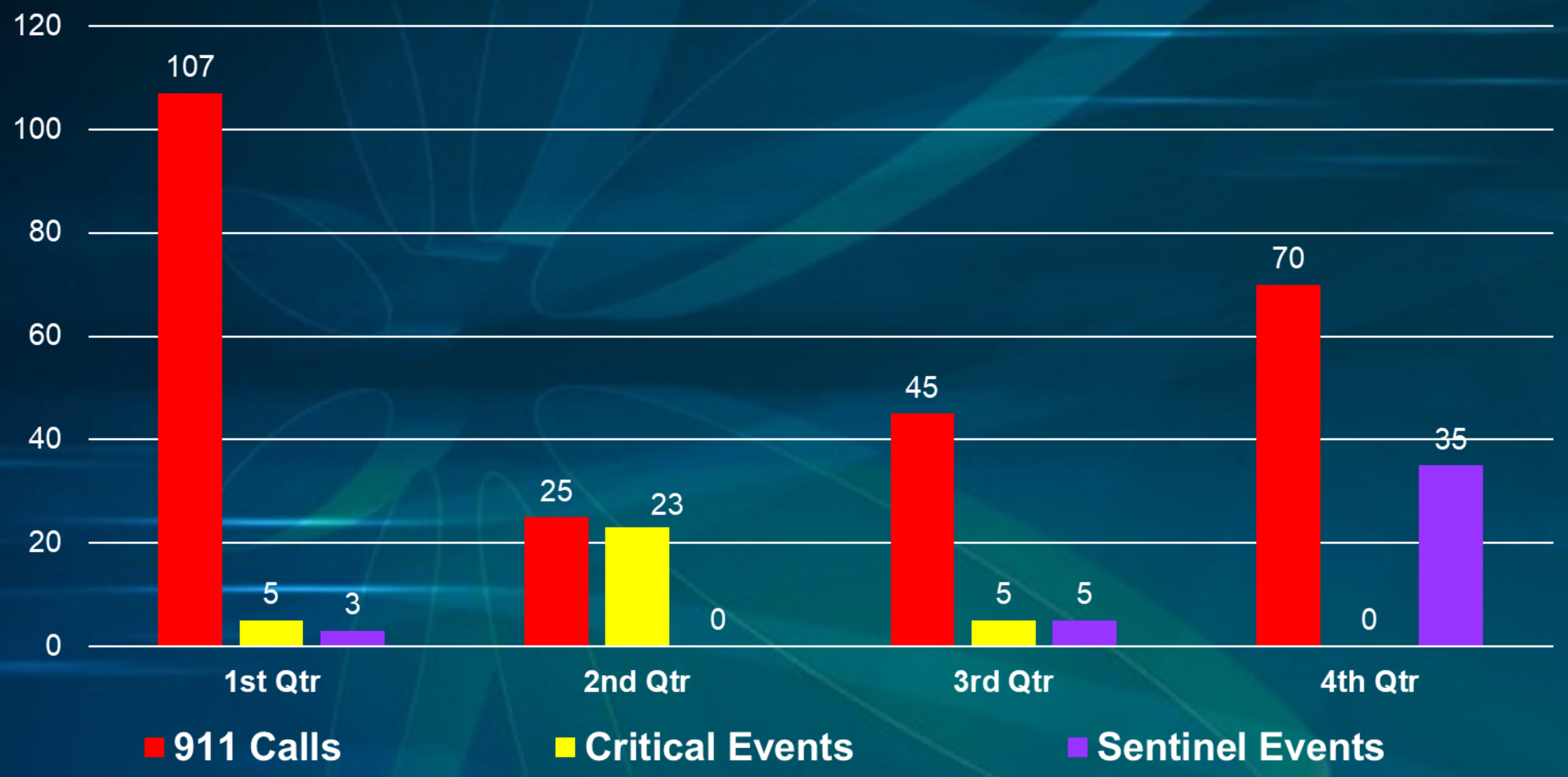
FY2021-2022 Continued…

- DWIHN is in full compliance with PIHP Administrative Review Procedures of Behavior Treatment (B.1) for the fourth consecutive year based on the findings of MDHHS Habilitative Supports Waiver 1915(c) Review.
- DWIHN staff continues to serve on MDHHS Behavior Treatment Advisory Group.
- 1495 Open cases.
- During FY2022, the network providers presented fourteen (14) complex cases.

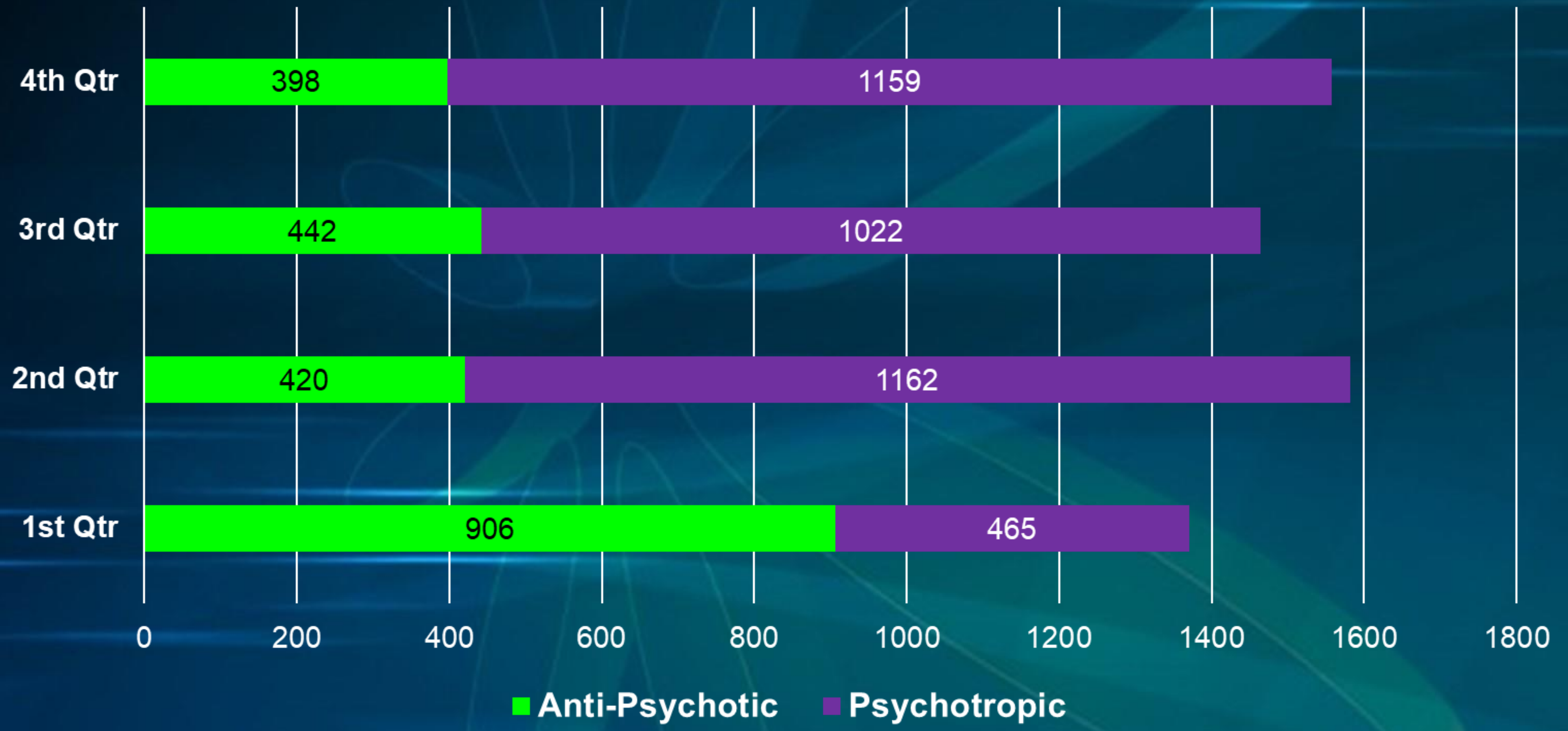
Total Behavior Treatment Plans Reviewed



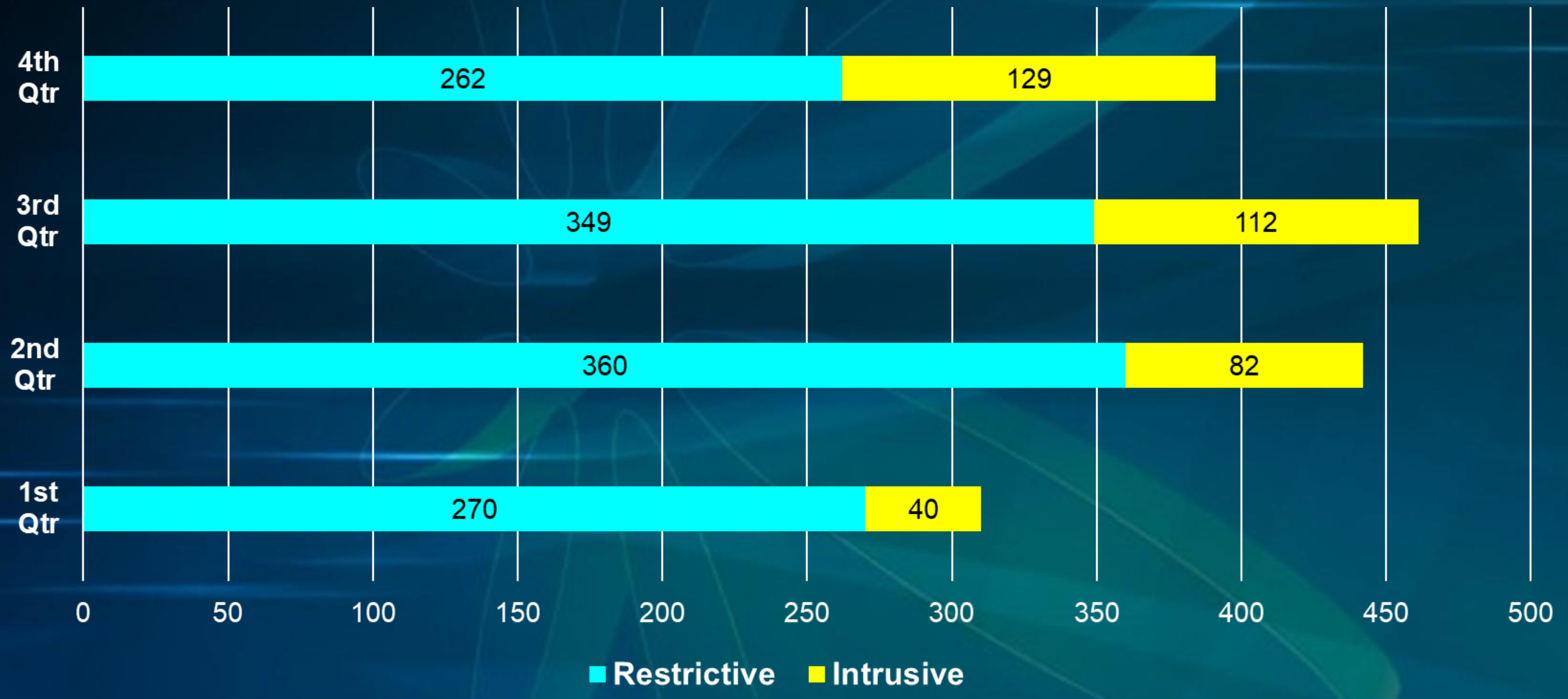
Reported 911 Calls and Critical/Sentinel Events



Reported Number of Medications



Restrictive and Intrusive Interventions



RECOMMENDATIONS

The following are the opportunities for systemic review and change:

- ❖ IPOS and Behavior Treatment Plans are specific, measurable, and are updated and revised per the policy/procedural guidelines;
- ❖ Improve the under-reporting of the required data of Behavior Treatment beneficiaries. (*Suicide, Non-suicide death, Emergency Medical Treatment due to Injury, Medication Error; and Arrest of Consumer when law enforcement states person is being arrested.)*
- ❖ In-service training is provided by the appropriately licensed and credentialed clinician;

RECOMMENDATIONS Continued….

- Continuation of Case Validation Reviews of randomly selected cases as a step towards continuous quality improvement at PIHP level;
- Regular consultations with network providers on the Technical Requirements of Behavior Treatment Plans;
- Each CRSP ensures the service site has member's IPOS and ancillary plans, before the delivery of services;
- Crisis Prevention Intervention (CPI) training is recommended to help reduce the high utilization of emergency department (ED) visits;

THANK YOU