Quality Operations Technical Assistance Workgroup Meeting Agenda
Wednesday, June 28, 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.	DWIHN Policies	
	▪ Self-Determination and Self-Directed Arrangements	L. Brown
	▪ CRSP Member Re-Engagement and Case Closure	M. Lyons
V.	**QAPIP Effectiveness**	
	Customer Service	
	a. Member Outcomes Report Update	M. Keyes-Howard
	Quality Improvement	
	b. BTAC Q2 Analysis Update	F. Nadeem
	c. CE/SE Reporting	S. Applewhite
	d. CE/SE Q2 Analysis	C. Mackey
	e. CE/SE Trainings	M. Lindsey
	f. HCBS Updates	D. Dobija/William Sabado
	• Setting on Heightened Scrutiny	
	• Documentation of HCBS services in the IPOS	
	• 2020 Survey Remediation & Validation Project	
	• Waiver Programs (HSW, CWP, & SEDW)	
VI.	Adjournment	

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Via Zoom Link Platform
9:30 a.m. – 11:30 a.m.
Note Taker: DeJa Jackson

1) **Item: Announcements:**
   - The roster for the QOTAW has been updated.
   - The next Provider performance indicator workgroup meeting will be scheduled for September 27th, 2023.
   - Due to the upcoming holiday, the Outpatient and Residential meetings scheduled for July 7th will be rescheduled for a later date.
   - HSAG will be conducting the Performance Measure Validation (PMV) review on July 10th.
   - HSAG will also be conducting the compliance review on August 18th.
   - DWIHN's HSAG Performance Improvement Project (PIP) Reducing Racial and Ethnic Disparity with African Americans Seen for Follow-Up Care Within 7-Days of Discharge from a Psychiatric Inpatient will be submitted to HSAG on July 14th, 2023. For this year, the PIP will focus on barriers and interventions with Remeasurement # 1 reported for calendar Year 2023.
   - New team members in Quality, Clinical Specialist Performance monitor, Mark Matthews and Clinical Specialist for Autism and Children Services Ashley Faulkner. Also, Danielle Dobija who has been promoted as the Performance Monitor Administrator.

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 from SUD services provided the workgroup with the following updates: • DWIHN's seventh annual Opioid and Substance Use Disorder Solutions Summit will take place on July 25th at the Laurel Manor and will be a hybrid event. The goal this year is creating supportive environments for prevention treatment and recovery. The event will be from 8am – 4:30pm. The cost to attend is $60. • DWIHN will also host our annual Faith Based Conference on August 17th and 18th from 9am – 2pm at Palestine Park, 9600 Ford rd., Dearborn, MI. There will be 8 breakout sessions, and this year's theme is wellness. The 8 dimensions of wellness: emotional, physical, occupational, intellectual, financial, social, environmental and spiritual. • DWIHN's SUD Provider meeting will take place on July 26th at 10am via Zoom.		
Provider Feedback	**Assigned To**	**Deadline**
No additional provider feedback was provided.		
Action Items	**Assigned To**	**Deadline**
None		

3) Item: Recipient Rights – Chad Witcher
Goal: Updates from 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		
No current updates from ORR.		
Provider Feedback	**Assigned To**	**Deadline**
Providers Questions/ Concerns: 1. Is it possible to receive an Excel format rather than a pdf format of the recipient rights reports? ORR's Reply/Answers: 1. Yes, the Recipient Rights Reports can be provided in an Excel format. Please send your request to the attention of Chad Witcher.		
Action Items	**Assigned To**	**Deadline**
None		

4) Item: DWIHN Policies

Goal: Self Determination and Self-Directed Arrangements

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

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

Discussion		
Lucinda Brown from DWIHN's UM department shared with the workgroup the following updates for the Self Determination and Self Directed Arrangements Policy and Procedure: It is the policy of the Detroit Wayne Integrated Health Network (DWIHN) that the option to Self-Direct services shall be available to all members who use Behavioral Health Services, including persons with intellectual and developmental disabilities, persons with mental illness, and persons with co-occurring disorders. Self-Directed services are a partnership between DWIHN and the member. • Self-directing services which was formally referred to as self-determination is one of the two methods of service delivery at Detroit Wayne Integrated Health Network, and it is required to be offered as a choice to our members during the pre-plan meeting. • In self-directed arrangements the member or legal representative are the employers. They take the lead in terms of their behavioral health funds and they can select what person they want to hire, whether it's a family member, an agency, or they can have a service provider. • Members who self-direct would have a financial management service agency that provides their payment for their services. • The highest number of people who self-direct are member who have intellectual and developmental disabilities, but any of the people that we support can self-direct.		
Provider Feedback	**Assigned To**	**Deadline**
No provider feedback.		
Action Items	**Assigned To**	**Deadline**
None		

4) Item: DWIHN Policies
Goal: CRSP Member Re-Engagement and Case Closure
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems ☐ Quality ☐ Workforce
NCQA Standard(s)/Element #: QI ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Discussion		
Marianne Lyons, Director of Adult Initiatives provided the following updates for the CRSP Member RE-Engagement and Case Closure Policy/Procedure: • The purpose of this policy is to provide procedural and operational guidance for the Clinically Responsible Service Providers (CRSP's) and all staff involved in the re-engagement in case closure policy. • Marianne went over the revisions made to the policy. One of the major changes were the number of attempts from 3 to 5 as well as changing "Consumer" to "Member" within the policy language.		
Provider Feedback	**Assigned To**	**Deadline**
Questions/Concerns 1. When does this policy take effect? 2. Just wanted to confirm that members with SMI'd can be closed after 60 days of no contact instead of the 90 days? 3. When are we to tell our staff to start making the five engagement attempts? Or are we waiting until this policy goes live? 4. What about for clients who's a no show for intake? Would that still be the three outreach attempts or are we still looking at five outreach attempts for a client who is no show for intake? Answers: 1. The policy will be uploaded with an effective date within the next two weeks. 2. Yes, that was a change that was made. 3. It will be a good idea and best practice to begin now. 4. Maryanne Lyons will need to review to address this question.		
Action Items	**Assigned To**	**Deadline**
Maryanne Lyons to address the questions to the policy regarding the no show for intake.	Maryanne Lyons, Adult Initiatives	September 30, 2023

5) Item: QAPIP Effectiveness – Customer Service
Goal: Member Outcomes Report Update

Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems ☐ Quality ☐ Workforce
NCQA Standard(s)/Element #: QI #5 CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Discussion		
Margret Keyes-Howard , Unit Manager Member Engagement provided the following updates: • The 2023 Member experience ECHO reports are being finalized. Margaret will provide an update within the next two months. • Margret also introduced Kiva Redmond to the group. Kiva will be the Member Experience Coordinator for the Member engagement team. • DWIHN is also looking at expanding the Constituent Voice Advisory Committee. The purpose of this committee is to provide action and recommendations to our CEO and our administration.		
Provider Feedback	**Assigned To**	**Deadline**
No provider feedback.		
Action Items	**Assigned To**	**Deadline**
2023 Member Experience (ECHO) results will be shared with the workgroup once finalized.	Margaret Keyes-Howard, CS	September 30, 2023

5) Item: QAPIP Effectiveness – Quality Improvement
Goal: BTAC Q2 Analysis Update

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		
Fareeha Nadeem, Clinical Specialist Quality Improvement shared with the workgroup the BTAC Q2 Analysis Update: • Background and Functions • Methodology • Use of Medication during the second quarter • Use of Restrictive and Intrusive Techniques • 911 Calls/ Sentinel Events • Quantitative Report of Each BTPRC for the Second Quarter • Trend and Patterns Recommendations include: ○ Increase training for network providers on the Technical Requirements of Behavior Treatment Plans and supervision. ○ Additional clinical staff with MDHHS required credentials for BTPRC review continues to be a challenge. Additional clinical staff will help to ensure compliance with BTPRC Technical Requirements. ○ Continuation of Case Validation Reviews of randomly selected cases is recommended as a step towards continuous quality improvement at the PIHP level. Please review the attached "BTAC Update Summary" for additional information.		
Provider Feedback	**Assigned To**	**Deadline**
No provider feedback.		
Decision Made	**Assigned To**	**Deadline**
None.		
Action Items	**Assigned To**	**Deadline**
None.		

5) Item: QAPIP Effectiveness – Quality Improvement
Goal: CE/SE Reporting

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		
Sinitra Applewhite, Clinical Specialist Quality Improvement shared the following updates: • For Critical/Sentinel Events DWIHN's QI team requests that you submit the information within 24 hours of your knowledge into our MHWIN system. For more information on this you can go to our DWIHN website and pull up the Critical Assistance Guidance manual. There is also training that is offered. • When the CRSP's are entering the event please ensure that you are including all of the follow-up documentation is included with the events. The events are not finalized without the documentation. Please make sure to upload documentation to the corresponding events under the attachment section.		
Provider Feedback	**Assigned To**	**Deadline**
No provider feedback.		
Decision Made	**Assigned To**	**Deadline**
None.		
Action Items	**Assigned To**	**Deadline**
None.		

5) Item: QAPIP Effectiveness – Quality Improvement
Goal: CE/SE Q2 Analysis

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

Discussion		
Carla Spight-Mackey, Clinical Specialist Quality Improvement shared with the where in MH-WIN to enter a CE/SE and the following updates: The aggregate data comparison for Quarter 1 and 2, categories include: ○ Administrative ○ Arrest ○ Behavior Treatment ○ Deaths ○ Environmental Emergencies ○ Injuries Requiring ER ○ Injuries Requiring Hospitalization ○ Medication Errors ○ Physical Illness Requiring ER ○ Physical Illness Requiring Hospitalization ○ Serious Challenging Behavior ○ Total number of reported Critical/Sentinel Events • Carla also shared a comparison of the top five providers with more than 15 events per 1,000 members which include: ○ Wayne Center ○ NSO ○ Team Wellness ○ CLS ○ Hegira • Carla also shared the 2nd quarter CRSPs Reported events and the trends and patterns and recommendations.		
Provider Feedback	**Assigned To**	**Deadline**
None		
Decision Made	**Assigned To**	**Deadline**
None.		

Action Items	Assigned To	Deadline
None.		

5) Item: QAPIP Effectiveness – Quality Improvement
Goal: CE/SE Trainings

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

Discussion		
Micah Lindsey, Clinical Specialist Quality Improvement, shared with the work group the following: • Critical/sentinel event reporting module training for 2023: The trainings are on the second Thursday of each month Via Teams Webinar 9:00 a.m. – Noon May 11th June 8th August 10th September 14th • Registration closes one week prior to the webinar. • Participants will not be admitted after 9:10 a.m. • Participants camera must remain on for the entire training. • Registration is required. Manager/supervisors must register staff. • Space is limited to the 1st 75 participants. Wait lists will be established.		
Provider Feedback	**Assigned To**	**Deadline**
No provider feedback.		
Decision Made	**Assigned To**	**Deadline**
None.		
Action Items	**Assigned To**	**Deadline**
None.		

5) Item: QAPIP Effectiveness – Quality Improvement
Goal: HCBS 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		

Danielle Dobija, QI Administrator Performance Monitoring discussed the following with the workgroup:
 	
HCBS Implementation/ Demonstrating Compliance
• HCBS Implementation DWIHN Network Responsibilities
  ○ Transition Planning
  ○ Non-Responder HS List Remediation Work
  ○ 2023 Survey Quarterly
  ○ Pre-Operational Reporting
  ○ 2020 Survey Remediation/Validation
• Heightened Scrutiny Remediation Work
  ○ Next steps
  ○ DWIHN status (To Date)
  ○ IPOS Documentation Expectations for demonstrating Compliance with HCBS Final Rule		

Provider Feedback	**Assigned To**	**Deadline**
No provider feedback.		
Decision Made	**Assigned To**	**Deadline**
None.		
Action Items	**Assigned To**	**Deadline**
None.		

New Business Next Meeting: 07/26/23
Adjournment: 06/28/2023

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Examining Member Experience Outcomes

Summary FY 2022

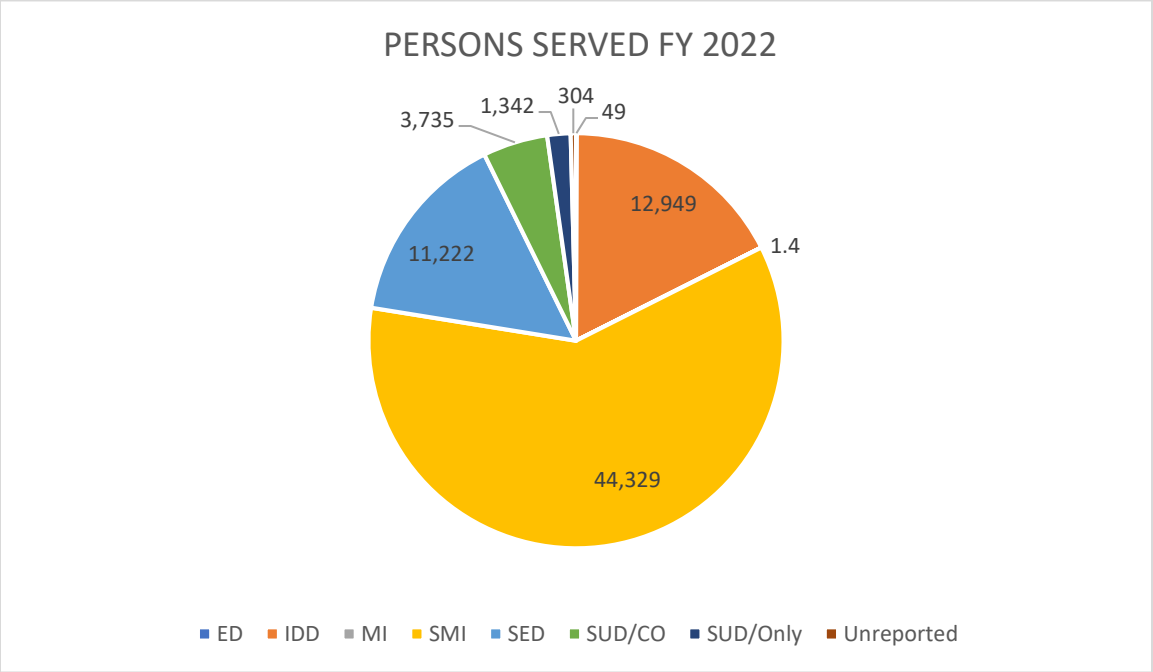
Submitted By: Margaret T. Keyes-Howard, M.A.

February 24, 2023

Member Experience is the total sum of all touch points experienced by the members we serve. At Detroit Wayne Integrated Health Network (DWIHN), we explore all avenues of opportunities to engage members and to assess what they experience during the various ways they interact with our system. While our system is vast it is also promising and hopeful as we endeavor to focus on a wholistic approach to healthcare. We utilize various tools and measurements to collect a realistic view of the member's recovery journey and analyze these outcomes for improving the system. This report is a summary and cross-walk of data collected and analyzed related to member's feedback. Along with the data in this report, we recognize the concept of perceived improvement, gaps in care, opportunities for enhancing the system and some next step - recommendations toward ensuring a more positive, welcoming, recovery- supported environment for all DWIHN members.

WHO WE SERVE:

DWIHN serves a diverse population with complex behavioral and physical health needs, (shown below), the chart depicts a general demographic of unduplicated services for members receiving behavioral health care treatment by diagnosis during fiscal year 2022.



Disability Designation Persons Served % Persons Served Emotional Disturbance 49 0.06% Intellectual/Developmental Disability 12,949 17.07% Mental Illness 1,908 2.52% Serious Emotional Disturbance 11,222 14.80% Serious Mental Illness 44,329 58.45% Substance Use Disorder 3,735 4.92% Substance Use Disorder Only 1,342 1.77% Unreported 304 0.40% Total 75,838

KNOWING WHO WE SERVE:

Knowing who we serve is important as we digest feedback from our members. More than 85% of the population we treat has a chronic and serious mental illness, therefore, merely identifying benchmarks in satisfaction amongst this population is more than just rationalizing the data. Satisfaction data is integrally tied to perceived improvement rather than based on measurables we commonly use in measuring core data sets used in clinical or performance indicators. Perception of satisfaction is a less tangible matter, because it broad and usually hinges on multi-faceted complex variables. Systemic trends in satisfaction surveys are not as easily identified because of this subjective variable. For instance, two members could actually experience the same treatment exactly, but one person's experience could be completely perfect and rated with high satisfaction, while the other's person's experience could be quite the opposite, conditional perception is a huge factor in this.

VARIABLE FACTOR: SOCIAL DETERMINANTS:

Persons with Mental Illness have higher mortality rates and are heavily challenged by conditions in their environment. These determinants strongly impact perception of satisfaction. DWIHN is reviewing data as expressed by the ECHO® and other sources in consideration of these determinants which are identified by five (5) primary domains of care, Access to Quality Healthcare, Issues of Poverty/Economic Stability, Educational Access/Equity, Environmental Conditions like affordable housing and living conditions and finally, social inclusion/community participation.

Social Determinants cannot be ignored when analyzing satisfaction data specifically in our population base. According to the U.S. Census Bureau (2021 Data) 20% of Wayne County citizens are below the poverty line, many of the persons we serve are therefore challenged significantly either as a result of poverty or due to their inability to maintain work as a result of the chronicity of their behavioral health diagnosis. This course significantly parlays into concerns that according recent studies which correlate poverty and higher rates of mental health disorders, more severe conditions as well as less happiness within those populations are noted. Such research is fairly new however, it is anecdotally understood amongst practitioner's and at DWIHN, so what we are seeing in significant numbers with our members is a multidimensional phenomenon. Therefore using standard comparison data is not really giving us insight to the root fact of serving severely ill, and often impoverished populations, particularly after the precedent of the Pandemic overlay that was experienced by us all.

SOME FINDINGS:

The Member Experience Unit was established to begin the regimented review of information, data and feedback received from DWIHN members. In 2017 the unit managed a baseline survey called the ECHO® Adult Survey. ECHO® is a trademark name of a behavioral health tool approved to be appropriate for accreditation purposes by NCQA. The ECHO® surveys are becoming one of the

most utilized surveys in behavioral systems across the nation, which has recently also established a data base tool for participants to begin to share data. The 2017 survey was administered to get a baseline of some broad areas of satisfaction while also looking at feedback that would offer us insight into our standing around Quality of Care, Access, Service and Attitude, and (member's) Relationship with Practitioner/Provider. The survey provided general insight and the Member Experience unit begin to look for greater opportunities for identifying strengths and weakness within the system. Since the initial baseline Adult ECHO® DWIHN has repeated the survey for 2020, 2021, and 2022 data is in progress now. The full reports of the Adult ECHO® remains an important mainstay of satisfaction feedback from DWIHN members. Below a chart of categories show general detail on the steady improvements made in specific areas identified in 2017 and as compared in the past two years.

While many scores may appear to be low, the value of the score is reflective of a percentage of the persons surveyed in most cases the feedback results in more than half participants consider they are satisfied, always or most of the time. Results on satisfaction drastically increase if we include members who are sometimes satisfied as opposed to imagining, that the existing balance of respondents are all dissatisfied, this would be a misnomer as it relates to the ECHO® data.

ECHO FINDINGS AT A GLANCE:

ADULT SNAPSHOT OVER THREE YEARS

CATEGORY	2021 RESULTS	2020 RESULTS	2017 RESULTS	STATUS
Overall Treatment	51% Satisfied	51% Satisfied	46% Satisfied	**UP 5%** Improved
Seen w/in 15 Min @ office visit	44% Satisfied	36% Satisfied	33% Satisfied	**UP 11%** Improved
Told About Meds and Side-effects	79% Satisfied	74% Satisfied	75% Satisfied	**UP 5%** Improved
Incl. engaging Family in Treatment	60% Satisfied	60% Satisfied	59% Satisfied	**Up 1%** Improved
Info on Managing Condition	75% Satisfied	81% Satisfied	78% Satisfied	Remains Above 75%
Given Info on Rights	88% Satisfied	88% Satisfied	91% Satisfied	Above 85%
Member feels can refuse treatment	84% Satisfied	81% Satisfied	78% Satisfied	**UP 6%** Improved
Confident on Privacy	93% Satisfied	91% Satisfied	91% Satisfied	**Up 2%** Highest Score 93%
Cultural Needs Met	69% Satisfied	69% Satisfied	76% Satisfied	Down -7% Room for Improvement
Helped by Treat-ment	57% Satisfied	58% Satisfied	52% Satisfied	**Up 5%** Improved

Info on Treatment after benefits depleted	56% Satisfied	55% Satisfied	48% Satisfied	**UP 8%** Improved

With nearly 1,000 adults participating in the 2021 ECHO® survey the graph above shows the areas of treatment that has room for improvement and areas above the 70% Satisfaction where DWIHN service providers are considered doing very well. The last column or / Status category demonstrates **a cumulative 43% increase** toward improvements made by DWIHN within these categories, from 2020 to 2021. Note, data from 2022 ECHO® is incomplete at this reporting juncture.

In addition to the ECHO® Adult Survey roll out, in 2020 DWIHN also initiated a roll out of the e Children's Version of the survey which addressed families and guardians of children under 18. The baseline established additional insight for are infant, youth, and adolescent population.

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CHILDREN's TWO YEAR - ECHO SURVEY /Snapshot View

CATEGORY	2021 RESULTS	2020 RESULTS	STATUS
Overall Treatment	54%	49%	**Up 5%** Still Needs Improvement
Seen within 15 min	63%	55%	**Up 8%** Still Needs Improvement
Given Treatment Options	76%	75%	**Up 1%**
Told about Side Effects of Medications	83%	79%	**Up 4%**
Given Info on Managing Condition	79%	78%	**Up 1%**
Given Info on Rights	92%	95%	Down 3% - above 90%
Felt like Treatment could be refused	85%	88%	Down 3% - still at 85%
Confident of Child's Privacy	95%	93%	**Up 2%** Good Job!
Cultural Needs Met	74%	82%	Down 8% @ 74% but not good enough
Treatment Helped Child	51%	49%	**Up 2%** Needs Improvement
Informed about other options after benefits are depleted	53%	58%	Down 5% Needs Improvement
Goals for Child's Treatment discussed	94%	93%	**Up 1%** Looks really good

The chart accounts for a total of **24% improvement in overall areas** for the global treatment of care categories for respondents to the ECHO®, 961 parents or named guardians fully completed the entire survey in 2021. The Children's 2022 ECHO® Survey is in progress at the release of this report.

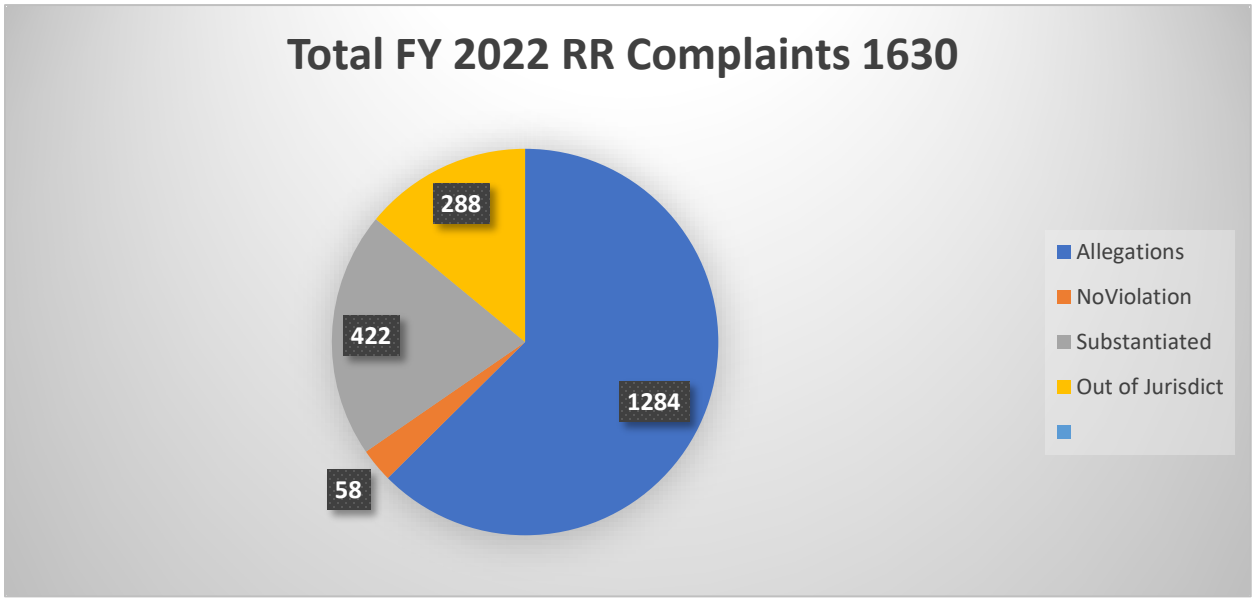
Overall for both the Adult and Children's Annual ECHO® surveys DWIHN scored very well in several categories. Those notably include from information on Confidence of Child's Privacy, (95%), Rights (92%), Told about Side-effects of Rx (83%) and 94% related to having been Informed About the Goals of their Child's Treatment. Other of the measures continue to need further investigation and continued analysis.

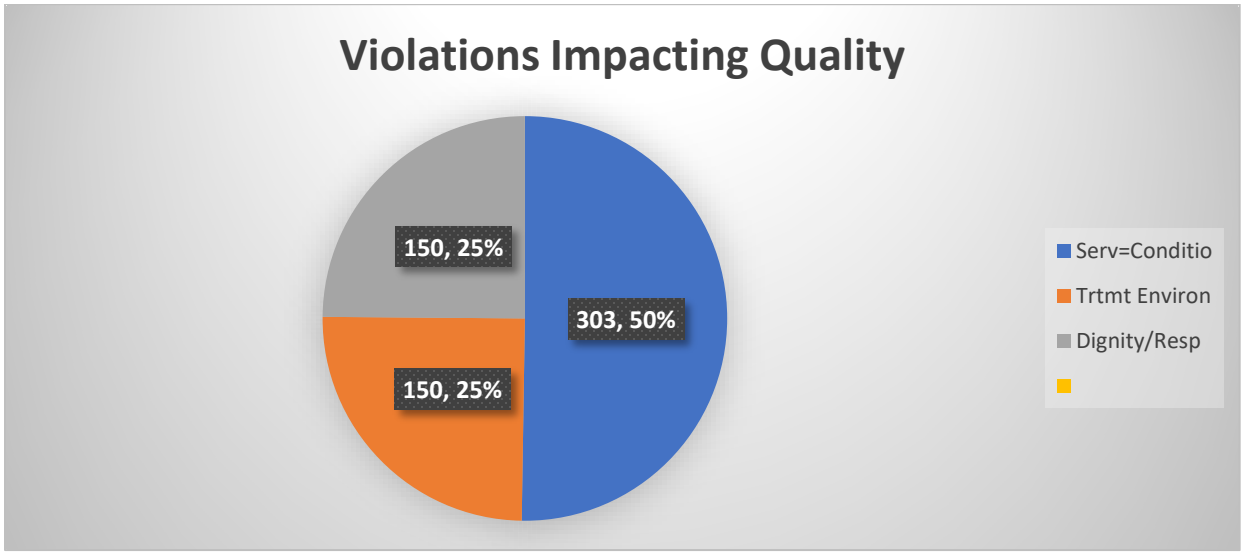
GRIEVANCE DATA:

DWIHN uses this data and other initiatives to determine priority actions and improvements to better engage members and stakeholders. Analyzing the data helps to forecast the direction and future of DWIHN's public behavioral health system by enhancing and developing policy, initiating process improvement plans, funding new programs and services to enhance our system of care. It also serves as a source to identify opportunities for improvement in the quality and delivery of behavioral health service within the DWIHN system. It is DWIHN's goal to educate members as well as providers on the importance of promoting expressions of member dissatisfaction as a means of identifying continuous quality improvements in our delivery of behavioral health care services. It supports staff in better understanding of the member's experience. Using the data along with other information a team examines through an analysis of trends and occurrences with particular attention to systemic issues such as access, quality, treatment services, environment and communication with practitioner. The Due Process action and availability of the process to members helps to support ones recovery and ensures that member are heard. It empowers individuals receiving services to become self-advocates and provides input for making the system better for everyone.

The results in the graph below include responses from members who received services in fiscal year 2022. There was a total of 205 grievances reported within the last three fiscal years. Grievances originated with either the Service Provider or DWIHN. As the graph below indicates with the gray bar, the greatest number of grievances were reported in FY 2022. More grievances give better insight to how members are navigating the system. These complaints give us an overview to determine patterns. As a matter of general analysis we see a sharp increase in the delivery of services category, but relatively inconsistent with other matters of satisfaction our members do not have significant complaint levels with any other service or experience.

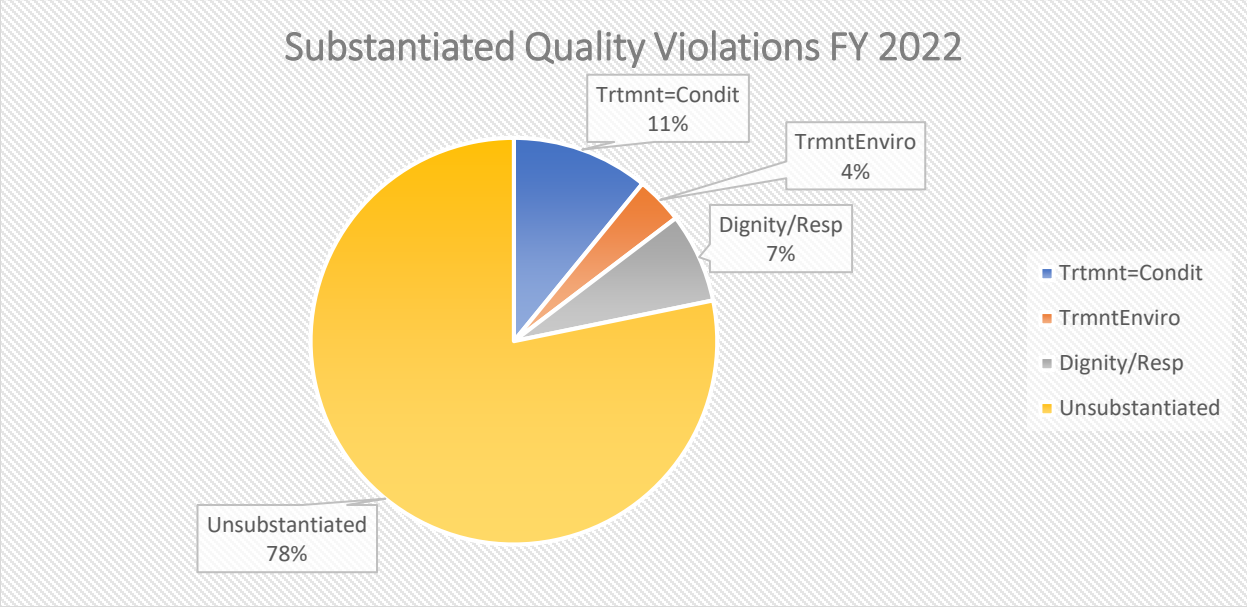
Conversely while grievances remain less frequent the DWIHN's Office of Recipient Rights continues to investigates complaint with a total of 1630 reported in FY 2022.





Investigations pursuant to the mental health code include categories related to Mental Health Services being suited to the recipient's condition (303), Safe, Sanitary and Humane Environments (150), Dignity and Respect (150).

Substantiated cases in those categories are reflected in the next pie chart, at 84 cases, 29, and 55 respectively, therefore **78% of reported violations in these categories were unsubstantiated.**



A crosswalk of these findings provides a glimpse of information while also supplying several opportunities for improvement. In consideration of the impactful correlation of Social Determinants around our population and the results of our initial study we can convey that while members may be satisfied around services generally DWIHN has yet to dig deep enough into the prospect of member feedback and research should be continued as well as expanded. While FY 2021 DWIHN entered into several plans to improve services, many of them do not firmly engage with the feedback received from members. A more in-depth process of member experience during the next several months could prove to be a worthwhile exploration in establishing not only how the member satisfaction data will be collected but also how DWIHN as system will begin to explore concepts around member perception and the effects training may have on members.

POTENTIAL OPPORTUNITIES:

- Continue with Annual Surveys and participate in data base exchanges on ECHO® results to begin to benchmark national comparisons utilizing CAHPS
- Research comparable data sources in behavioral health for Medicaid recipients check evaluative opportunities on benchmarking with Health Plans in similar categories.
- Create a basic Member Satisfaction Tool to be used by Service Providers that digs deeper into the social determinant factors of their members to help shape resources and care around the population. Results to be submitted to DWIHN. Overlay with epidemiological studies on Wayne County.
- Create a Peer Tool to be used by designated peer agents working in the system.

- Engage in a member study where members are trained by Peers to develop their strengths and to have more defined PCP that specifies their personal goals along with a plan that helps them to measure their satisfaction based on non-external factors, but rather that goals. Proposed LTSS study for this endeavor.
- Monitor uses of Member Mobile Data App for relevant information.
- Continue to use, share and market MyStrength® tool to members.
- SEC/PR cases seek input from members related to their crisis experience post situation for study purposes.
- Integrate Peer trainers to assist in the QI cycle examining measures toward improvement goals and prioritizing opportunities for members to give feed back into that cycle.
- Create Member Experience Feedback Consortium to tackle life issues
- Consider creation of resource center for members/ Peer reps could help navigate issues around housing, transportation, food insecurity, substance use prevention.
- Create member wellness center, offer nutrition programs, smoking cessation, walking programs, physicals, oral health programs, "living room" setting ran by Peers.
- Address/assess literacy issues amongst members to increase communication abilities between member and practitioner.
- Review Root Cause Analysis Data and Incident Reports to correlate statistics that offer a more expansive view of the member's experience.
- Continue implementation of Call Center surveys for persons accessing services
- Elevate member experience feedback by team review of grievances around quality or access of care.
- Continue multi-discipline conversations to help resolve systemic issues
- Create a Think Tank of Solution oriented persons to discuss member feedback engaging members, families and stakeholders.

In closing this summary is intended to initiate serious continuation for planning around the expansion of resources in better understanding the member's experience. Comparable data sources are limited and do not fairly engage issues related to DWIHN's members social determinants. While DWIHN's QI cycle engages in improving scores, our data does not drill down to individual's (to protect anonymity), so some of our data is disconnected to specific members, problems as specific providers, or otherwise issues that can be pinpointed. Therefore, more studies are needed to better enable DWIHN to understanding satisfaction more fully. Finally exploring concepts of perceived improvement amongst members must be further investigated. A wholistic approach to better serving our members needs would be to consider filling the gaps with process improvement planning that includes more training to provider's, involving peers at the direct service level, and to support a culture where empathetic responses are rewarded throughout the system. DWIHN must develop a system which links member satisfaction to direct care and better health outcomes. DWIHN could achieve this by implementing the following;

- ✓ Create a Culture which rewards documented Improve Planning on every level of system.
- ✓ Engage Human Resource Staff toward the development and recognition of trained staff.

- ✓ Design and Implement Practical Strategies that gather feedback from Members and appropriately create resources to tackle issues discovered.
- ✓ Enhance Customer Service Structure, training, tool kits.
- ✓ Tackle low literacy and LEP gaps throughout system.
- ✓ Sure-up Cultural gaps, more training, and utilization of diverse trained Peers.
- ✓ Broader Training for the organization and system to realize importance of Member Feedback/Satisfaction.
- ✓ Adopted Empathetic Practices * documented research shows this is one of the most valuable ways to equalized social determinants, which ultimately improves recipient's outcomes, increases interpersonal trust, increases adherence to treatments, which increases better clinical results and usually increases satisfaction of care with participants.

Summary of Behavior Treatment Advisory Committee (BTAC) Data

2nd Quarter Fiscal Year 2022-2023

Background and Functions:

- 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.
- The Committee oversights the functioning of the twenty Behavior Treatment Plan Review Committees (BTPRC) across DWIHN network and evaluates each committee's overall effectiveness and corrective action as necessary.
- Network providers present their complex cases to the BTAC for a case review. During the second quarter, four cases were presented to the BTAC.
- On going assistance to the network BTPRCs, Performance Monitoring unit, Sentinel Events Review Committee and DWIHN internal departments on matters related to Technical Requirements of BTPRC processes.
- Furthermore, MDHHS has recently revised the codes for required Functional Behavior Assessment (FBA) before writing a behavior treatment plan. DWIHN did not have the FBA code set up for psychologists to use when they complete FBAs. Based on the MDHHS requirements, DWIHN has prepared the bulletin guidelines for the network on the appropriate use of 97151 (Replacement of FA-H0031) for nonbeneficiaries of the Hab & Children's Waivers. The FBA bulletin

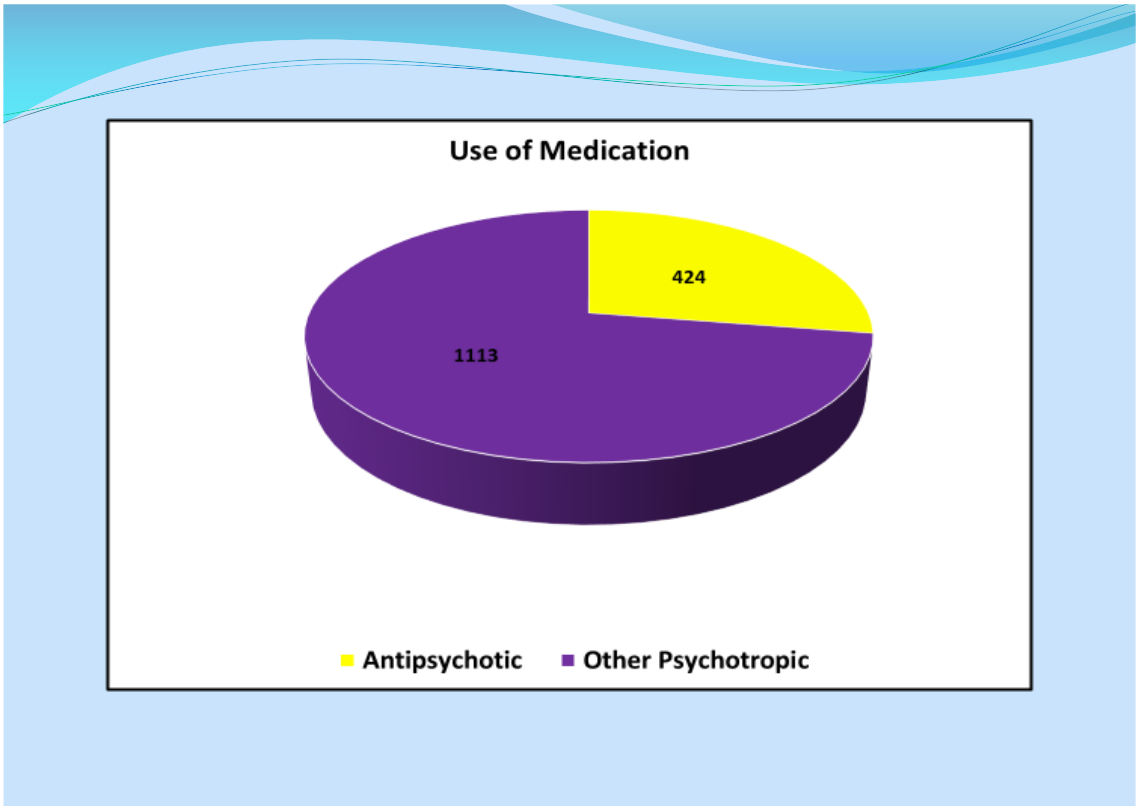
*Data included in this report is from January 1-March 31, 2023.

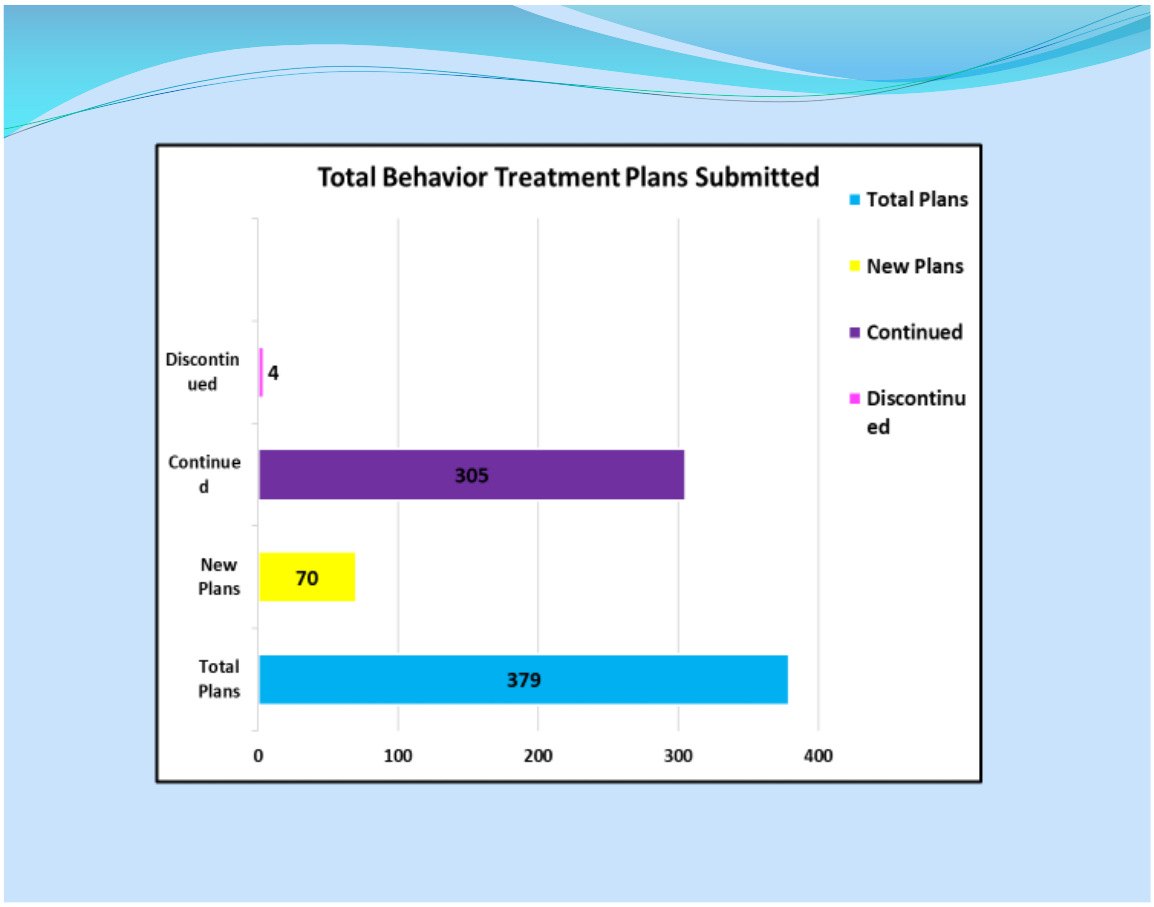
has been published on DWIHN website and has been sent to the network providers effective January 1, 2023.

Methodology:

- Network BTPRCs review each of the Restrictive and Intrusive Interventions before approving them for 90 days.
- PIHP Office of Recipient Rights representatives attend network BTPRC meetings as ex-officio that only the techniques permitted by MDHHS Technical Requirements are approved.
- BTPRC data includes the number of interventions and time (Duration of approval is 90 days).
- Most BTPs overlap in the use of Restrictive and Intrusive Interventions.
- This report is based on the data spreadsheets submitted by the BTPRCs of the following providers:
  - Community Living Services, Inc.
  - Development Center.
  - The Children's Center.
  - The Guidance Center.
  - Team Wellness Center.
  - Neighborhood Service Organization
  - Easterseals-MORC, Inc.
  - PsyGenics, Inc.
  - Wayne Center.

*Data included in this report is from January 1-March 31, 2023.





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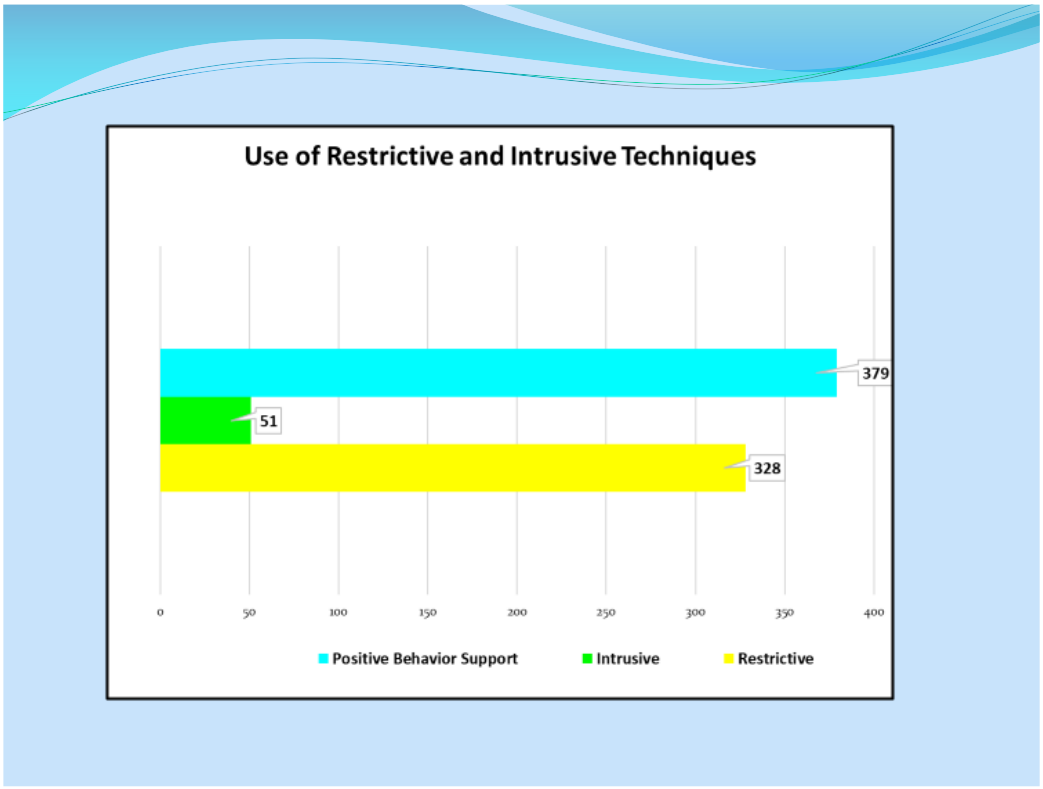
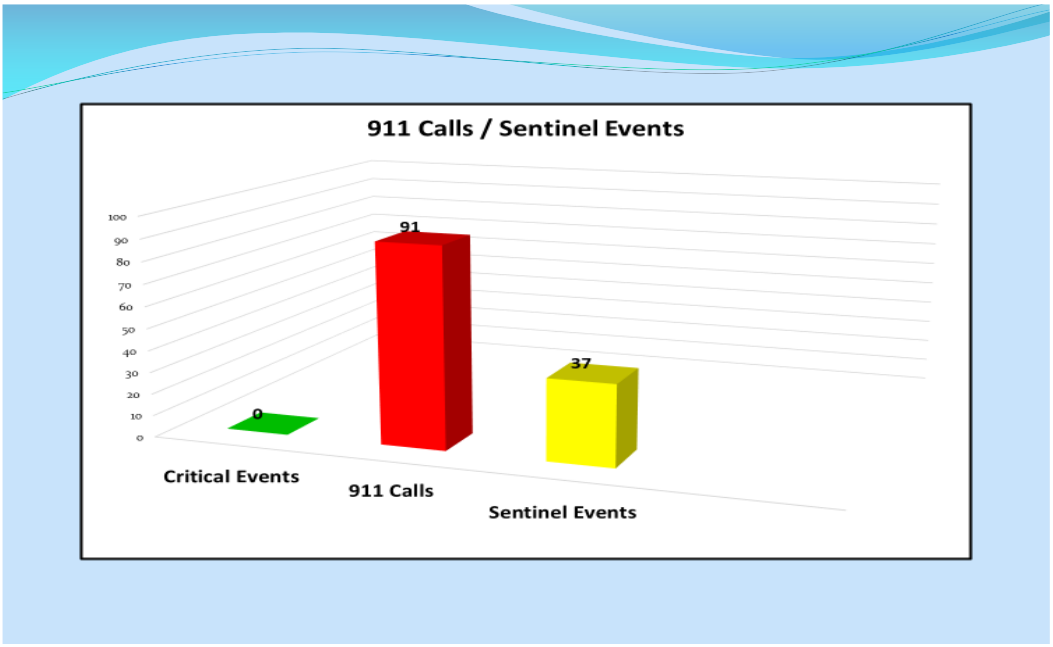




*Data included in this report is from January 1-March 31, 2023.

Quantitative Report of Each BTPRC for the Second Quarter:

Community Living Services, Inc. (CLS) BTPRC
Total: 232 New:0 Continued: 231 Dis: 1 Defered:0
Restrictive: 231 Intrusive:0
911 Calls: 63 SE/CE: 20

The Development Center, Inc. BTPRC
Total: 1 New: 0 Continued: 1 Dis: 0 Defered:0
Restrictive: 1 Intrusive:
911 Calls: 0 SE/CE: 0

The Children Center (TCC) BTPRC
Total: 2 New: 0 Continued: 2 Dis: 0 Defered:0
Restrictive: 2 Intrusive: 0
911 Calls: 0 SE/CE: 0

The Guidance Center (TGC) BTPRC
Total: 13 New: 2 Continued: 11 Dis: 0 Defered:0
Restrictive: 2 Intrusive: 11
911 Calls: 01 SE/CE: 0

Teams Wellness Center (TWC) BTPRC
Total: 11 New: 0 Continued:11 Dis: 0 Defered:0
Restrictive: 11 Intrusive: 0
911 Calls: 0 SE/CE: 0

Neighborhood Services Organization (NSO) BTPRC
Total: 9 New: 9 Continued: 0 Dis: 0 Defered:0
Restrictive: 9 Intrusive: 0
911 Calls: 0 SE/CE:0

MORC-Easterseals BTPRC
Total: 39 New: 2 Continued: 36 Dis: 1 Defered:0
Restrictive: 18 Intrusive: 8
911 Calls: 16 SE/CE: 16

PsyGenics BTPRC
Total: 8 New: 3 Continued: 5 Dis: 0 Defered:0
Restrictive: 3 Intrusive: 5
911 Calls: 1 SE/CE: 0

Wayne Center BTPRC
Total: 64 New: 54 Continued: 8 Dis: 1 Defered:1
Restrictive: 60 Intrusive: 2
911 Calls: 10 SE/CE: 1

*Data included in this report is from January 1-March 31, 2023.

Trends and Patterns:

There is an improvement in the trend of under-reporting of 911 calls. The PIHP is making progress on the systemic issue of under-reporting and tracking 911 calls. There were **twenty-two 911 calls reported in Q1(FY 2023), whereas ninety-one 911 calls were reported in Q2 as part of the BTPRC required data.** DWIHN continues to work with network BT providers to address this issue.

The network BTPRCs have an electronic health record system that is not patched with the DWIHN PCE system (MHWIN), one of the barriers to reporting 911 calls and other reportable categories of the events.

Shortage of the clinical staff with MDHHS required credentials for BTPRC review continues to be a challenge.

The QPI staff continues to work with the network BTPRCs at the Clinically Responsible Service Provider (CRSP) level to provide technical assistance on MDHHS Technical Requirements of BTPRC.

Recommendations:

- The Behavior Treatment category was made live in the Sentinel Events Reporting module to improve the systemic under-reporting of Behavior Treatment beneficiaries' required data, including 911 Calls, Deaths, Emergency Treatment, and Use of Physical Management. Network BTPRCs electronic data should be patched into the PIHP PCE system (MHWIN) to improve the systemic under-reporting of Behavior Treatment beneficiaries' required data.

- As appropriate, there are recommendations to increase training for network providers on the Technical Requirements of Behavior Treatment Plans and supervision.
- Additional clinical staff with MDHHS required credentials for BTPRC review continues to be a challenge. Additional clinical staff will help to ensure compliance with BTPRC Technical Requirements.
- Continuation of Case Validation Reviews of randomly selected cases is recommended as a step towards continuous quality improvement at the PIHP level.

CRITICAL/SENTINEL EVENT – PERFORMANCE IMPROVEMENT DATA

FY 2022/2023 - Second Quarter Report

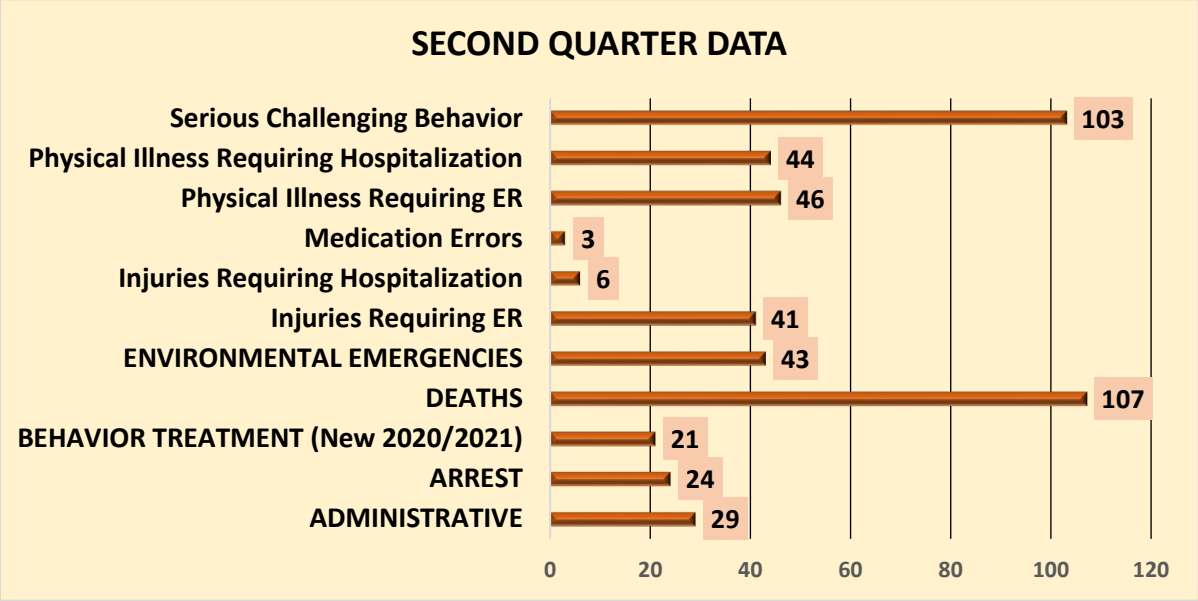
This report contains information for all areas monitored by DWIHN Quality Performance Improvement staff and includes all MDHHS reportable categories.

AGGREGATE DATA COMPARISON – QUARTER 1 AND 2:

Meeting Notes QOTAW June 28 202 QUANTITATIVE DATA BY CATEGORY	1ST QUARTER 10/1/2022 – 12/31/2022	2ND QUARTER 1/1/2023 – 3/31/2023
ADMINISTRATIVE	22	29
ARREST	2	24
BEHAVIOR TREATMENT (New 2020/2021)	17	21
DEATHS	92	107
ENVIRONMENTAL EMERGENCIES	4	43
Injuries Requiring ER	32	41
Injuries Requiring Hospitalization	11	6
Medication Errors	4	3
Physical Illness Requiring ER	31	46
Physical Illness Requiring Hospitalization	34	44
Serious Challenging Behavior	79	103
TOTAL # of reported Critical/Sentinel Events	328	467*

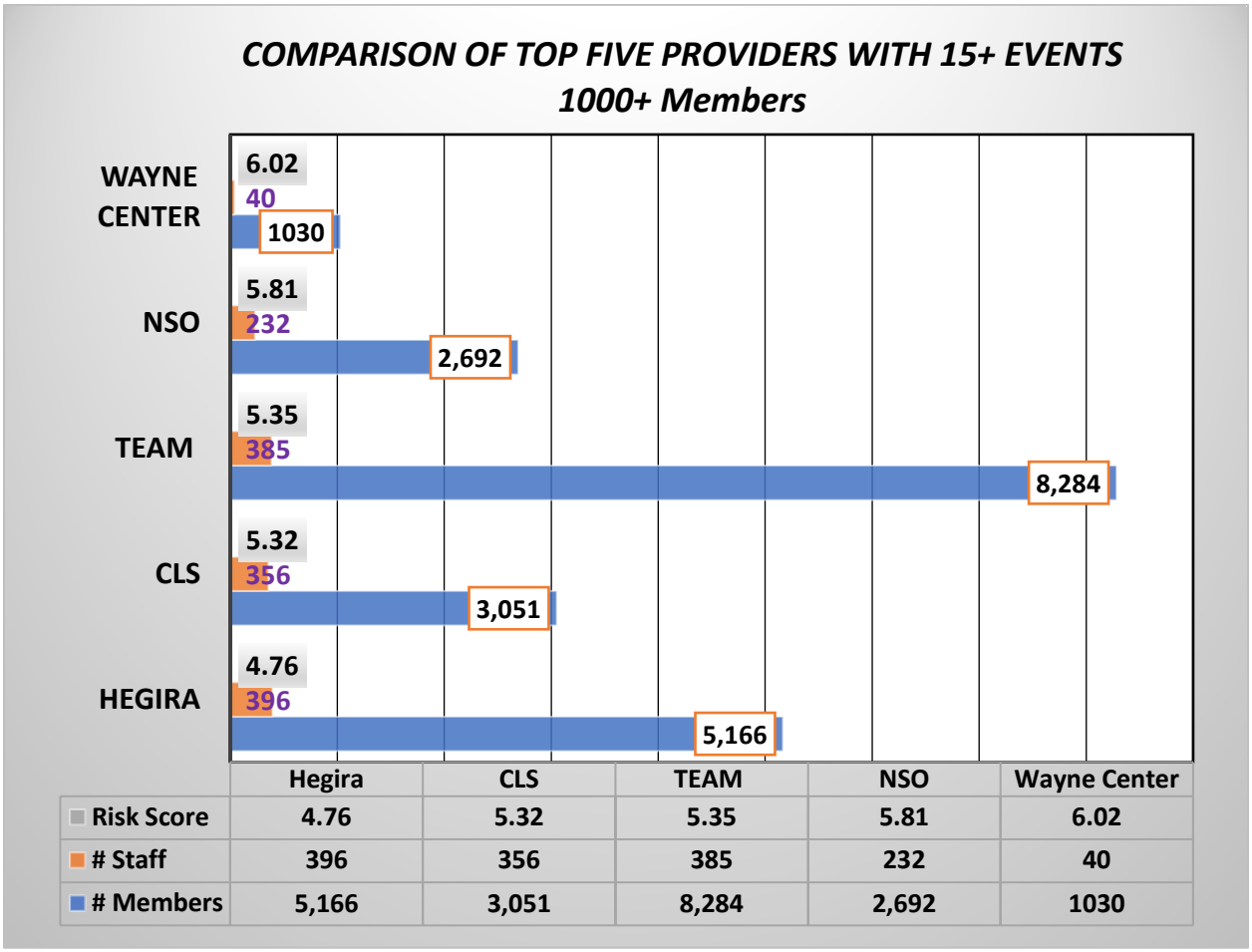
Total is 466 (1 event attributed to "John Doe" test subject)

2ND QUARTER AGGREGATE CHART OF EVENTS:



QUANTITATIVE SECOND QUARTER REPORT:

- **466 Critical/Sentinel Events** were reported and filed during the second quarter FY 2022/2023. (1 REPORT is a Test Case entered by QPIT*)
- **39 cases** have completed the first level of **Peer Review** by the QPI team and documents have been requested from the CRSP to forward those cases to the Sentinel Event **Peer Review Committee**.
- **327 cases still need information** submitted from the CRSP in order to meet the review requirements of HSAG, MDHHS, and NCQA review.
- **78 cases** have been closed after reviewing.
- **4 cases** require further action
- **15 cases** do not meet the criteria and should not have been entered
- **4 cases** have not yet been reviewed



	Hegira	CLS	TEAM	NSO	Wayne Center
Risk Score	4.76	5.32	5.35	5.81	6.02
# Staff	396	356	385	232	40
# Members	5,166	3,051	8,284	2,692	1030

Populations Served (NOTE: This section of the report was gathered from member specific events. Details of member specific information is protected under HIPPA**)**

- **Hegira:** SMI; Dual Diagnosis; SUD, ACT Program
- **Community Living Services (CLS):** Medically fragile, I/DD; Behavior Treatment
- **TEAM:** Homeless, SUD, Dual Diagnosis, SMI
- **Neighborhood Service Organization (NSO):** Medically Fragile; Older Population
- **Wayne Center:** Medically Fragile/High Risk Older Population; I/DD; Behavior Treatment

Upon review of these top five providers and the populations served reveals the following systemic trends and patterns:

Wayne Center, although serving a smaller population provides for members with higher needs resulting in a high number of events during the quarter. Trends within this provider included direct care staff not being trained on the IPOS or on how to utilize specialized adaptive equipment required to safely assist a member. There were 31 events resulting in hospital visits or serious behavior issues that may have been avoided with appropriate levels of training and

supports. This has been addressed with the leadership and is being monitoring through the Critical Event system; Quality Monitoring System, and Performance Indicators. Additional involvement of the Behavior Treatment team both at the provider level and DWIHN Behavior Treatment Committee/Staff level.

Wayne Center (57 Total Events/ 53 Unduplicated)

TOTAL # Members Served 1030/40 staff; member:staff ratio 25.75. Risk score 6.02

- 4 – Administrative
- 16 – Behavior Treatment
    - 12 - 911 Calls
    - 4 – Emergency Hospitalization
- 5 – Deaths
    - 1 – Pending (Medical Examiner Report)
    - 4 – Unknown (Need Death Certificate)
- 14- Environmental Emergency
    - 1 – Bed Bugs
    - 1 – Fire
    - 12 – Power Outage
- 7 – Injuries Requiring Emergency Room
    - - 1 Assault
    - 6 – Injury
- 6 – Physical Illness Requiring Emergency Room
    - 1 – Admitted
    - 5 – Released
    - 3 – Physical Illness Requiring Hospitalization
        - 3 – Admitted
- 2 – Serious Challenging Behavior
- 2 - Behavior

CLS serves a similar population to Wayne Center which had very similar trends/patterns of events. In the case of the provider, services are rendered through a contractual provider who has failed to keep coordination of care information up-to-date; training to Behavior Treatment Plans is inconsistent and sometimes missing. Behavior Treatment Plans are often not explained or modeled for all staff providing care as required by MDHHS regulations. As a result, technical assistance to both the provider and the contracted services agency has been provided. Close monitoring occurs through the Quality Performance Improvement Team Critical/Sentinel Event Peer Review, Behavior Treatment Committee. Quality Monitoring Audit Team, Performance Indicators, Managed Care Operations (contracts), and Credentialing as appropriate.

Community Living Services (CLS – 92 total events – 82 unduplicated members)

3,051 members – 356 staff; 8.57 member:staff ratio. Risk score 5.32

- 20 Injuries Requiring Emergency Room
  - 4 members with injuries 1 with repeat injury (1-member deceased)
- 1 Injuries requiring Hospitalization
- 24 Environmental Emergency
  - 23 Power Outage
  - 1 Fire
- 17 Deaths
  - 15 Pending
  - 1 Unknown
- 12 Administrative
  - 2 Illegal Activity
  - 9 Alleged Abuse/Neglect
  - 1 Exploitation
- 2 Medication Error
- 3 Behavior Treatment
- 9 Physical Illness requiring Hospitalization
- 4 Seriously Challenging Behavior (Risk Events)

TEAM delivers services to both behavioral health and SUD populations. This provider also has several locations throughout Wayne County. During this second quarter review several trends/patterns were addressed that included staff inconsistencies with training or licensure to provide specific services to the members they were assigned. Failure to have appropriate training to the IPOS or other plans within the members treatment protocols. Technical assistance and monitoring in collaboration with the management and clinical teams has resulted in less incidents thus far. DWIHN Clinical Department has provided additional training to all staff on the IPOS and other required clinical protocols, Quality Performance Improvement Team has offered and provided additional training on Critical/Sentinel Events; Quality Performance Indicator staff has continued to monitor other aspects of hospitalizations, etc.; and Managed Care Operations continues to monitor contractual obligations. Through these collaborative efforts continuous quality improvement is improving.

Team Mental Health Services, Inc. (49 Total Events/ 45 Unduplicated)
8,284 total members/385 staff – 21.52 member:staff ratio
Risk Score: 5.35

- 1 – Administrative (Alleged Neglect/Abuse)

- 7 – Arrest of Recipient
  - 3 - Arrests
  - 3 - Assaults
  - 1 - Violation of Probation
- 1 – Behavior Treatment
  - 1- Use of Physical Management
- 14- Death of Recipient
  - 5- Pending (Need Medical Examiner Report)
  - 1 – Suspected Overdose
  - 8 – Unknown (Need Death Certificate)
- 1 – Injury requiring Hospitalization
  - 1- Injury
- 4 – Physical illness Requiring Emergency Room
  - 1 – Admitted
  - 3 - released
- 4 – Physical illness Requiring Hospitalization
  - 1 – physical health reason
  - 2 – Seizure Disorder
  - 1 – stroke
- 17- Serious Challenging Behavior
  - 1 – Assault
  - 1 – Assault on another member
  - 1 – Assault on staff
  - 4 - Behavior
  - 7 – Requiring Inpatient Hospitalization
  - 1 – Suicide Attempt
- 1 – ULOA

Neighborhood Service Organization (NSO) provides services to medically fragile, serious mentally ill, older population prone to falls among other chronic physical health related issues. During this quarter the trend of hospital visits and emergencies continues. Pinpointing specific remediation has remained difficult in spite of on-going communication since documentation from hospitals and doctors' visits has not been made available for review. This issue continues to be handled through Quality Management meetings with NSO leadership. It must be noted that the timely reporting of events does occur; however, the Quality Performance Improvement team continues to focus on receiving information from hospital interactions that will allow for remediation to occur from a collaborative effort between the provider and DWIHN supports.

Neighborhood Service Organization (37 Total Events/34 unduplicated)

2,692 members/232 staff – 11.60 member:staff ratio. Risk score 5.81

- 7 – Deaths
  - 1 – Pending Medical Examiner Report
  - 7 – Unknown – need Death Certificate
- 3 – Injuries Requiring Emergency Room
  - 1 – Assault
  - 2 – Injury
- 22 – Physical illness requiring Emergency Room
  - 2 – COVID-19
  - 20 – Released
- 5 – Physical Illness Requiring Hospitalization
  - 2 COVID – 19
  - 1 – STROKE
  - 1 – Respiratory
- 1 – Physical Illness

Hegira provides services to dually diagnosed, SUD only, ACT members, Crisis Center, Outpatient, and residential members. During this second quarter review period, staff specific training and licensure in several instances was not sufficient to meet the standard of care required for the member. As a result, in the case of the suicide, in particular, the staff did not have a SUD credential to appropriately address the member's need for substance abuse treatment. Technical assistance and collaborative meetings were held with management and clinical staff which should lead to improvement in service delivery and development in the IPOS for SUD and dually diagnosed members.

Hegira – 9 Divisions (Total 40 unduplicated Events: AOP -15; COS-3; Health-7; ACT -2; LPOP/CLINIC -5; Oakdale MI/I/DD-1; Recovery-2; Taylor OP/HSB-4; COPE -1) 5,166 total members/396 staff – 13.05 member:staff ratio. Risk Score 4.76

- 3- Arrests
- 16 – Deaths
  - 1 – Suicide
  - 1 – COVID 19
  - 5 – Pending ME Report

- 9 – Unknown – need Death Certificate

➢ 2 – Environmental Emergency
- 1- Bed Bug
- 1 – Water Leak

➢ 1 – Injury requiring Emergency Room

➢ 3 – Physical Illness Requiring Emergency Room

➢ 15 - Serious Challenging Behavior (Risk Events)
- 2 – Assault
- 1- Assault on staff
- 3 – Requiring Inpatient Hospitalization
- 8 – Suicide Attempts

2nd QUARTER CRSPs Reported Events	# of Events Reported
Abundant Community	7
Adult Well Being	2
Arab-American & Chaldean Council (Acc)	17
Beginning Step, Inc.	3
Black Family Development, Inc.	3
Central City Integrated Health (CCIH)	4
CNS Healthcare	7
Community Living Services	92
Development Centers, Inc.	17
Goodwill Industries of Greater Detroit	4
Hegira - Hegira Adult Outpatient Services	15
Hegira COS	3
Hegira Health, Inc.	7
Hegira House ACT	2
Hegira-- Lincoln Park Outpatient Services & UBH Clinic	5
Hegira Oakdale House - MI, I/DD	1
Hegira Oakdale Recovery Center	2
Hegira-- Taylor Outpatient, Home & School Based Services	4
Hegira--COPE	1
LBS Redford ACT Program	1
Lincoln Behavioral Services Inc.	25
Macomb-Oakland Regional Center, Inc.	2
Metro East Harper/Chalmers Clinic	13
Neighborhood Service Organization	37
PsyGenics-Dearborn	5
PsyGenics-Trenton	1
PsyGenics-W.Outer Drive	5

Services To Enhance Potential - Dearborn North Resource Center	**5**
Spectrum Community Services, Inc.	**1**
Starfish Family Services-Michigan	**10**
Starfish Family Services - Lifespan Clinical Programs	**16**
Starfish Family Services, Inc.	**2**
Starfish Lifespan Westland Clinic	**5**
Team Mental Health Services - Jefferson	**1**
Team Mental Health Services, Inc - Main Office	**48**
The Children's Center of Wayne County	**6**
The Guidance Center	**30**
Wayne Center	**57**
TOTAL	**466**

****One report from data for John Doe – Test/Training example = 467***

The number of events does not depict the number of members involved; however, it represents the number of times an event occurred. Specific members and events information are protected by the Mental Health Code and cannot be subpoenaed or reviewed outside of the Peer Review Process.

QUALITATIVE REPORT

Trends and Patterns

During the **second quarter** (January through March), the QPI team met with the Risk Management Committee to examine methods to review events that would contribute to understanding risk from a preventable and non-preventable standard. As a result, during this quarter, the QPI team began to collect data when closing events making the determination of preventable vs non-preventable events.

The ***definition for preventable events*** classification is as follows:
"An event deemed avoidable based on review of all documentation including Plan of Care, treatment provided in accordance with standard of care and scope of services by the CRSP, DWIHN Internal departments, and all other related to the case, including DWIHN Peer Review Committee. This includes all events with deficits in service." The ability to track this information has been added to the Critical/Sentinel Event module in MH-WIN by the IT Department.

Overall ***systemic trends and patterns*** continue to uncover:

- staff shortages (a national trend) both in outpatient and residential settings;
- high caseloads;
- lack of appropriate training to implement members IPOS as written;
- failure of IPOS to capture some of the most critical needs expressed by the member during the initial assessment process – specifically dually diagnosed SUD/MH members;
- Staff Burnout; stress; anxiety
- Where there are a higher number of members with complex medical/behavioral diagnosis there are the highest number of member events.
- There continues to be an ***upward trend*** in Serious Challenging Behaviors often related to standard of care provided by clinicians new in the field of practice or direct care workers who could benefit from more intensive training

The additional trends identified in the first quarter continue with some improvement. This quarter, the QPI team met with the Credentialing Department to discuss on-going reporting of staff providing services with inappropriate and/or expired credentials that will assist in ensuring appropriate standard of care.

Recommendations for remediation/elimination:

- Ongoing activities include DWIHN continuation to solicit and hire new staff and provide referrals and support to DWIHN staff as appropriate and requested;
- DWIHN staff encourages all providers to give support to their staff and has advocated for additional funding on behalf of the provider network to raise the salaries of their staff
- Technical Assistance to the provider network (CRSP) by Quality and other departments supporting high level review and recommendations for member treatment
- Development of additional DWIHN Department oversight including Risk Matrix discussions and evaluations on a daily/monthly basis to assist providers in identifying and rectifying levels of care and treatment protocols
- Updating and development of interim assessments (I.e. Fall Risk assessment and Protocols; IPOS training; Critical/Sentinel Event Training; Behavior Treatment reviews, Med Drop, Performance Indicator interventions for hospitalizations, etc.)
- Monthly technical assistance for identified providers addressing systemic issues identified through Quality reviews and monitoring
- Intra-departmental collaborations occur during Critical/Sentinel Event initial reviews as appropriate with:
    - Credentialing, to identify staffing licensure/training concerns and implement remedial plans timelier;

- CRSP provider management (including executive leadership as appropriate);
- Residential Provider education through monthly meetings and technical assistance as appropriate; and close collaboration with Quality Monitors and Quality Performance Improvement staff for on-going oversite.

All other recommendations from first quarter remain in effect along with all HSAG corrective action plan improvements that are monitored during regular clinical reviews at the CRSP level and through (1) Quality Monitoring Audits; and (2) Performance Indicator Technical Assistance meetings