Quality Operations Technical Assistance Workgroup Meeting Agenda
Wednesday, October 25, 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	
	✚ Services Suited To Condition-Least Restrictive Setting	P. McCalister
	✚ PHQ-A and PHQ-9 Guidelines	A. Gabridge
	✚ Quality Improvement Oversight and Monitoring	D. Dobija

V. QAPIP Effectiveness

Integrated Health

a. ***Performance Improvement Projects (Update)*** — A. Oliver

- AMM Antidepressant Medication Management
- FUH-Follow up After Hospitalization
- SSD-Diabetes Screening for People with Schizophrenia or Bipolar Disorder
- HCV RNA

Quality Improvement

b. HSAG Compliance Review SFY2023 — T. Greason

c. Updates on Training Dates for FY 2023/2024 — M. Lindsey

d. Documentation submission Dates — S. Applewhite

e. HCBS Updates — D. Dobija

- 2020 HCBS Survey Remediation/Validation project
- Ongoing HCBS monitoring

VI. Adjournment

Quality Operations Technical Assistance Workgroup Meeting Agenda
Wednesday, October 25, 2023
Via Zoom Link Platform
9:30 a.m. – 11:30 a.m.
Note Taker: DeJa Jackson

1) **Item: Announcements:**
   - A reminder was provided regarding DWIHN's transportation agreement with two vendors, Mariners and GodSpeed. This is a piolet program in which members and providers can set up non-emergency transportation services. Please review our website for more information.
   - There is a total of six (6) staff members at DWIHN that are retiring by the end of this year: Annette A. 19 years, Dean B. 30 years, Dorothy H. 19 years, Ann M. 38 years, Karen K. 26 years, Esther T. 33 years. Congratulations and best wishes were provided.

2) **Item: Substance Use Disorder (SUD) – Gregory Lindsey**

Goal: Updates from SUD (Tabled)

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 SUD.		
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**
No provider feedback.		
Action Items	**Assigned To**	**Deadline**
None		

4) Item: DWIHN Policies

Goal: Services Suited To Condition-Least Restrictive Setting

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

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

Discussion		
Polly McCallister, Director of Recipient Rights shared the following updates with the group for the Services Suited To Condition-Least Restrictive Setting Policy: It is the policy of the Detroit Wayne Integrated Health Network (DWIHN) that each recipient of DWIHN-contracted services shall receive services suited to his/her condition in the least restrictive setting. Those services shall be determined in partnership with the recipient through a person-centered planning process. The policy is intended to t provide direction to ensure that each recipient of DWIHN-contracted services receives services suited to his/her condition in the least restrictive setting. Polly discussed with the workgroup the 330.1708 Suitable services; treatment environment; setting; rights. Sec. 708 which outlines the following: ○ A recipient shall receive mental health services suited to his or her condition. ○ Mental health services shall be provided in a safe, sanitary, and humane treatment environment. ○ Mental health services shall be offered in the least restrictive setting that is appropriate and available. ○ A recipient has the right to be treated with dignity and respect. Please review the attached "Services Suited Presentation" for additional information.		
Provider Feedback	**Assigned To**	**Deadline**
No Provider Feedback.		
Action Items	**Assigned To**	**Deadline**
None Required.		

4) Item: DWIHN Policies
Goal: PHQ-A and PHQ-9 Guidelines
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems ☐ Quality ☐ Workforce
NCQA Standard(s)/Element #: QI ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Discussion		
Alison Gabridge, Manager of Clinical Practice Improvement provided the following updates for the PHQ-A and PHQ-9 Guidelines. It is the purpose of Detroit Wayne Integrated Health Network (DWIHN) to provide evidence-based practices to improve the lives of the people and families who live in the Detroit Wayne County area. To that end, DWIHN will implement the utilization of the PHQ-9 and PHQ-A (version of the PHQ-9 for adolescents) for screening, as well as monitoring treatment outcomes. DWIHN expects the goal of clinicians to treat depression to remission, and tools such as the PHQ-9 and PHQ-A can assist clinicians and those they serve monitor the target symptoms and overall progress in treatment. Alison explained the expected outcome for each guideline: ○ PHQ-9 ○ Adults aged 18 and older for specialty behavioral healthcare populations will have a PHQ-9 screening completed at intake and at time of re-assessment and/or at least annually. Consumers who present with a PHQ-9 score greater than or equal to 10 must have their PHQ-9 scores measured and documented at least quarterly. The consumer's score will drive their therapeutic interventions. ○ PHQ-A ○ Youth ages 11-17 for specialty behavioral healthcare populations will have a PHQ-A screening completed at intake and at time of re-assessment and/or at least annually. Youth who present with a PHQ-A score of 10 or higher must have the PHQ-A re-administered and scores documented at least quarterly. The youth's score will drive therapeutic interventions.		
Provider Feedback	**Assigned To**	**Deadline**
No Provider Feedback was Provided.		
Action Items	**Assigned To**	**Deadline**
None Required.		

4) Item: DWIHN Policies

Goal: Quality Improvement Oversight and Monitoring

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, provided the following updates to the work group for the Quality Improvement Oversight and Monitoring Policy. The purpose of this policy is to provide procedural and operational guidance to DWIHN, the Access Center, the Crisis Service Vendors, Contractual staff, Network and Out of Network Providers, enrollees/ members and all staff involved in the delivery of covered services to assure all eligible Wayne County residents are receiving the medically necessary and clinically appropriate services for mental health issues, substance disorders and/or developmental disabilities. In addition, these services must conform to accepted standards of care directed at achieving the members' desired goals and improving outcomes. This policy serves the following populations: Adults, Children, Individuals with Intellectual and/ or Developmental Disabilities (I/DD), SMI, Serious Emotional Disturbance (SED), Substance Use Disorder (SUD), Autism and MI-Health Link		
Provider Feedback	**Assigned To**	**Deadline**
No Provider Feedback.		
Action Items	**Assigned To**	**Deadline**
None Required		

5) Item: QAPIP Effectiveness – Integrated Health

Goal: Performance Improvement Projects (Update)

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

NCQA Standard(s)/Element #: QI 10 CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Discussion		
Alicia Oliver, Clinical Specialist OBRA/PASRR discussed and provided updates for the following Performance Improvement Projects (PIP's): • AMM Antidepressant Medication Management (Measurement period, rate of results, & Comparison Goal) Effective Acute Phase Treatment: Adults who remained on an antidepressant medication for at least 84 days (12 weeks). • AMM Antidepressant Medication Management (Measurement period, rate of results, & Comparison Goal) Effective Continuation Phase Treatment: Adults who remained on an antidepressant medication for at least 180 days (6 months). • FUH-Follow up after Hospitalization 30 days ages 6-17 (Measurement period, rate of results, comparison benchmark) • FUH-Follow up after Hospitalization 30 days ages 18-64 (Measurement period, rate of results, comparison benchmark) • FUH-Follow up after Hospitalization 30 days ages 65+ (Measurement period, rate of results, comparison benchmark) • FUH-Follow up after Hospitalization 7 days ages 6-17 (Measurement period, rate of results, comparison benchmark) • FUH-Follow up after Hospitalization 7 days ages 18-64 (Measurement period, rate of results, comparison benchmark) • FUH-Follow up after Hospitalization 7 days ages 65+ (Measurement period, rate of results, comparison benchmark) • SAA – Adherence to Antipsychotic Medications for individuals with Schizophrenia (Measurement period, rate of results, comparison benchmarks) • SSD – Diabetes Screening for people with Schizophrenia of Bipolar Disorder (Measurement period, rate of results, comparison benchmarks) • HCV RNA test results: 2020 rate of results, 2021 rate of results, and 2022 rate of results. Please refer to the handout "QISC October PIP Summary" for more information.		

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

5) Item: QAPIP Effectiveness – Quality Improvement
Goal: HSAG Compliance Review SFY2023

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

Discussion		
Tania Greason, QI Administrator, shared the following updates for the HSAG (EQR) reviews. MDHHS contracts with Health Services Advisory Group (HSAG) to complete external quality reviews (EQR). The HSAG Compliance review is a review that is over a three (3) year period. For this current cycle, the DWIHN was reviewed during FY2021 for standards one through six, the second year was FY2022 where we were reviewed for standards seven through thirteen and then the final year FY2023 HSAG reviewed our implementation of any Corrective Action Plans required from FY2021 and FY2022. The remote review for FY2023 was conducted in August. DWIHN's results demonstrate that we corrected 33 out of the 35 noted deficiencies. The two citations were a system issue for the API and Provider information in which all the PIHP's are working with MDHS to resolve. DWIHN did not have to have to participate in a Technical Advisory (TA) session with the HSAG. During FY2024 the three-year cycle review will begin and will conclude in FY2026.		
Provider Feedback	**Assigned To**	**Deadline**
No Provider Feedback.		
Action Items	**Assigned To**	**Deadline**
None Required.		

5) Item: QAPIP Effectiveness – Quality Improvement

Goal: Updates on Training Dates for FY 2023/2024

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

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

Discussion		
Sinitra Applewhite and Micah Lindsey, Provider Network Clinical Specialists, shared with the group the following updates for CE/SE reporting: • There will be a CE/SE training scheduled each month for FY2024, please see DWIHN's website, there's a direct link on the flyer to sign up. • The trainings are held on the second Thursdays through Microsoft Teams Webinar. The next training will be scheduled for November 9th. The QI team also discussed the requirements for documentation to include the following: • Documentation is required for the event within 7 business days of entering the event. • Follow-up documentation is required, if you're not able to get documentation within 7 days, please communicate that with the team and document in the CE/SE. • When filling out the critical event and sentinel event make certain to include: Who?, What?, When?, Where?.in your documentation.		
Provider Feedback	**Assigned To**	**Deadline**
No Provider Feedback.		
Action Items	**Assigned To**	**Deadline**
None Required.		

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, discussed the following with the workgroup the 2020 HCBS Survey Remediation/Validation project: • HCBS Survey was completed in 2020. Survey responses suggesting non-compliance with HCBS Final Rule must be remediated. Survey responses suggesting compliance with HCBS Final must be validated. • The team was able to filter out the survey responses for those members that were no longer receiving services from the same provider they were receiving back in 2020. This resulted in the team working with approximately 55 provider settings to remediate or validate a total of 1,063 survey responses for a total of 158 members. • The team was able to obtain evidence of remediation where needed, and they were able to verify or validate compliance. • We're going to conclude this project at the end of the month and the next steps are to submit a report to MDHHS for their review. They may or may not require additional evidence of compliance. Ongoing HCBS monitoring ○ Annual reviews of settings ○ Compressive biennial reviews of members receiving HCBS services For all HCBS questions, please contact the Contact the Quality Residential/HCBS Team: ○ HCBSInforPIHP@dwihn		
Provider Feedback	**Assigned To**	**Deadline**
No Provider Feedback.		
Action Items	**Assigned To**	**Deadline**
None Required.		

New Business Next Meeting: 01/31/24
Adjournment: 10/25/2023

DETROIT WAYNE INTEGRATED HEALTH NETWORK

800-241-4949

www.dwihn.org

Mental Health Code

- **330.1708 Suitable services; treatment environment; setting; rights.**
- Sec. 708.
- (1) A recipient shall receive mental health services suited to his or her condition.
- (2) Mental health services shall be provided in a safe, sanitary, and humane treatment environment.
- (3) Mental health services shall be offered in the least restrictive setting that is appropriate and available.
- (4) A recipient has the right to be treated with dignity and respect.
-

Services Suited to Condition In the Least Restrictive Setting

- What does services suited to condition in the least restrictive setting mean?
- It encompassing the Person-Centered philosophy, that a recipient is entitled to treatment suitable to his or her own condition, medical care, and medication for mental and physical health, as needed.
- How are the services determined ?
- The services shall be determined in partnership with the recipient through a person-centered planning process…. The IPOS…….

Least Restrictive Setting …..

- Least Restrictive setting could include the concept of the continuum from the most restrictive to least restrictive;
- Such as, a State Facility to a Psychiatric Hospital to a Specialized Residential to a regular AFC home toa Supported Independent Living (SIL) to a Self-Determined residence to Independent Living (living on their own)

The IPOS

- Shall identify the needs and goals of the recipient as well as the medical necessity, the amount, duration and scope of services and supports that need to be provided
- For example, if the recipient displays challenging behavior, there shall be a comprehensive assessment regarding the recipient behaviors
- Any restrictions, limitations or any intrusive behavior treatment techniques shall be reviewed by a formal committee of mental health professionals with specific knowledge and training
- Each IPOS shall have specific dates and plans outlined and will be reviewed whenever a modification or revisions occurs

IPOS

- The recipient can request persons be excluded for the planning process only if the inclusion of that person would constitute a substantial risk of physical or mental harm to the recipient
- or if it causes a disruption of the planning process to the recipient
- The IPOS must reflect that the recipient selected where they want to reside

IPOS

- Recipients shall be informed orally and in writing of his or her clinical status or progress at reasonable internals established in the IPOS
- If a recipient is not satisfied with his or her IPOS, the recipient, the guardian or the person making decisions about the plan or the parent with legal custody of a minor may request for a review of the plan to request the necessary changes.
- Any exclusion of personal property shall be written and posted in each setting. Additional limitations may be imposed in the recipient's plan of service.
- The review shall be completed within 30 days

Please follow the orders of ……

- The Medical Doctors
- Nurse Practitioners
- Physician Assistants
- Physical Therapist
- Which includes the treatment **order** and
- Services authorized in the IPOS

Examples of Services Suited to Condition Violations

- Not giving the recipient a choice of physician or other mental health professionals
- A recipient plan states they will see their therapist 2 times a week but does not
- A recipient is supposed to have 1:1 staffing however who does not receive it

- **For example, PER IPOS**: The recipient is supposed to have 24 hours Personal Supports per day for health and safety reasons, however the one staff is shared with 3 other recipients.
- A recipient is supposed to have only liquid meals however the recipient is given peanut butter

Examples of Services Suited to condition violations

- A recipient needs to take medication with food, however there is never enough food when it is time to take his medication
- The setting is not physically accessible to the individual.
- The recipient requires assistance with bathing or going to the bathroom and does not receive it
- A recipients food is supposed to be chopped up and it is not

The End

DETROIT WAYNE INTEGRATED HEALTH NETWORK

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Performance improvement Plan Rate of Results

AMM Antidepressant Medication Management

Effective **Acute Phase** Treatment	**Measurement Period** 2020	**Rate of Results** 26.94%	**Comparison Goal** 77.32%
Effective **Acute Phase** Treatment	2021	41.28%	77.32%
Effective **Acute Phase** Treatment	2022	35.55%	77.32%

- *Effective Acute Phase Treatment*: Adults who remained on an antidepressant medication for at least 84 days (12 weeks).

Performance improvement Plan Rate of Results

AMM Antidepressant Medication Management

Effective **Continuation Phase** Treatment	**Measurement Period** 2020	**Rate of Results** 21.66%	**Comparison Goal** 63.41%
Effective **Continuation Phase** Treatment	2021	13.36%	63.41%
Effective **Continuation Phase** Treatment	2022	12.5%	63.41%

- *Effective Continuation Phase Treatment:* Adults who remained on an antidepressant medication for at least 180 days (6 months).

Performance Improvement Plan Rate of Results

FUH-Follow up After Hospitalization 30 days ages 6-17

30 day Follow up After Hospitalization for Mental Illness Age 6-17	**Measurement Period** 2020	**Rate of Results** 62.96%	**Comparison Benchmark** 70%
30 day Follow up After Hospitalization for Mental Illness Age 6-17	2021	66.32%	70%
30 day Follow up After Hospitalization for Mental Illness Age 6-17	2022	67.99%	70%

Performance Improvement Plan Rate of Results

FUH-Follow up After Hospitalization 30 days ages 18-64

30 day Follow up After Hospitalization for Mental Illness Age 18-64	**Measurement Period** 2020	**Rate of Results** 48.74%	**Comparison Benchmark** 58%
30 day Follow up After Hospitalization for Mental Illness Age 18-64	2021	46.67%	58%
30 day Follow up After Hospitalization for Mental Illness Age 18-64	2022	50.81%	58%

Performance Improvement Plan Rate of Results

FUH-Follow up After Hospitalization 30 days agers 65+

30 day Follow up After Hospitalization for Mental Illness Age 65+	**Measurement Period** 2020	**Rate of Results** 27.37%	**Comparison Benchmark** 58%
30 day Follow up After Hospitalization for Mental Illness Age 65+	2021	22.58%	58%
30 day Follow up After Hospitalization for Mental Illness Age 65+	2022	36.36%	58%

Performance Improvement Plan Rate of Results

FUH-Follow up After Hospitalization 7 days ages 6-17

7 day Follow up After Hospitalization Ages 6-17	**Measurement Period** 2020	**Rate of Results** 41.33%	**Comparison Benchmark** 70%
7 day Follow up After Hospitalization Ages 6-17	2021	44.14%	70%
7 day Follow up After Hospitalization Ages 6-17	2022	45.70%	70%

Performance Improvement Plan Rate of Results

FUH-Follow up After Hospitalization 7 days ages 18-64

7 day Follow up After Hospitalization Ages 18-64	**Measurement Period** 2020 measurement period	**Rate of Results** 29.14%	**Comparison Benchmark** 58%
7 day Follow up After Hospitalization Ages 18-64	2021 measurement period	28.33%	58%
7 day Follow up After Hospitalization Ages 18-64	2022 measurement period	30.74%	58%

Performance Improvement Plan Rate of Results

FUH-Follow up After Hospitalization 7 days ages 65+

7 day Follow up After Hospitalization Ages 65+	**Measurement Period** 2020	**Rate of Results** 17.89%	**Comparison Benchmark** 58%
7 day Follow up After Hospitalization Ages 65+	2021	14.19%	58%
7 day Follow up After Hospitalization Ages 65+	2022	28.49%	58%

Performance Improvement Plan Rate of Results

SAA -Adherence to Antipsychotic Medications for Individuals with Schizophrenia

SAA	**Measurement Period**	**Rate of Results**	**Comparison Benchmark**
SAA	2021	46.42	85.09
SAA	2022	47.05	85.09

Performance Improvement Plan Rate of Results

SSD- Diabetes Screening for People with Schizophrenia or Bipolar Disorder

SSD	**Measurement Period** 2020	**Rate of Results** 64.38%	**Comparison Benchmark** 86.36%
SSD	2021	64.86%	86.36%
SSD	2022	70.69%	86.36%

Performance Improvement Plan Rate of Results

HCV RNA test results:
2020 rate of results average is 0.70%
DWIHN Goal 5%

Measurement Period	Measurement	Numerator	Denominator	Rate or Results
2020 Q1	***Baseline***	25	3591	0.70%
2020 Q2	***Baseline***	26	3744	0.70%
2020 Q3	***Baseline***	13	3922	0.33%
2020 Q4	***Baseline***	26	2670	0.98%

Hepatitis C is a liver infection caused by the hepatitis C virus (HCV). Hepatitis C is spread through contact with blood from an infected person. Today, most people become infected with the hepatitis C virus by sharing needles or other equipment used to prepare and inject drugs.

Performance Improvement Plan Rate of Results

HCV RNA test results:

2020 rate of result average is 0.70% in comparison to 2021 rate of result average 2.22%. This is an increase of 1.52%. DWIHN goal of 5% was not achieved.

Measurement Period	Measurement	Numerator	Denominator	Rate or Results
2021 Q1	Remeasurement 1	65	2685	2.42%
2021 Q2	Remeasurement 2	66	2911	2.26%
2021 Q3	Remeasurement 3	64	3084	2.07%
2021 Q4	Remeasurement 4	69	3250	2.12%

Performance Improvement Plan Rate of Results

HCV RNA test results:
2021 rate of result average is 2.22% in comparison to 2022 rate of result average 0.60%.
This is a decrease of 1.62%.
DWIHN goal of 5% was not achieved.

Measurement Period	Measurement	Numerator	Denominator	Rate or Results
2022 Q1	Remeasurement 5	15	3097	0.50%
2022 Q2	Remeasurement 6	19	3109	0.61%
2022 Q3	Remeasurement 7	22	3195	0.70%
2022 Q4	Remeasurement 8	20	3423	0.60%

Performance Improvement Plan Rate of Results

For all measures, quarterly scores are mailed to providers Chief Medical Officer or Chief Executive Officer.

They are asked to provide a plan of action to increase the scores.

Several providers have responded with a plan of action.

Resources

AskTheDoc@dwihn.org.

https://dwihn.org/brochures-and-handouts-DWIHN-Services.pdf

https://dwihn.org/access-mymobileapp

https://dwihn.org/health-wellness-support

https://dwihn.org/providers-HEDIS

Quality Improvement Performance Monitoring

10/25/2023

2020 Survey Remediation and Validation

HCBS Survey completed in 2020

Survey responses suggesting non-compliance with HCBS Final Rule must be remediated.

Survey responses suggesting compliance with HCBS Final Rule must be validated.

2020 Survey Remediation and Validation

THANK YOU

HCBS Compliance Ongoing Monitoring

Annual reviews of settings

Compressive biennial reviews of members receiving HCBS services

All HCBS Questions

Contact the Quality Residential/HCBS Team:

HCBSInforPIHP@dwihn.org

Critical/Sentinel Event Reporting Module Training

FY 2023/2024 Training

SECOND (2nd) THURSDAY TEAMS WEBINAR
9:00 a.m. – Noon

October 12
November 9
December 14
January 11
February 8
March14
April 11
May 9
June 13

Registration closes one (1) week prior to the webinar

PARTICIPANTS WILL NOT BE ADMITTED AFTER 9:10 A.M.
Participants camera MUST REMAIN ON for ENTIRE training

This training prepares and updates participants for the electronic submission of the Critical & Sentinel Events into the MHWIN Critical/Sentinel Event Module.

CRSP's may register a maximum of 10 staff per training. Additional training may be available based on the workload of the trainers (Request to Carla Spight Mackey, Sinitra Applewhite, or Micah Lindsey).

Registration is required. **Managers/Supervisors** must register staff by clicking on the link below and completing ALL of the information requested.

Email address MUST BE the organization email NOT personal emails.

Space is Limited to the 1st 75 participants. Wait lists will be established.

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Detroit Wayne Integrated Health Network
DWIHN
Your Link to Holistic Healthcare