Quality Operations Technical Assistance Workgroup Meeting Agenda
Wednesday, January 31, 2024
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	
	▪ UM Authorizations Procedures for MI Health Link	M. Hampton
	▪ Use of Behavior Treatment in CMH	F. Nadeem
	▪ CRSP Responsibility Procedure	J. Davis
V.	**QAPIP Effectiveness**	
	Childrens Initiatives	
	a. ***Performance Improvement Projects (Update)***	C. Phipps
	▪ Children's Metabolic Screening for Children on Antipsychotics (APM)	
	▪ Follow-Up on Children with ADHD Medication	
	▪ Improving the time for Initiation of Autism Services	
	Quality Improvement	
	b. Death Reporting Requirements	C. Spight-Mackey
	• Care Academy	
	c. CRM/MICAI Updates	M. Lindsey
	d. Documentation submission Dates	S. Applewhite
	e. CRSP Notification Forms	D. Dobija

f.	Status of MDHHS Review	D. Dobija
g.	Annual Provider Reviews	D. Dobija
h.	Quarterly Self-Monitoring Reviews	D. Dobija

VI. Adjournment

Quality Operations Technical Assistance Workgroup Meeting Agenda
Wednesday, January 31, 2024
Via Zoom Link Platform
9:30 a.m. – 11:30 a.m.
Note Taker: DeJa Jackson

1) **Item: Announcements:**
   DWIHN continues to work on the CRISIS Center and the Administrative Offices. Openings are expected in early spring.

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		
Chad Witcher, Prevention Manager ORR, discussed the following with the workgroup: ORR is currently going through the assessment of DWIHN's Recipient Rights Protection System with the State of Michigan. Also, it is encouraged for everyone to take a look at Prevention of Recipient Rights Violations from the perspective of remedial action on substantiated violations. The Workgroup was reminded that when you're hiring someone, you can always have them sign a consent form for employee recipient rights background check to find out if that individual has a substantiated violation.		
Provider Feedback	**Assigned To**	**Deadline**
Questions: • The recipient's right background check is not a requirement for CRSP providers, correct? • Is there a form that needs to be filled out to request a background check? Answers: • Yes. That is correct. • Yes, that form is on our website under the provider resources tab.		
Action Items	**Assigned To**	**Deadline**
None Required.		

4) Item: DWIHN Policies

Goal: UM Authorizations Procedures for MI Health Link

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

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

Discussion		
Marlena Hampton, Higher Levels of Care (HLOC) Administrator**,** shared with the group the Utilization Management Authorizations Procedures for MI Health Link. The UM Authorization Procedure for MI Health Link provides operational guidance to providers and delegated entities involved in requesting authorization from DWIHN for treatment services. The expected outcome is for providers seeking coverage for treatment services will have a clear understanding of the authorization process ensuring consistent application throughout the provider network. The procedure has remained relatively unchanged for some time and only have a few minor changes were made. Facilities are required to submit documentation on the first uncovered day instead of on the last covered day. This will allow for a clearer process for hospitals and reduce administrative denials. Also, there are the additional requirements for continued stay reviews. Please review the "UM Authorization Procedures for MI Health Link" procedure for additional information.		
Provider Feedback	**Assigned To**	**Deadline**
No provider feedback.		
Action Items	**Assigned To**	**Deadline**
None Required.		

4) Item: DWIHN Policies
Goal: Use of Behavior Treatment in CMH

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, Clinical Specialist Performance Improvement, provided the following updates for the DWIHN Policy "Use of Behavior Treatment in Community Mental Health"
• There are no procedural changes, however, MDHHS revised some terminology in July 2023, replacing some terms with better terminology, more in alignment with the mental health code. DWIHN offered a training last year in September on the changes.
• These changes and this policy apply to all the programs, waiver services, iSPA services, PIHP and CMHS. The changes include:
  ○ New language removes "target behavior is not due to an active substantiated psychotic process" and added "beneficiary's challenging behavior is due to the active symptoms of a serious mental illness and serious emotional disturbance".
  ○ Terms taken out: Psychosis and Members
  ○ Terms included: Serious Mental Illness (SMI) and Beneficiaries
• Required BTPRC Members
  ○ The required BTPRC members must be present during the review as approval process.
• BTPRC Process
• Inclusion in BTPRC Process
• BTPRC Decision
• Nonvoting Staff
• In-Service and Monitoring
• Medications
Please review the Use of Behavior Treatment in Community Mental Health policy for additional information.		

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

4) Item: DWIHN Policies
Goal: CRSP Responsibility Procedure

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

Discussion		
Jacquelyn Davis, Clinical Officer, provided the group with some of the changes made to the CRSP Responsibility Procedure. The purpose of the CRSP Responsibility Procedure is to provide guidelines and supplement the DWIHN Provider Manual and to the Scope of Service in the contracts with the providers in the DWIHN Network that have been identified as "Clinically Responsible Service Providers" or CRSP (as seen in the Member/Enrollee Chart in MH-WIN). The expected outcome is clearly articulated roles and responsibilities will ensure the highest level of services are delivered to the individuals within DWIHN. DWIHN Staff and Network Providers will understand the following: ○ The process by which a CRSP is assigned and changed as requested by the member/enrollee. ○ The expectations for a CRSP to coordinate effectively and efficiently for all individuals within the network, ○ Data reporting and quality assurance Changes to the procedure include the following: • Under 'Administrative Services' line B. Current address or known address a statement was added to see where information can be sent if an individual doesn't have a current address • Line 2 for Determining Medicaid eligibility, assist member/enrollee with applying and ensuring that Medicaid benefits do not lapse. You will see that noted a couple of places. • Clinical Services added information about hospital discharges and jail releases. • Coordinating with the Justice System is a new section that's been added to the procedure. Please see the CRSP Responsibility Procedure for additional information.		
Provider Feedback	**Assigned To**	**Deadline**
No provider feedback.		
Action Items	**Assigned To**	**Deadline**
None Required.		

5) Item: QAPIP Effectiveness – Children's Initiatives
Goal: Performance Improvement Projects (Update)

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

Discussion		

Cassandra Phipps, Director of Children Initiatives, discussed the following Performance Improvement Projects updates:
Follow-Up on Children with ADHD Medication
• Children ADHD Medication Statistics
  ○ ADHD Medication: Why It matters
  ○ ADHD Medication: Tips and Best Practice
• Baseline Data:
  ○ Quantifiable Measure #1: Percentage of members taking ADHD medication completed initial doctor visit. Ability to increase the goal to 64%.
  ○ Quantifiable Measure #2: Percentage of members taking ADHD medication completed continuation doctor visits. Able to increase the goal to 76%.
Children's Metabolic Screening for Children on Antipsychotics (APM)
• Antipsychotics medication statistics
• Best Practices
• No progress was made with ages 1-11, but progress was made for ages 12-17. The goal has been increased to 38%.
Improving the time for Initiation of Autism Services
Because of the service starts within 90 days performance improvement plan dropped below the baseline we're unable to use it for NCQA accreditation of showing significant progress. It was discussed and decided through IPLT that a new measurement will be addressed to include the starting timeframe of ABA services within 14 days of the authorization effective date. The baseline data begins during fiscal year 2023 (65%.) with a goal set at 70%.		

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

5) Item: QAPIP Effectiveness – Quality Improvement
Goal: Death Reporting Requirements

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 Performance Improvement, shared the following for Death Reporting Requirements: • All providers MUST report deaths to DWIHN-ORR within 24 hours of knowledge of the death AFTER primary sources verification (ADT, ME office, Funeral home, etc.). A Death Log Number will be assigned, which is documentation that the process has been followed. • All providers MUST enter a Critical/Sentinel event into the DWIHN- MH-WIN member record within the 24-hour reporting period (unless it is a Media Event which is immediately reportable). • All SUD events are Hie'd over to MDHHS CRM system daily and reviewed by MDHHS staff. DWIHN Quality Performance Improvement staff MUST respond to MDHHS if all information/documentation is not included in the CE/SE. Remediation at the MDHHS level is done daily. (i.e. We have received 50 requests for remediation in the first 2 days this week). • Critical/ Sentinel Event Training is held monthly. Registration is currently available for the remainder of this FY on the DWIHN website under the Provider tab. • Care Academy – Notification to CRSP Leadership will be arranged along with support during the implementation and pilot program process. When the standard of care is attributable to an individual practitioner within the pilot group, FY 2023/2024, that staff person will be assigned training through the Care Academy based on severity of event.		
Provider Feedback	**Assigned To**	**Deadline**
No Provider Feedback.		
Action Items	**Assigned To**	**Deadline**
None Required.		

5) Item: QAPIP Effectiveness – Quality Improvement

Goal: CRM/MiCal 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		
Micah Lindsay, Clinical Specialist Performance Improvement, shared with the group CRM/MiCal updates: • CRM,Customer Relationship Management system, is a system that has been introduced which allows the ability for MDHHS to properly monitor the type of care and services that members are receiving. All our Critical/Sentinel Events are Hie'd over to the CRM daily, allowing MDHHS to review in "Real Time" all reported events. If there are questions and or follow-up a "Remediation" is submitted to DWIHN's QPI team. In some cases, the State wants more clarity and in-depth details regarding what happened to the member as well as any remedial actions that the provider has initiated to review and correct the identified issue. This information is provided to MDHHS based on provider information that the QPI team receives. It was noted that it is very important to make sure that all requested information is submitted timely and to the best of each providers knowledge and ability.		
Provider Feedback	**Assigned To**	**Deadline**
No Provider feedback.		
Action Items	**Assigned To**	**Deadline**
None Required.		

5) Item: QAPIP Effectiveness – Quality Improvement

Goal: Documentation submission Dates

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, Clinical Specialist Performance Improvement, discussed the following for CE/SE and RCA documentation: • All Critical and Sentinel events, when you receive them, must be entered into the MH-WIN system within 24 hours of your knowledge of the incident. • It is imperative that all supporting documentation or evidence that you are providing care according to the plan is also included with the CE/SE or RCA entry. An example of follow up documentation, or supporting documentation are hospital discharge summaries, updated crisis, or safety plans. If an extension is required for submitting additional supporting documentation, please reach out to the CPI team with an email documenting the request and the timeline for completing.		
Provider Feedback	**Assigned To**	**Deadline**
No provider feedback.		
Action Items	**Assigned To**	**Deadline**
None Required.		

5) Item: QAPIP Effectiveness – Quality Improvement

Goal: CRSP Notification Forms, MDHHS Review, Annual Provider Reviews

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, Quality Administrator - Performance Monitoring discussed the following updates: **CRSP Notification Forms:** • The purpose of the form is to facilitate collaboration between CRSP and Service providers. • Designed to **not** include PHI so it can be shared in traditional email communications • Trend Noted: Increase in request to assist with expired authorizations • Need your help: Plan for addressing expired Authorizations when not pending **Status of MDHHS Review:** CRSP Providers – Staff Files due this Friday, Feb. 2, 2024 Use the MDHHS Staff Credentialing forms to help guide you with determining staff files that need to be submitted. Expectations are different for each of the waiver programs and the iSPA If the service discipline of a staff member is not on the credentialing form, it is not required. Be sure to complete the correct section of the cover sheet that corresponds to the staff's professional discipline **Annual Provider Review:** 2024 MDHHS Waiver & iSPA Review • 21 providers • 118 members Participation in the MDHHS Review will be incorporated into this year's annual reviews. For providers not participating in the annual review, your reviews will take place sometime between May – September 2024. **Quarterly Self-Monitoring Reviews:** During FY2024 QI reduce the number of case records from 35 to 20 **Q1 FY2024 Self-monitoring:** • Self-reviews of member records selected by MDHHS • Due to tardiness, number of records will be reduced to 12 (for Q1 only)		
Provider Feedback	**Assigned To**	**Deadline**
No provider feedback.		
Action Items	**Assigned To**	**Deadline**
None Required.		

New Business Next Meeting: 02/28/24

Adjournment: 1/31/2024

HEDIS MEASURES

ADD – FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION

Presented By: CHILDREN'S INITIATIVE DEPARTMENT

QISC – 1.30.2024

ADHD MEDICATION STATISTICS:

ADHD Medication: Why It Matters

Attention-deficit/hyperactivity disorder (ADHD) is one of the most common mental disorders affecting children. 11% of American children have been diagnosed with ADHD. The main features include hyperactivity, impulsiveness and an inability to sustain attention or concentration.[1,2] Of these children, 6.1% are taking ADHD medication.[1]

When managed appropriately, medication for ADHD can control symptoms of hyperactivity, impulsiveness and inability to sustain concentration. To ensure that medication is prescribed and managed correctly, it is important that children be monitored by a pediatrician with prescribing authority.

ADHD MEDICATION STATISTICS:

ADHD Medication: Tips and Best Practice

https://www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/health-care-performance-measures/hedis/follow-up-care-children-prescribed-adhd-med

- Age Clarification: 6 years as of March 1 of the year prior to the measurement year to 12 years as of the last calendar day of February of the measurement year.
- Timing of scheduled visits is key based on the prescription day supply to evaluate medication effectiveness, any adverse effects and to monitor the patient's progress.
- When prescribing a new ADHD medication for a patient:
  - Schedule follow-up visits to occur before the refill is given.
  - Schedule a 30-day, 60-day and 180-day follow-up visit from the initial visit before member leaves office.
  - Consider scheduling follow-up visit within 14 to 21 days of each prescription.
  - Consider prescribing an initial two-week supply and follow-up prescriptions to a 30-day supply to ensure patient follow-up.
  - Only one of the two visits (during days 31–300) may be an e-visit or virtual check-in.

ADHD MEDICATION STATISTICS:

- **References**

1. Visser, S.N., M.L. Danielson, R.H. Bitsko, J.R. Holbrook, M.D. Kogan, R.M. Ghandour, … & S.J. Blumberg. 2014. "Trends in the parent-report of health care provider-diagnosed and medicated attention-deficit/hyperactivity disorder: United States, 2003—2011." Journal of the American Academy of Child & Adolescent Psychiatry, 53(1), 34–46.

2. The American Psychiatric Association. 2012. Children's Mental Health. http://www.psychiatry.org/mental-health/people/children

HEDIS GOAL:

ADD – Follow-Up Care for Children Prescribed ADHD Medication (Initial Doctor Visit):

Goal: The goal is for Children Providers to improve compliance with meeting the minimum requirement for the HEDIS Measure ADD – Follow-Up Care for Children Prescribed ADHD Medication.

Initial Phase: Assesses children between 6 and 12 years of age who were diagnosed with ADHD and had one follow-up visit with a practitioner with prescribing authority within 30 days of their first prescription of ADHD medication.

- Initially the goal was 50% per DWIHN recommendation since the baseline data was at 12.98%
- As of October 2022 the goal changed to 46.1% in accordance to the regional goal
- As of April 2023 the goal changed to 58.95% in accordance to the regional goal

HEDIS GOAL:

ADD – Follow-Up Care for Children Prescribed ADHD Medication (Continuation Doctor Visit):

Goal: The goal is for Children Providers to improve compliance with meeting the minimum requirement for the HEDIS Measure ADD – Follow-Up Care for Children Prescribed ADHD Medication.

Continuation Phase: Assesses children between 6 and 12 years of age who had a prescription for ADHD medication and remained on the medication for at least 210 days, and had at least two (2) follow-up visits with a practitioner in the 9 months after the Initiation Phase.

- Initially the goal was 50% per DWIHN recommendation since the baseline data was at 13%
- As of October 2022 the goal changed to 62.04% in accordance to the regional goal
- As of April 2023 the goal changed to 70.25% in accordance to the regional goal

KEY NOTES:

- NCQA: QI 11 – Element A
  - Meaningful Improvement
  - Includes 1 year of Baseline Data and at least 2 years of Remeasurement Data
  - Remeasurement does not decrease below the baseline data
- The number of eligible youth member varies throughout the year
- The date range is from March through February
- Data is measured annually
- Challenge with HEDIS Measures data transferring into Vital Data system. As of June 2022 data was not available for 2022.
- Cascade: Strategic Plan due date is 2/1/2024
- As of November 2023 the Vital Data system no longer lists the "Estimated End of the Year Rate". Also, "NO GROUP" is showing in the report as well; which means case is closed and no CRSP is assigned.

Is there a way to remove the "NO GROUP" cases from the report / data?

BASELINE DATA:

- Quantifiable Measure #1: Percentage of members taking ADHD medication completed initial doctor visit

Measurement Period	Type	Compliant Members	Eligible Members	Goal	Total	Statistical Significance
3/1/2020 – 2/28/2021	Baseline	145	1117	50%	12.98%	NA
3/1/2021 – 2/28/2022	Remeasurement 1	393	678	50%	56.3%	Above Goal
3/1/2022 – 2/28/2023	Remeasurement 2	246	456	46.1%	59.01%	Above Goal
3/1/2023 – 2/28/2024 ***as of 11/30/203	Remeasurement 3	425	782	NA	54.35%	

Remeasurement 1: There was a significant increase from the baseline data

- 11 out of 15 Children Providers (73%) met the 50% goal

Remeasurement 2: There continued to be an increase above the baseline data and above the 1st Remeasurement.

- 11 out of 19 Children Providers (57.89%) met the 46.01% goal

***Proposal Request: To increase the goal to 64% (5 points above the current score of 59.01%)

BASELINE DATA:

- **Quantifiable Measure #2: Percentage of members taking ADHD medication completed continuation doctor visits**

Measurement Period	Type	Compliant Members	Eligible Members	Goal	Total	Statistical Significance
3/1/2020 – 2/28/2021	Baseline	59	454	50%	13%	NA
3/1/2021 – 2/28/2022	Remeasurement 1	42	60	50%	63.25%	Above Goal
3/1/2022 – 2/28/2023	Remeasurement 2	188	264	62.04%	71.21%	Above Goal
3/1/2023 – 2/28/2024 ***As of 11/30/23	Remeasurement 3	NA	NA	NA	68.57%	

Remeasurement 1: There was a significant increase from the baseline data

- 10 out of 15 Children Providers (66%) met the 50% goal

Remeasurement 2: There continued to be an increase above the baseline data and above the 1st Remeasurement.

- 11 out of 18 Children Providers (61%) met the 62.04% goal

***Proposal Request: To increase the goal to 76% (5 points above the current score of 71.21%)

IPLT MEETINGS:

- **Feb 2022:** Initially presented ADHD Medication HEDIS Measure at the Improving Practices Leadership Team (IPLT) meeting .
- **May 2022:** Presented ADHD Medication HEDIS Measure at the Improving Practices Leadership Team (IPLT) meeting and discussed first re-measurement results and moving from a goal set by the organization to utilizing data from Quality Compass to allow DWIHN to compare themselves to other health plans in our region.(Michigan, Ohio, Wisconsin, Illinois) and set a benchmark.
- **April 2023:** Presented at Improving Practices Leadership Team (IPLT) to increase the overall goal due to progress. For Measurement #1 increase the goal from 46.01% to 58.95% for Remeasurement 3 reporting period. For Measurement #2 increase the goal from 62.04% to 70.25% for Remeasurement 3 reporting period.

BARRIERS:

- 1. Initial issues with the state changing the pharmacy codes; as a result, DWIHN needed to collaborate with Vital Data to resolve the data discrepancies
- 2. Children Providers were not aware of the HEDIS ADHD Medication measure expectation
- 3. Children Providers were not aware of how to view and monitor data for this HEDIS measure
- 4. Members / Families were not aware of the benefit of attending follow up visits when taking ADHD medications
- 5. Transportation challenges resulting in members unable to attend follow up doctor visits
- 6. The total number of eligible youth decreased during the Covid 19 pandemic during Remeasurement 1 reporting period
- 7. There was a shortage in ADHD medication; thus, members were unable to refill the medication
- 8. Children Provider staff shortages
- 9. Member unable to complete more than 1 Medicaid service in the same day

INTERVENTIONS:

- **Sept 2021:** DWIHN Finance Department submitted Children Services Value Based Incentive proposal to MDHHS for approval to begin Oct 2021. There is a total of 5 different incentives to be paid quarterly to 11 Children Providers.
- **Jan 2022:** Presented ADHD Medication HEDIS Measure to Quality Directors on 1/26/2022
- **Feb 2022:** Presented ADHD Medication HEDIS Measure progress, barriers, interventions at the Cross System Management Meeting on 2/23/2022.
- **March 2022:** Presented ADHD Medication HEDIS Measure progress, barriers, interventions at the Cross System Management Meeting on 3/23/2022. Trained Providers on how to access the HEDIS scorecard via MHWIHN system to view data.
- **April 2022:** Distributed Children HEDIS memo on 4/1/2022 that explained the ADHD Medication HEDIS Measure expectations.
- **May 2022:** Presented ADHD Medication HEDIS Measure to Children Provider Chief Medical Officers on 5/2/2022 . The total number of attendees is unknown. Consisted of 14 SED Children Providers and 13 IDD Children Providers.

INTERVENTIONS:

- **June 2022:** Included the ADHD Medication HEDIS Measure in the System of Care Pediatric Integrated Healthcare Work Plan.
- **June 2022:** Presented at Quality Improvement Steering Committee (QISC)
- **September 2022:** Vicky Politowski (Director of Integrated Healthcare) trained Children Providers on how to access the HEDIS data scorecard via MHWIN system.
- **Jan 2023:** The Quality Assurance Performance Improvement Plan (QAPIP) was last updated Jan 2023 that includes elements for NCQA Q1.
- **April 2023:** Presented at Quality Improvement Steering Committee (QISC)
- **March 2023:** Attention Deficit Hyperactivity Disorder (ADHD) information was included in Clinical Practice Guidelines for common behavioral disorders; in which the policy was updated March 2023.
- **April 2023:** Presented at Improving Practices Leadership Team (IPLT) to increase the overall goal due to progress. For Measurement #1 increase the goal from 46.01% to 58.95% for Remeasurement 3 reporting period. For Measurement #2 increase the goal from 62.04% to 70.25% for Remeasurement 3 reporting period.
- **September 2023:** Children Providers were sent the summary of HEDIS measure data for Remeasurement 3 reporting period for Measure #1 and Measure #2.
- **October 2023:** DWIHN sent communication to all Providers informing of the 2 new contracted Providers that can provide transportation assistance for therapy and doctor related appointments.

INTERVENTIONS:

- **Sep 2023:** Sent Children Provider a summary of HEDIS Measure data for FY 2023 for both measures
- **Sep 2023:** Shared Transportation resource during IDD Provider Meeting that consisted of 18 attendees included supervisors and managers. 7 out of 13 IDD Children Providers were in attendance; however, all IDD Children Providers received the meeting presentation. This meeting is held bi monthly.
- **Oct 2023:** DWIHN sent communication to all Providers informing of the 2 new contracted Providers that can provide transportation assistance for therapy and doctor related appointments. The transportation resource was also added to DWIHN mobile app as well. The DWIHN Mobile App was included in the Persons Point of View Newsletter Fall 2023 edition. Transportation resource was also discussed during Children System Transformation meeting. 24 attendees that represented 9 SED Children Providers and consisted of supervisors and managers. Although 9 Children Providers were present, all 14 SED Children Providers receive the meeting presentation information. This meeting is held monthly.

OPPORTUNITIES FOR IMPROVEMENT:

As of October 2022 – Improving Practices Leadership Team (IPLT):

- Review data per Provider and follow up with Provider regarding action steps
- Continue System of Care Pediatric Integrated Health Care Workgroup to resolve barriers
- Next year increase goal from 50%
- Educate families on this HEDIS measure (ex: Flyer)
- Discuss HEDIS Measure during Provider MDHHS Performance Measure meetings
- Discuss at the Medical Director meeting on 10/14/22

OPPORTUNITIES FOR IMPROVEMENT:

As of April 2023 – Improving Practices Leadership Team (IPLT):

- **ADD medication is a controlled substance and to be prescribed monthly. Consider why the number of eligible youth receiving ADD medication is decreasing? Review the raw data for eligible youth completing initial doctor visit and compare to the eligible youth with ongoing doctor visits to determine which youth are dropping off the list. Review raw data for Prescriber information.**
- **Propose the Initial doctor visit goal increase from 46.01% to 55%**
- **Review this Quality Improvement Plan at next NCQA meeting on 4/20/2023**
- **Present at Quality Improvement Steering Committee (QISC) on 4/25/2023**

OPPORTUNITIES FOR IMPROVEMENT:

As of November 2023 – Improving Practices Leadership Team (IPLT):

- Include Transportation resources and track the number of times members view on dwihn mobile app
- Update the DWIHN HEDIS website with Children Initiative HEDIS Info Sheet and track the number of times the website is viewed
- Include the Children Initiative HEDIS Info Sheet in FY 24, Q1 Provider quarterly newsletter
- Include the Children Initiative HEDIS Info Sheet in Winter 2024 Persons Point of View newsletter
- Develop a Provider HEDIS Feedback Survey for Providers to complete quarterly that will include barriers and interventions implemented https://forms.office.com/g/WSSKyXrKHm
  - Determine if the prescriber is Child Psychiatrist vs. Primary Doctor
  - CRSP policy on ADHD medication adherence
- Start including CRSP Chief Medical Officers and Quality Directors in quarterly data reports and HEDIS communications
- Measurement #1: Recommend keeping the goal at 46.01% until the end of the Remeasurement 2 reporting period . Effective 3/1/2024 the goal increase to the regional goal of 58.95% that was approved at IPLT in April 2023.
- Measurement #2: Recommend keeping the goal at 62.04% until the end of the Remeasurement 2 reporting period. Effective 3/1/2024 the goal increase to the regional goal of 70.25% that was approved at IPLT in April 2023.
- Would Complex Management Referral be applicable?
- Federal laws on ADHD medications for 2023

OPPORTUNITIES FOR IMPROVEMENT:

As of December 2023 – Improving Practices Leadership Team (IPLT):

- **Measurement 1: Request to increase the goal to 64% (5 points above the current score of 59.01%) was approved**
- **Measurement 2: Request to increase the goal to 76% (5 points above the current score of 71.21%) was approved**

QUESTIONS:

- Any questions?

HEDIS MEASURES

APM - METABOLIC MONITORING FOR CHILDREN AND ADOLESCENTS ON ANTIPSYCHOTICS

Presented By: CHILDREN'S INITIATIVE DEPARTMENT

QISC – 1.30.2024

ANTIPSYCHOTICS MEDICATION STATISTICS:

- Approximately 14% to 20% of children and adolescents have a diagnosable mental illness with an annual cost of about $247 billion.
- Common child related psychiatric disorders that would warrant antipsychotic medications include: Tourette's syndrome, Autistic Disorder, Schizophrenia, and Bipolar Disorder.
- Antipsychotic medications to treat these symptoms and disorders are:
  - Haldol
  - Mellaril
  - Risperdal
  - Abilify
  - Seroquel
  - Zyprexa
  - Geodon
- Antipsychotic prescribing for children and adolescents has increased rapidly in recent decades. These medications can elevate a child's risk for developing serious metabolic health complications associated with poor cardiometabolic outcomes in adulthood. Given these risks and the potential lifelong consequences, metabolic monitoring (blood glucose and cholesterol testing) is an important component of ensuring appropriate management of children and adolescents on antipsychotic medications.

BEST PRACTICES:

- At least one test for blood glucose or HbA1c and at least one test for LDL-C or cholesterol.
- If the medications are dispensed on different dates, even if it's the same medication, test both blood glucose with either a glucose or HbA1c test, and cholesterol with either a cholesterol or LDL-C test.
- Measure baseline lipid profiles, fasting blood glucose level and body mass index.
- Ordering a blood glucose and cholesterol test every year and building care gap alerts in the electronic medical record.
- Testing blood glucose and cholesterol at a member's annual checkup or school physical to reduce additional visits.
- Measure any abnormal involuntary movements before starting an antipsychotic medication, at regular intervals during treatment and while tapering medication
- Frequently monitor for side effects
- When prescribing antipsychotics consider a "start low and go slow" approach to find the lowest effective evidence-based dose

<u>Educate members and caregivers about the:</u>

- Increased risk of metabolic health complications from antipsychotic medications.
- Importance of screening blood glucose and cholesterol levels.

<u>Behavioral health providers:</u>

- Ordering blood glucose and cholesterol screening tests for members who do not have regular contact with their PCP and within 1 month of changing a member's medication.
- Reach out to caregivers who cancel appointments and assist with rescheduling as soon as possible

REFERENCES:

1. Patten, S.B., W. Waheed, L. Bresee. 2012. "A review of pharmacoepidemiologic studies of antipsychotic use in children and adolescents." *Canadian Journal of Psychiatry* 57:717–21.

2. Cooper, W.O., P.G. Arbogast, H. Ding, G.B. Hickson, D.C. Fuchs, and W.A. Ray. 2006. "Trends in prescribing of antipsychotic medications for US children." *Ambulatory Pediatrics* 6(2):79–83.

3. Correll, C. U., P. Manu, V. Olshanskiy, B. Napolitano, J.M. Kane, and A.K. Malhotra. 2009. "Cardiometabolic risk of second-generation antipsychotic medications during first-time use in children and adolescents." *Journal of the American Medical Association*

4. Andrade, S.E., J.C. Lo, D. Roblin, et al. December 2011. "Antipsychotic medication use among children and risk of diabetes mellitus." *Pediatrics* 128(6):1135–41.

5. Srinivasan, S.R., L. Myers, G.S. Berenson. January 2002. "Predictability of childhood adiposity and insulin for developing insulin resistance syndrome (syndrome X) in young adulthood: the Bogalusa Heart Study." *Diabetes* 51(1):204–9.

HEDIS GOAL:

The **goal** is for Children Providers to improve compliance with meeting the minimum requirement for the Hedis Measure **APM - Metabolic Monitoring for Children and Adolescents on Antipsychotics (including Blood Glucose and Cholesteral labwork).**

- **APM (age 1 to 11) - Metabolic Monitoring for Children and Adolescents on Antipsychotics (Blood Glucose & Cholesterol)**
  - Year 2020 Baseline Goal = 50%
  - Year 2021 Remeasurement 1 Goal = 50%
  - Year 2022 Remeasurement 2 Goal = 23.36%
  - Year 2023 Remeasurement 3 Goal = 23.36%

HEDIS GOAL:

The **goal** is for Children Providers to improve compliance with meeting the minimum requirement for the Hedis Measure **APM - Metabolic Monitoring for Children and Adolescents on Antipsychotics (including Blood Glucose and Cholesteral labwork).**

- **APM (age 12 to 17) - Metabolic Monitoring for Children and Adolescents on Antipsychotics (Blood Glucose & Cholesterol)**
  - Year 2020 Baseline Goal = 50%
  - Year 2021 Remeasurement 1 Goal = 50%
  - Year 2022 Remeasurement 2 Goal = 32.70%
  - Year 2023 Remeasurement 3 Goal = 32.70%

KEY NOTES:

- NCQA: QI 10 Element B
- The number of eligible youth member varies throughout the year
- The date range is from January – December
- Data is measured quarterly
- The goal changed from 50% to 23.36% effective October 2022 for Measurement # 1
- The goal changed from 50% to 32.71% effective October 2022 for Measurement # 2
- As of November 2023 the Vital Data system no longer lists the "Estimated End of the Year Rate". Also, "NO GROUP" is showing in the report as well; which means case is closed and no CRSP is assigned.

- Is there a way to remove the "NO GROUP" cases from the report / data?

BASELINE DATA:

- Quantifiable Measure #1: Percentage of youth ages 1 to 11 with ongoing antipsychotic medication with completed metabolic testing for blood glucose and cholesterol levels

Measurement Period	Measurement	Compliant Members	Eligible Members	Goal	Total	Statistical Significance
1/1/2020 – 12/31/2020	Baseline	94	589	50%	15.96%	NA
1/1/2021 – 12/31/2021	Remeasurement 1	100	517	50%	19.34% (+)	Below Goal
1/1/2022 – 12/31/2022	Remeasurement 2	30	177	23.36%	16.95% (-)	Below Goal
1/1/2023 – 12/31/2023 ***as of 11/30/2023	Remeasurement 3	121	650	23.36%	18.62% (+)	Below Goal

Remeasurement 1: There was a 3.44% increase from the baseline data of 15.96%

Remeasurement 2: There was a .99% increase from the baseline data of 15.96%

- As of Sep 2023 - 5 out of 18 Children Providers met the goal of 23.36% (27.77% compliance)

***Proposal Request: Keep the goal as 23.36%

BASELINE DATA:

- Quantifiable Measure #2: Percentage of youth ages 12 to 17 with ongoing antipsychotic medication with completed metabolic testing for blood glucose and cholesterol levels

Measurement Period	Measurement	Compliant Members	Eligible Members	Goal	Total	Statistical Significance
1/1/2020 – 12/31/2020	Baseline	327	1211	50%	27%	NA
1/1/2021 – 12/31/2021	Remeasurement 1	339	1155	50%	29.35% (+)	Below Goal
1/1/2022 – 12/31/2022	Remeasurement 2	127	376	32.7%	33.78% (+)	Above Goal
1/1/2023 – 12/31/2023 ***as of 11/30/2023	Remeasurement 3	379	1378	32.7%	27.5% (-)	NA

Remeasurement 1: There was a 2.35% increase from the baseline data of 27%

Remeasurement 2: There was a 6.78% increase from the baseline data of 27%

- As of Sep 2023 – 4 out of 20 Children Providers met the goal of 32.71% (20% compliance)

***Proposal Request: Increase the goal to 38% , 5 points above current goal of 32.7%

IPLT MEETINGS:

APM – Metabolic Monitoring for Children and Adolescents on Antipsychotics

- **Feb 2022:** Initially presented Antipsychotic Medication HEDIS Measure at the Improving Practices Leadership Team (IPLT) meeting .
- **May 2022:** Presented Antipsychotic Medication HEDIS Measure at the Improving Practices Leadership Team (IPLT) meeting and discussed first re-measurement results and moving from a goal set by the organization to utilizing data from Quality Compass to allow DWIHN to compare themselves to other health plans in our region.(Michigan, Ohio, Wisconsin, Illinois) and set a benchmark.

BARRIERS:

- 1. Initial issues with the state changing the pharmacy codes; as a result, DWIHN needed to collaborate with Vital Data to resolve the data discrepancies
- 2. Children Providers were not aware of the HEDIS Antipsychotic Medication measure expectation
- 3. Children Providers were not aware of how to view and monitor data for this HEDIS measure
- 4. Members / Families were not aware of the benefit of completing metabolic testing
- 5. Transportation challenges resulting in members unable to attend follow up doctor visits
- 6. The total number of eligible youth decreased during the Covid 19 pandemic during Remeasurement 2 reporting period
- 7. Requires more than 1 staff to complete bloodwork

INTERVENTIONS:

- **Jan 2022:** Presented HEDIS Measure to Quality Directors on 1/26/2022
- **Feb 2022:** Presented HEDIS Measure at the Improving Practices Leadership Team (IPLT) meeting.
- **Feb 2022:** Presented HEDIS Measure progress, barriers, interventions at the Cross System Management Meeting on 2/23/2022.
- **March 2022:** Presented HEDIS Measure progress, barriers, interventions at the Cross System Management Meeting on 3/23/2022. Trained Providers on how to access the HEDIS scorecard via MHWIHN system to view data.
- **April 2022:** Distributed Children HEDIS memo on 4/1/2022 that explained the HEDIS Measure expectations.
- **May 2022:** Presented HEDIS Measure at the Improving Practices Leadership Team (IPLT) meeting.
- **June 2022:** Included the HEDIS Measure in the System of Care Pediatric Integrated Healthcare Work Plan.
- **June 2022:** Presented HEDIS Measure progress, barriers, interventions at the Cross System Management Meeting on 6/23/2022.

INTERVENTIONS:

- **June 2022:** Included the ADHD Medication HEDIS Measure in the System of Care Pediatric Integrated Healthcare Work Plan.
- **June 2022:** Presented at Quality Improvement Steering Committee (QISC)
- **September 2022:** Vicky Politowski (Director of Integrated Healthcare) trained Children Providers on how to access the HEDIS data scorecard via MHWIN system.
- **April 2023:** Presented at Quality Improvement Steering Committee (QISC)
- **March 2023:** Attention Deficit Hyperactivity Disorder (ADHD) information was included in Clinical Practice Guidelines for common behavioral disorders; in which the policy was updated March 2023.
- **November 2023:** Children Providers were sent the summary of HEDIS measure data for 1/1/2023 – 9/30/2023

OPPORTUNITIES FOR IMPROVEMENT:

As of October 2022 – Improving Practices Leadership Team (IPLT):

- Review data per Provider and follow up with Provider regarding action steps
- Continue System of Care Pediatric Integrated Health Care Workgroup to resolve barriers
- Next year increase goal from 50%
- Educate families on this HEDIS measure (ex: Flyer)
- Discuss HEDIS Measure during Provider MDHHS Performance Measure meetings
- Discuss at the Medical Director meetings

OPPORTUNITIES FOR IMPROVEMENT:

As of April 2023 – Improving Practices Leadership Team (IPLT):

- For youth ages 1 to 11 does the Diagnosis support youth receiving antipsychotic medication?
- What are barriers for youth ages 1 to 11 getting blood work completed? (Ex: Are youth requiring additional staffing for bloodwork)
- Review this Quality Improvement Plan at next NCQA meeting on 4/20/2023
- Present at Quality Improvement Steering Committee (QISC) on 4/25/2023

OPPORTUNITIES FOR IMPROVEMENT:

As of November 2023 – Improving Practices Leadership Team (IPLT):

- Include Transportation resources and track the number of times members view on dwihn mobile app
- Update the DWIHN HEDIS website with Children Initiative HEDIS Info Sheet and track the number of times the website is viewed
- Include the Children Initiative HEDIS Info Sheet in FY 24, Q1 Provider quarterly newsletter
- Include the Children Initiative HEDIS Info Sheet in Winter 2024 Persons Point of View newsletter
- Develop a Provider HEDIS Feedback Survey for Providers to complete quarterly that will include barriers and interventions implemented https://forms.office.com/g/PNdzdjEaCw
  - Determine if have a psychosis diagnosis
  - Determine if need more than 1 staff to complete bloodwork
- Start including CRSP Chief Medical Officers and Quality Director in quarterly data reports and HEDIS communications
- Recommend keeping the goal at 23.36% for Measurement #1 (still below the overall goal, can review after 12/31/2023)
- Recommend keeping the goal at 32.7% for Measurement #2 (although showed progress above the goal, the estimated year end is projected a decrease, can review after 12/31/23).
- Providers develop an alert system in EHR when Antipsychotic medication is prescribed for youth.

OPPORTUNITIES FOR IMPROVEMENT:

As of November 2023 – Improving Practices Leadership Team (IPLT):

- Explore Barriers: Was the metabolic order written by the CRSP vs. Did the member follow up to complete the metabolic testing?
- CRSPs look to partner with in house lab to complete bloodwork
- Complex Case Management Referral

As of December 2023 – Improving Practices Leadership Team (IPLT):

- Measurement 1 – request to keep goal at 23.36% was approved because current rate of 16.95% is below the goal
- Measurement 2 – request to increase the goal from 32.7% to 38% was approved because current rate achieved higher than the goal (33.78%)

QUESTIONS:

- Any questions?

QI 11 Element B: Autism Benefit

QISC 1/29/24
Presented By: Autism Department

Autism Benefit Steps

- Chart depicts the total meetings per provider type along with required documentation timelines.
- Chart includes initial diagnosis of ASD and IPOS meeting.
- Timelines are only accurate if caregiver choice of provider has availability to accept individual.
- At least 10 appointments occur before ABA services can begin.
- If all timelines are followed and minimal difficulty connecting with caregiver or providers occur, a total of 14-days will be left before the 90-day deadline occurs.

Care Coordination Timeline of Services

Appointment(s)	Required Individual(s)	Meeting or Paperwork	Time Requirement	Days
1	Caregiver, Access	Request for Services		
2	Caregiver, CRSP	IBPS	1-14 days	14
3	Caregiver, CRSP	Pre-IPOS/IPOS	15-30 days	30
4	Caregiver, DE	Initial Diagnostic Evaluation	1-14 days	*
5	Caregiver, DE	Feedback on Report	Included above	*
*	DE	ADOS-2 Worksheet/Benefit Approval/SC updated	Included above	*
*	CRSP	SC Referral to ABA	1-14 days	31-45
*	Varies	Authorization Request for BA	Included above	*
6	Caregiver, CRSP	Addendum Meeting-Caregiver Signature	Included above	*
*	CRSP	Submission of ABA Authorization Request	Included above	*
*	DWIHN	Auth approved/returned	Included above	*
7	Caregiver, ABA	ABA Intake, Assessment	1-14 days	46-60
8	Caregiver, ABA	ABA Treatment Plan & Parent signature	Included above	*
*	ABA	ABA Goals submission	Included above	*
*	ABA	Behavioral Assessment Worksheet	Included above	*
*	ABA	Authorization Request for ABA Therapy	1-14 days*	61-75
9	Caregiver, CRSP,	Addendum Meeting-Caregiver Signature	1-14 days	*
*	CRSP	Submission of ABA Authorization Request	Included above	*
*	DWIHN	Auth approved/returned	Included above	*
*	CRSP, ABA	IPOS Training for Direct Care Staff	Included above	*
10	Caregiver, ABA	Begin 1:1 Therapy	Included above	76-89 Days

Quality Improvement

Improve timely Access to Applied Behavior Analysis (ABA) services for Eligible Individuals with Autism Spectrum Disorders (ASD), ages 0 to 21 years of age, covered by Medicaid in Wayne County.

Quantifiable Measure:

The percentage of eligible members who start ABA services within the 90-day service approval date per quarter.

- Numerator
  - Number of eligible members that start ABA services (CPT Code 97153) within the 90-days from when ABA Provider received the ABA referral.

- **Denominator:**
  - Number of eligible members that request ABA services per quarter.

Detroit Wayne Integrated Health Network
DWIHN
Your Link to Holistic Healthcare

DATA: ABA Provider received ABA referral

Time period	Measurement	Numerator	Denominator	Rate	Goal	Statistical Significance
FY 21 - Q1 10/1/20 - 12/31/20	Baseline	63	202	31%	100%	NA
FY 21 - Q2 1/1/21 - 3/31/21	Remeasurement 2	63	211	30%	100%	Below Goal
FY 21 - Q3 4/1/21 - 6/30/21	Remeasurement 3	84	226	37%	100%	Below Goal
FY 21 - Q4 7/1/21 - 9/30/21	Remeasurement 4	89	272	33%	100%	Below Goal
FY 2021 Total	33%					
FY 22 - Q1 10/1/21 - 12/31/21	Remeasurement 1	89	307	36%	100%	Below Goal
FY 22 - Q2 1/1/22 - 3/31/22	Remeasurement 2	91	292	31%	100%	Below Goal
FY 22 - Q3 4/1/22 - 6/30/22	Remeasurement 3	70	274	26%	100%	Below Goal
FY 22 - Q4 7/1/22 - 9/30/22	Remeasurement 4	89	254	35%	100%	Below Goal
FY 2022 Total	30%					
FY23 - Q1 10/1/22 - 12/31/22	Remeasurement 1	89	247	36%	100%	Below Goal
FY 23 - Q2 1/1/23 - 3/31/23	Remeasurement 2	78	223	35%	100%	Below Goal
FY 23 - Q3 4/1/23 - 6/30/23	Remeasurement 3	76	125	61%	100%	Below Goal
FY 23 - Q4 7/1/23 - 9/30/23	Remeasurement 4	63	111	57%	100%	Below Goal
FY 2023 Total	47%					

DATA REQUEST: ABA services start within 14 days of ABA auth effective date

Reporting Period	Numerator	Denominator	Result
FY 21 - Q1	22	28	79%
FY 21 - Q2	35	35	100%
FY 21 - Q3	30	42	71%
FY 21 - Q4	31	39	79%
		FY 21 Total	82%
FY 22 - Q1	26	40	65%
FY 22 - Q2	45	66	68%
FY 22 - Q3	43	56	77%
FY 22 - Q4	22	27	81%
		FY 22 Total	73%
FY 23 - Q1	28	48	58%
FY 23 - Q2	41	52	79%
FY 23 - Q3	40	70	57%
FY 23 - Q4	32	48	67%
		FY 23 Total	65%

IPLT Request: 12/5/23

1. To sunset the measurement of tracking autism timeliness from ABA referral to ABA services start.

❑ Request was approved

1. Request to start a new Performance Improvement Plan of improving ABA services starting within 14 days of auth effective date.

- Reminder: Providers are expected to send an Adverse Determination if services are delayed past 14 days.

❑ Request was approved:

- ❑Baseline Data / FY 2023 = 65%
- ❑FY 2023 Goal = 70%
- ❑Relook at data again in Jan 2024 once claims have been processed for FY 23, Q4

Barriers & Interventions

Barriers Identified: *Initial Diagnostic Evaluation*

- ❑ Significant delay in receiving initial diagnostic evaluation reports following evaluation to determine eligibility for ASD benefit.
- ❑ Bias during diagnosis can occur if the diagnosing provider also provides the therapeutic services recommended.

Intervention:

- Request for Proposal bid to identify diagnostic evaluation providers not affiliated with any direct therapy specifically avoiding ABA therapy. The RFP resulted in two (2) Diagnostic Evaluation providers independent from any form of therapy. The addition of these providers resulted in a system process change in reporting diagnoses to the ASD Department improving oversight and timeliness measures.

Barriers & Interventions

Barriers Identified: *Challenges with Coordination of Care*

- ❑ Delay with completing annual Individual Plan of Service (IPOS)
- ❑ Delay with case holder submitting ABA authorizations
- ❑ Behavior Technicians are unable to provide ABA Direct Services until IPOS and Authorization are input timely.
  - **Intervention:**
    - Implemented system process changes by adding ASD Benefit Request Form (auth),
    - Behavior Assessment Worksheet,
    - Auto-Authorization Approval Process

Barriers & Interventions

Barrier(s) Identified: *Network Capacity Issues*

- There is not enough capacity in the current network to meet the number of enrolled members.
  - **Intervention:**
    - Request for Qualification to expand DWIHN ABA provider network
      - DWIHN added six (6) additional ABA providers to the network
      - RFQ continues for 5 years

Barriers & Interventions

- Minimal coverage in high need areas
  - RFP completed adding additional 5 sites
- Delay with CRSP submitting and resolving authorizations
  - UM Specialist is added to delayed response emails to enforce follow through
  - DWIHN implemented alerts for providers to be forwarded to staff when authorizations are approved or returned
- CRSP not knowing the ABA case holder
  - IT added the ability for both ABA case holder and supervisor contact information to the members' chart
- High turnover with CRSP staff; inability to determine case holder
  - CRSP contact information for leadership and SC/CM is updated automatically on a quarterly basis; ABA providers receive contact information to improve connecting
- Shortage of ABA CRSP Intakes
  - Expanding CRSPs via RFP
- CRSP staff are new to position and need training by ABA
  - Autism Benefit is providing CRSP ABA Refresher Trainers
- ABA service fee schedules are not comparable to commercial insurance & rates vary between providers
  - DWIHN has provided several supplemental 5% provider rate increase
- ABA Providers choose other county and private insurance cases due to the higher ratio of supervision of Behavior Technician
  - DWIHN updated SUG to best practice of 20% supervision for every 10 hours

Barriers & Interventions

Barriers Identified: *Continued Challenges with Capacity Issues*

- ABA providers continue to experience staff shortages which also impacts CRSPs by requiring a higher rate of caregiver engagement and coordination as ABA services are aligned.
- Data indicates a high rate of discharge from ABA providers during the 90-day wait period.
  - **PROJECTED Intervention: Grant to Build Parent Training into 90-day wait period**
    - Address the critical need to provide an effective parent training and support intervention model to providers
    - Support parents in underserved populations with children diagnosed with Autism Spectrum Disorder (ASD) enrolled in or waiting for Applied Behavior Analysis (ABA) services for their children.
      - Focus on educating parents of children with ASD about their child's diagnosis, teaching them to better understand how their family functions and strategies to use with their child to improve social and communication skills and reduce maladaptive behavior.
      - Topics also include care coordination and techniques to improve stress and communication amongst family members and members of their child's treatment team.

Feedback / Questions

QOTAW MEETING
QUALITY PERFORMANCE IMPROVEMENT UPDATES
CRITICAL/SENTINEL EVENTS
January 30, 2024

DEATH REPORTING

- **ALL** Providers MUST report deaths to DWIHN-ORR within 24 hours of your knowledge of the death AFTER primary source verification (ADT, ME office, Funeral Home, etc.). You will receive a Death Log# which is our documentation that the process has been followed.
- **ALL** Providers MUST enter a Critical/Sentinel Event into the DWIHN – MH-WIN member record within that 24 hour reporting period (unless a Media Event which is immediately reportable).
- **ALL** SUD events are HIE'd over to MDHHS CAM system daily and reviewed by MDHHS staff. DWIHN Quality Performance Improvement staff MUST respond to MDHHS if all information/documentation is not included in the CE/SE. Remediation at the MDHHS level is done daily. (ie. We have received 50 requests for remediation in the first 2 days this week)
-

CRITICAL/SENTINEL EVENT TRAINING is held monthly. Registration is currently available for the rest of this FY on the DWIHN website under the Provider Tab (Quality & Compliance – Quality Improvement – 2023-24 Sentinel/Critical Event Trainings). Link below as well:

Space is Limited to the 1st 75 participants. Wait lists will be established.
https://app.smartsheet.com/b/form/33026fe9b0c7463fadd398bbc8f1c4d4

PROFESSIONAL CREDENTIALS – please ensure that licensed staff are including their entire credential (i.e. LMSW – Clinical & Macro Specialty)

CARE ACADEMY – *Notification to CRSP Leadership will be arranged along with support during the implementation and pilot program process.*

Rating Scale for Compliance to Root Cause Analysis

Beginning FY 2023/2024 second quarter– RCAs will be rated along with final designations:

1. Standard of care met, no action needed
2. Standard of care met, with room for improvement
3. Standard of care not met, attributable to systems
4. Standard of care not met, attributable to individual practitioner

When the Standard of Care is attributable to an individual practitioner **within the pilot group, FY 2023/2024**, that staff person will be assigned training through the CareAcademy based on severity of event. (This applies to the seven identified CRSPs only during this pilot program). The training is time-framed and upon testing and completion a certificate is provided. These events are considered preventable.

Quality Operations
Technical Assistance Workgroup
Performance Monitoring Updates

1/31/2024

CRSP Notification Forms

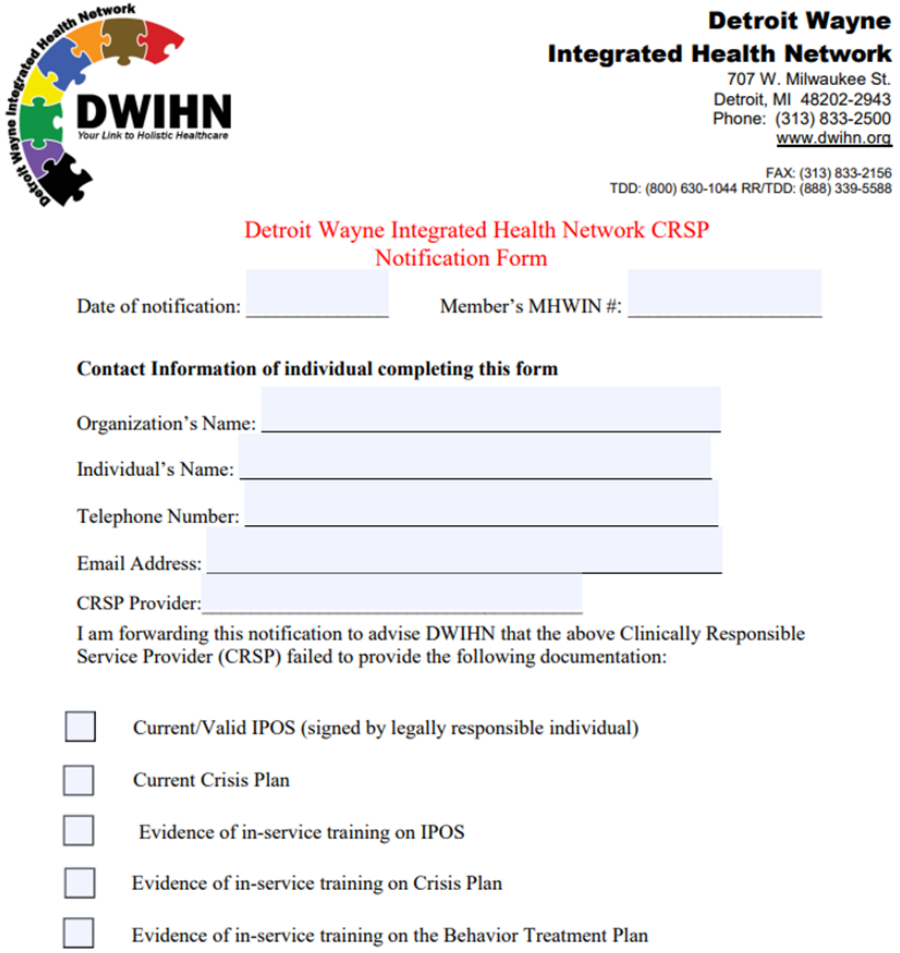
Purpose: to facilitate collaboration between CRSP and Service providers.

Limited to Items on Form

Designed to not include PHI so it can be shared in traditional email communications.

Trend Noted:
Increase in request to assist with expired authorizations

Need Your Help
Plan for addressing expired Authorizations (when not pending with DWIHN)



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Integrated Health Network
707 W. Milwaukee St.
Detroit, MI 48202-2943
Phone: (313) 833-2500
www.dwihn.org

FAX: (313) 833-2156
TDD: (800) 630-1044 RR/TDD: (888) 339-5588

Detroit Wayne Integrated Health Network CRSP Notification Form

Date of notification: _____ Member's MHWIN #: _____

Contact Information of individual completing this form

Organization's Name: _____

Individual's Name: _____

Telephone Number: _____

Email Address: _____

CRSP Provider: _____

I am forwarding this notification to advise DWIHN that the above Clinically Responsible Service Provider (CRSP) failed to provide the following documentation:

- ☐ Current/Valid IPOS (signed by legally responsible individual)
- ☐ Current Crisis Plan
- ☐ Evidence of in-service training on IPOS
- ☐ Evidence of in-service training on Crisis Plan
- ☐ Evidence of in-service training on the Behavior Treatment Plan

Status of MDHHS Review Preparations

CRSP Providers – Staff Files Due this Friday, Feb. 2, 2024

Use the MDHHS Staff Credentialing forms to help guide you with determining staff files that need to be submitted.

Expectations are different for each of the waiver programs and the iSPA

If the service discipline of a staff member is not on the credentialing form, it is not required.

Be sure to complete the correct section of the cover sheet that corresponds to the staff's professional discipline.

Status of MDHHS Review Preparations

CRSP Providers – Staff Files Due this Friday, Feb. 2, 2024

iSPA Professional staff Credentialing Coversheet:

<u>Evaluator of needs-based criteria</u>
This is the staff listed in the WSA for completing the needs-based assessment

- if no longer employed, a staff file will not be needed (please be sure to identify their date of separation on the “Staff & Provider List” Excel Spreadsheet)
- identify on Staff & Provider List if you are still completing the form

Thank you for those who have submitted their lists early

Status of MDHHS Review Preparations

CRSP Providers – Staff Files Due this Friday, Feb. 2, 2024

iSPA Professional staff Credentialing Coversheet:

iSPA members that are youth
Evidence of staff credentials will follow the member's disability designation

- SED – QMHP, MHP
- I/DD – QIDP, MHP

Status of MDHHS Review Preparations

CRSP Providers – Staff Files Due this Friday, Feb. 2, 2024

For the CWP and SEDW, any Medicaid funded service being provided is being reviewed, **except for** ABA support (no staff providing ABA services are being reviewed).

Peer services and Psychiatric services are expected under CWP or SEDW only.

For HSW and iSPA, there are fewer services under these programs. Let the coversheet guide you as to what to submit for review.

Annual Provider Reviews

2024 MDHHS Waiver & iSPA Review

- 21 providers
- 118 members

Participation in the MDHHS Review will be incorporated into this year's annual reviews.

For providers not participating in the annual review, your reviews will take place sometime between May – September 2024.

Quarterly Self-Monitoring Reviews

FY2024

Reducing the number of case records from 35 to 20

Q1 FY2024 Self Monitoring

- Self-reviews of member records selected by MDHHS
- Due to tardiness, number of records will be reduced to 12 (for Q1 only)
  - Sent out Mon. 2.12.2024
  - Completion due date 3/31/2024