Quality Improvement Steering Committee (QISC)
January 30, 2024
10:30am – 12:00pm
Via Zoom Link Platform
Agenda

I.	Welcome /Introductions	T. Greason
II.	Authority Updates	Dr. S. Faheem
III.	Approval of Agenda	Dr. S. Faheem/Committee
IV.	Approval of Minutes • October 31, 2023	Dr. S. Faheem/Committee
V.	**QAPIP Effectiveness:**	

a. Information Technology — G. Herman
   - DWIHN Data Integration Process

b. Quality Improvement — A. Siebert/T. Greason
   - QAPIP Description FY2023-2025
   - QAPIP FY2023 Evaluation
   - QAPIP FY2024 Work Plan

c. BTAC Annual Report for FY2023 — F. Nadeem

d. Utilization Management — L. Wayna

- UM Evaluation FY2023 **(Tabled)**

e. Integrated Health
- Population Assessment FY23 — V. Politowski
- Complex Case Management (CCM) FY23 — V. Politowski

f. Customer Service — M. Vasconcellos/D. Johnson
- CS Year End Report FY2023

g. Children Initiatives — C. Phipps
- Performance Improvement Projects Review of Barriers/Interventions
  - Metabolic Monitoring for Children/Adolescents on Antipsychotics (APM)
  - ADHD
  - Autism

VII. Adjournment

Next QISC meeting scheduled for February 27th, 2024, via Zoom.

Committee Chairs: Dr. Shama Faheem, DWIHN Chief Medical Officer and Tania Greason, DWIHN Provider Network QI Administrator

1) Item: Welcome: Tania asked the committee to put their names, email addresses, and organization into the chat for attendance.

2) Item: Authority Updates: Dr. Faheem shared the following updates: No Authority Updates provided, will be tabled for the next meeting.

3) Item: Approval of Agenda: Agenda for January 31, 2024, Meeting Approved.

4) Item: Approval of Minutes: QISC Meeting Minutes for October 31, 2023, were approved by Dr. Faheem and the QISC as written.

5) Goal: QAPIP Effectiveness: Information Technology (DWIHN Data Integration Process)

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		
Gary Herman, IT Manager, shared with the committee DWIHN's Data Integration Process flow. DWIHN utilizes its system Mental Health Wellness Information Network (MHWIN) to administer the collection, integration, and reporting of Outpatient claims, Inpatient claims, Demographic data, electronic health records, Pharmacy data, Laboratory results, and much more. The following is a summary of MHWIN and its capabilities. MHWIN is a comprehensive benefits administration system and claims processing software solution designed to support behavior health management. MHWIN was designed from the ground up keeping in mind the Health Insurance Portability and Accountability Act (HIPAA) rules. A key strength of the DWIHN model is the ability to document most information related to patient care in a single electronic health record, which is shared across service areas. This has led to better integration of care and clearer connections between patients and the members of their care teams. DWIHN has also created an integrated data warehouse (summarized below), which eventually hosts the majority of routine and ad-hoc analysis. The data warehouse contains: • Administrative Data • Assessment Data • Claims and encounter data (Inpatient and Outpatient) • Pharmacy Data • Physical Health Claims data DWIHN's integrated data warehouse represents a unique opportunity to understand the breadth of members' involvement with different aspects of the behavioral and physical health services and how they influence outcomes. Please see handout: DWIHN's Data Integration Process for additional information.		
Provider Feedback	**Assigned To**	**Deadline**
No provider feedback.		
Action Items	**Assigned To**	**Deadline**

DWIHN's Data Integration Process was approved by Dr. Faheem and the QISC members as written.	Dr. Faheem and QISC	January 30, 2024.

5) Item:

Goal: QAPIP Effectiveness: Quality Improvement (QAPIP Description FY2023-25, QAPIP Evaluation FY2023 and Workplan FY2024)

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		
April Siebert, Director of Quality Improvement, shared with the committee the following: **The (QAPIP) Description** is a two-year plan that covers FY2023 through FY2025. The plan is reviewed annually at a minimum to ensure compliance. The Plan Description follows a structured format that aligns with the MDHHS contract, NCQA standards, and 42 CFR Federal Regulations. Updates and outcomes to the QAPIP Plan include the following: • Sentinel Events Committee/Peer Review Committee (pg.43) • Behavioral Treatment Advisory Committee (pg.45) • Customer Service Committee (pg.49) • Access Committee (pg.50) • Constituent's Voice (pg.52) • Workplan for FY2024 (pg.58) The **QAPIP Evaluation FY2023 and Workplan for FY2024** were also presented for review and approval. The QAPIP Evaluation is an annual document that is completed at the end of each fiscal year that assesses the evaluation of effectiveness, barriers, and opportunities for improvement. The **Work Plan** is also created annually that directs the activities that are the focus of Quality Improvement efforts for the coming year. In the Work Plan for FY2023, there was a total of 35 objectives with goals that are aligned with the six (6) pillars (Customer, Access, Quality, Workforce, Finance, Advocacy) that are identified in DWIHN's Strategic Plan along with page numbers of the analysis. • 35 objectives, 26 met the evaluation outcomes identified in the work plan. • 3 objectives were partially met (Access to services for 7-day follow-up appointments and Recidivism) (pg.24) • 6 objectives that did not meet the established goals (Performance Improvement Projects) (pg.54-75) • The objectives that were partially met and/or not met will be continued in FY2024 (pg.93) **Strengths:** The following are performance standards that exceeded expectations.		

• External Quality Reviews (HSAG) (pg.85-88) • Performance Indicators (pg. 19-28) • Member Experience with Services (pg.4-5) • Performance Monitoring of provider network (pg.44) • Verification of Services (pg.46) • Critical and Sentinel Events Reporting (pg.47) • Behavioral Treatment Review Reporting (pg.48) **Opportunities for Improvement:** • Performance Improvement Projects (PIPs) (pg. 54-75) • Adult Recidivism to inpatient hospitalization (pg.24) April also discussed with the committee the next steps which include the following: • Approval from QISC • Share with the Constituents Voice (CV) Committee, • Approval from Program Compliance Committee (PCC) • Approval from the Full Board, Once the QAPIP Description, Evaluation, and Workplan has been approved documents will be posted to DWIHN's website for Stakeholder, Member, and Provider Review. Please review the attachment: QAPIP Evaluation Executive Summary for additional information.		
Provider Feedback	**Assigned To**	**Deadline**
No Provider Feedback		
Action Items	**Assigned To**	**Deadline**
Dr. Faheem and the QISC members approved the QAPIP Description FY2023-2025, QAPIP Evaluation FY2023 and the Workplan FY2024 as written.	Dr. Faheem and the QISC	January 30, 2024.

5) Item:
Goal: QAPIP Effectiveness: BTAC Annual Report FY2023

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, QI Clinical Specialist, shared and reviewed with the committee the Behavior Treatment Advisory Committee Annual FY2023 report. Fareeha shared with the committee the background, data, accomplishments and trends and patterns. Detroit Wayne Integrated Health Network (DWIHN) started the Behavior Treatment Advisory Committee (BTAC) in 2017. The Committee is comprised of DWIHN network providers, members, and DWIHN staff, including Psychiatrists, Psychologists, and the Office of Recipient Rights. BTAC reviews process implementation of MDHHS requirements by the network Behavior Treatment Plan Review Committee (BTPRC). Accomplishments over the last year include that Michigan Department of Health and Human Services (MDHHS) has recently updated the Technical Requirements for Behavior Treatment Plans. Compliance with the Technical Requirements is a contractual obligation of DWIHN to the MDHHS. DWIHN policy “Use of Behavior Treatment Plans in Community Mental Health Settings” and the ten attachments have been updated with effect from October 1, 2023. The BTAC staff offered a virtual technical assistance session via Zoom to update the network BTPRCs on September 18, 2023. The total number of participants was 150. Some of the noted trends and patterns include under-reporting of 911 calls, and critical and sentinel events is an opportunity to improve the system. While DWIHN has made some progress in this area, we continue to work with network providers to address this issue. The network BTPRCs have an electronic health record system that is not patched with the DWIHN PCE system (MHWIN), and that is one of the barriers to improving the under-reporting of 911 calls and other reportable categories of the events. Please see the attachment: BTAC Annual Data Summary for more information.		
Provider Feedback	**Assigned To**	**Deadline**
No provider feedback.		
Action Items	**Assigned To**	**Deadline**
Dr. Faheem and the QISC approved the BTAC Annual Report FY2023 as written.	Dr. S. Faheem and QISC Members	January 30, 2024.

5): Goal: QAPIP Effectiveness: UM Evaluation FY2023

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

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

Discussion		
Leigh Wayna, Director of Utilization Management presented the UM Evaluation for FY2022. Leigh will present the UM Evaluation for FY2023 at the next QISC meeting scheduled for February 27th, 2024.		
Provider Feedback	**Assigned To**	**Deadline**
No provider feedback.		
Action Items	**Assigned To**	**Deadline**
Leigh Wayna to present the UM Evaluation for FY2023 at the next QISC Meeting scheduled for February.	Leigh Wayna	February 27, 2024

5. Goal: QAPIP Effectiveness: Children Initiatives –APM Performance Improvement Project

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

NCQA Standard(s)/Element #: QI 10, 11 CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Discussion		
Cassandra Phipps, Director of Children Initiatives reviewed with the committee the Metabolic Monitoring for Children/Adolescents on Antipsychotics (APM) PIP. Cassandra shared with the group that this PIP is being presented to receive approval to keep the goal as 23% for the Quantifiable Measure# 1: Percentage of youth ages 1 to 11 with ongoing antipsychotic medication with completed metabolic testing for blood glucose and cholesterol levels. The goal is for child 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 Cholesterol lab work). For the Quantifiable Measure #2: Percentage of youth ages 12 to 17 with ongoing antipsychotic medication with completed metabolic testing for blood glucose and cholesterol levels the request is to increase the goal from 32% to 38% since we have met the initial goal of 33%. Please see the APM Performance Improvement PP for more information.		
Provider Feedback	**Assigned To**	**Deadline**
No provider feedback.		
Action Items	**Assigned To**	**Deadline**
Dr. Faheem and the QISC Approved the Goal changes as recommended for the APM PIP.	Dr. S. Faheem and the QISC	January 30, 2024

5) Goal: QAPIP Effectiveness: Children Initiatives – ADHD Performance Improvement Project
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems **X Quality** ☐ Workforce
NCQA Standard(s)/Element #: QI 10, 11 CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Discussion		
Cassandra Phipps, Director of Children Initiatives the ADD – follow-up care for children prescribed ADHD Medication PIP provided a synopsis on the following: 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, children must be monitored by a pediatrician with prescribing authority. The request for the QISC is to review and increase the Quantifiable Measure #1: Percentage of members taking ADHD medication completed initial doctor visit 64% (5 points above the current score of 59.01%) Please see the ADHD/ADD Performance Improvement PP for more information		
Provider Feedback	**Assigned To**	**Deadline**
No provider feedback.		
Action Items	**Assigned To**	**Deadline**
Dr. S. Faheem and the QISC approved the increase change of the goal as recommended for the ADHD/ADD Performance Improvement Project.	Dr. S. Faheem and QISC Members	January 30, 2024.

Goal: QAPIP Effectiveness: Children Initiatives – Autism Benefit Performance Improvement Project

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

NCQA Standard(s)/Element #: QI 10, 11 CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Discussion		
Cassandra Phipps, presented to the Committee the Autism Benefit Performance Improvement Project. The PIP is being presented to sunset the measure of tracking autism timeliness from ABA referral to ABA services start date. The request is to start a new Performance Improvement Plan for improving ABA services starting within 14 days of the auth effective date, with the reminder that Providers are expected to send an Adverse Determination if services are delayed past 14 days. Barriers identified include the following: • 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 of 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. Please see the ASD Performance Improvement Project PP for more information.		
Provider Feedback	**Assigned To**	**Deadline**
No provider feedback.		
Action Items	**Assigned To**	**Deadline**
Dr. S. Faheem and the QISC approved sunset the measure from the previous PIP and start the new measure for starting within the 14 days of the authorization effective date.	Dr. S. Faheem and QISC Members	January 30, 2024.

Goal: QAPIP Effectiveness: Integrated Health – Population Assessment FY2023

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

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

Discussion		
Vicky Politowski, Director of Integrated Health, presented to the committee the Population Assessment for FY2023. Vicky discussed that DWIHN recognizes the importance of analyzing member data to ensure that our programs and services meet the diverse needs of the members we serve. The information includes gender, age, primary language spoken, ethnic background, disability designation, residency, and insurance. We use this information to create topic and language-appropriate materials, establish partnerships with other organizations serving ethnic communities, inform our vendors about specific ethnic and cultural needs; and develop competency training for staff. This information is gathered annually. Some of the data reviewed included that during FY23, DWIHN provided services to a total of 75,638 members. This is a slight decrease of 201 (.3%) from FY22. Only 71% of members had an identified Primary Care Physician in 2023. This is an increase from 66% of members in 2022 and 69% of members in 2021 who had an identified Primary Care Physician. During FY23, 63 members were enrolled in Complex Case Management Services. The CCM team currently consists of a Clinical Specialist and 2 Complex Case Managers. Our current staffing ratios are adequate to meet the needs of the population. CCM works closely with the Clinical Specialist OBRA/PASSR nurse to have an increased understanding of member medical conditions as well as having a Registered Nurse available to work on member cases as needed. Based on the FY23 report no changes have been made to CCM eligibility criteria for children and adults. Please see the attachment: FY2023 Population Assessment PP for more information.		
Provider Feedback	**Assigned To**	**Deadline**
No provider feedback.		
Action Items	**Assigned To**	**Deadline**
Dr. S. Faheem and the QISC approved the Population Assessment for FY2023 as written.	Dr. S. Faheem and QISC Members	January 30, 2024.

Goal: QAPIP Effectiveness: Integrated Health – Complex Case Management FY2023

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

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

Discussion		
Vicky Politowski shared with the committee the Complex Casement Management Evaluation for FY2023. The ultimate goals of DWMHA's/DWIHN's Complex Case Management (CCM) Program are to: Improve medical and/or behavioral health concerns and increase overall functional status as well as improve overall quality of life as evidenced by a 10% improvement in PHQ scores and/or a 10% improvement in WHO-DAS scores at CCM closure. To provide early intervention for members appropriate for Complex Case Management to prevent recurrent crisis or unnecessary hospitalizations as evidenced by a 10% reduction in Emergency Department (ED) utilization and/or a 10% reduction in hospital admissions from 90 days before receiving CCM services to 90 days after receiving CCM services. Increased participation in outpatient treatment as evidenced by a 10% increase in outpatient behavioral health services from 90 days before receiving CCM services to 90 days after receiving CCM services. u Assist members to access community resources and obtain a better understanding of the physical and/or behavioral health conditions as evidenced by improved compliance with behavioral health and physical health appointments and a decrease in ED visits and/or inpatient admissions. u 80% or greater member satisfaction scores for members who have received CCM services. Please review the Complex Case Management FY2023 PP for more information.		
Provider Feedback	**Assigned To**	**Deadline**
No provider feedback.		
Action Items	**Assigned To**	**Deadline**
Dr. S. Faheem and the QISC approved the Complex Case Management FY2023 Evaluation as written.	Dr. S. Faheem and QISC Members	January 30, 2024.

Goal: QAPIP Effectiveness: Customer Service – CS Year End Report FY2023
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems Quality ☐ Workforce
NCQA Standard(s)/Element #: QI CC# 1 ☐ UM #____ ☐CR # ___ ☐ RR # ___

Discussion		
Michele Vasconcellos, Director of Customer Service, shared with the committee the Customer Service 2022/2023 Year End Report. Michele shared the Significant Activities within the CS Department. One activity was related to the Customer Service Call Center, in comparing the Fiscal years 21/22 and 22/23, the number of calls continues to vary from year to year that come into the switchboard area, with an abandonment rate well below 5%. During the Fiscal Year 22/23, the Call Center has shown a significant improvement from the previous Fiscal Year relative to the abandonment rate (<5%), which is attributed to the repositioning of staff during PTO requests and staff working together as a team to make sure we have adequate staffing during requested time off as well as the call volume has decreased. Michele also discussed the Member Experience. The Customer Services' Member Experience team conducted a variety of member experience-related surveys i.e. On-Line Provider Directory User Friendliness, Follow-up Appointment Visits Post Hospital Discharge, Peer Workforce, Peer Liaison, Long Term Support Services, National Core Indicator, and in partnership with Wayne State University Center for Urban Studies, the ECHO Adult, and Children surveys. The Persons Point of View member newsletters continued to be published quarterly and enjoyed by many. For more information, please review the CS 2022/2023 Year End Report.		
Provider Feedback	**Assigned To**	**Deadline**
No provider feedback.		
Action Items	**Assigned To**	**Deadline**
Dr. S. Faheem and the QISC approved Customer Service Year End Report FY2023	Dr. S. Faheem and QISC Members	January 30, 2024.

New Business Next Meeting: February 27, 2024
Adjournment: October 31, 2023

Executive Summary

The Executive Summary provides an overview of the Quality Assurance Performance Improvement Plan (QAPIP) Description (FY2023- 2025), Evaluation (FY2023) and Work Plan (FY2024). Once approved by the Full Board, copies of the QAPIP Plan Description, Evaluation and Work Plan are sent to MDHHS. The documents will also be posted on DWIHN's website for stakeholders and members to review.

QAPIP Plan Description FY 2023-2025

The (QAPIP) Description is a two-year plan that covers FY2023 through FY2025. The plan is reviewed annually at a minimum to ensure compliance. The Plan Description follows a structured format that aligns with the MDHHS contract, NCQA standards and 42 CFR Federal Regulations. Updates and outcomes to the QAPIP Plan include the following:

- Sentinel Events Committee/Peer Review Committee (pg.43)
- Behavioral Treatment Advisory Committee (pg.45)
- Customer Service Committee (pg.49)
- Access Committee (pg.50)
- Constituent's Voice (pg.52)
- Workplan for FY2024 (pg.58)

QAPIP Evaluation and Work Plan FY2023

The QAPIP Evaluation is an annual document that is completed at the end of each fiscal year that assesses the evaluation of effectiveness, barriers, and opportunities for improvement. The Work Plan is also created annually that directs the activities that are the focus of Quality Improvement efforts for the coming year. In the Work Plan for FY2023, there was a total of 35 objectives with goals that are aligned with the six (6) pillars (Customer, Access, Quality, Workforce, Finance, Advocacy) that are identified in DWIHN's Strategic Plan along with page numbers of the analysis.

- Of the 35 objectives, 26 met the evaluation outcomes identified in the work plan.
- 3 objectives were partially met (Access to services for 7-day follow-up appointments and Recidivism) (pg.24)
- 6 objectives that did not meet the established goals (Performance Improvement Projects) (pg.54-75)
- The objectives that were partially met and/or not met will be continued in FY2024 (pg.93)

STRENGTHS	OPPORTUNITIES FOR IMPROVEMENT
The following are performance standards that exceeded expectations. • External Quality Reviews (HSAG) (pg.85-88) • Performance Indicators (pg. 19-28) • Member Experience with Services (pg.4-5) • Performance Monitoring of provider network (pg.44) • Verification of Services (pg.46) • Critical and Sentinel Events Reporting (pg.47) • Behavioral Treatment Review Reporting (pg.48)	Performance Improvement Projects (PIPs) (pg. 54-75) Adult Recidivism to inpatient hospitalization (pg.24)

Next Steps
• Approval from QISC • Share with Constituents Voice (CV) Committee • Approval from Program Compliance Committee (PCC) • Approval from Full Board • Post to DWIHN’s website for Stakeholder, Member and Provider Review

Behavior Treatment Advisory Committee Summary of Data Analysis 2022-2023

Prepared by: Fareeha Nadeem, M.A., LLP.
Clinical Specialist, Quality Improvement

BACKGROUND

- Detroit Wayne Integrated Health Network (DWIHN) started Behavior Treatment Advisory Committee (BTAC) in 2017.
- The Committee is comprised of DWIHN network providers, members, DWIHN staff, including Psychiatrists, Psychologists, and the Office of Recipient Rights.
- BTAC reviews process implementation of MDHHS requirements by the network Behavior Treatment Plan Review Committee (BTPRC).

BACKGROUND Contd'…

- BTAC reviews system-wide Behavior Treatment Plan Review Committees' trends and patterns compared to performance indicators such as psychiatric hospitalization, behavior stabilization, 911 calls, Critical and Sentinel Events, and reductions or increase in the use of Behavior Treatment Plans.

BTPRC DATA

- Network BTPRCs collect, review, and report to DWIHN quarterly, where intrusive and restrictive techniques have been approved for use with individuals, and where physical management or 911 calls to law enforcement have been used in an emergency behavioral situation.
- The BTPRC data provides DWIHN an oversight through analysis on a quarterly basis to address any trends and/or opportunities for quality improvement.

BTPRC DATA Contd'….

- DWIHN conducts randomly selected clinical chart reviews for those with recommended restrictive and/or intrusive interventions, in addition to the annual review of BTPRC policy and procedures.
- Network BTPRCs collect data provides trends from previous quarters, need for trainings, interventions done to minimize use of restrictions.

ACCOMPLISHMENTS

- Michigan Department of Health and Human Services (MDHHS) has recently updated the Technical Requirements for Behavior Treatment Plans. Compliance with the Technical Requirements is a contractual obligation of DWIHN to the MDHHS. DWIHN policy “Use of Behavior Treatment Plans in Community Mental Health Settings” and the ten attachments have been updated with effect from October 1, 2023.
- The BTAC staff offered a virtual technical assistance session via zoom to update the network BTPRCs on September 18, 2023. The total number of participants was 150.

ACCOMPLISHMENTS Contd'….

- DWIHN does not have the FBA code set up for psychologists to use when they complete FBAs. The staff prepared the bulletin guidelines on the appropriate use of 97151 (Replacement of FA-H0031) for nonbeneficiaries of 1915(c) Waivers.
- The FBA bulletin has been published on DWIHN website and has been sent to the network providers.
- DWIHN submits quarterly data analysis reports on systemwide trends of BTPRC to MDHHS.

ACCOMPLISHMENTS Contd'….

- During FY2022-2023, the network providers presented Thirteen (13) complex cases with severe behavior challenges to the BTAC.
- The BTPRC requirements continue to be included in the Outpatient and Residential contract for FY 2022-2023.

ACCOMPLISHMENTS Contd'....

- DWIHN is in full compliance with PIHP Administrative Review Procedures of Behavior Treatment (B1) for the fifth consecutive year as part of MDHHS Habilitative Supports Waiver 1915(c) Review.
- Similarly, based on the Health Services Advisory Group (HSAG) Review findings, DWIHN fully complies with the required elements for the BTPRCs.
- The BTAC staff has been appointed to serve on the MDHHS Behavior Treatment Advisory Group for a fourth consecutive year.

BTPRC DATA

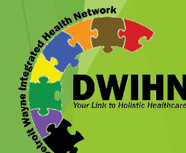
The following BTPRC submitted the data included in this report:

- Community Living Services, Inc.
- Development Center, Inc.
- Hegira Downriver
- The Children's Center.
- The Guidance Center.
- Team Wellness Center.
- Neighborhood Service Organization
- Easterseals-MORC, Inc.
- PsyGenics, Inc.
- Wayne Center.

The charts below illustrate the BTAC Summary of Data Analysis FY 2022-2023

Total Behavior Treatment Plans Reviewed

	Total	New	Continued	Discontinued
1st Qtr	398	73	322	3
2nd Qtr	379	70	305	4
3rd Qtr	379	67	305	2
4th Qtr	395	17	372	6



Restrictive and Intrusive Interventions

Quarter	Restrictive	Intrusive
4th Qtr	314	142
3rd Qtr	323	81
2nd Qtr	328	51
1st Qtr	318	84

0 50 100 150 200 250 300 350 400 450 500

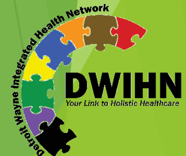
■ Restrictive ■ Intrusive

Reported Number of Medications

	Anti-Psychotic	Psychotropic
4th Qtr	460	1125
3rd Qtr	418	1134
2nd Qtr	424	1113
1st Qtr	408	1102

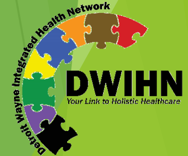
0 500 1000 1500 2000

■ Anti-Psychotic ■ Psychotropic



Reported 911 Calls and Critical/Sentinel Events

	911 Calls	Sentinel Events
1st Qtr	22	7
2nd Qtr	91	37
3rd Qtr	76	19
4th Qtr	33	18



TRENDS AND PATTERNS

- Under-reporting of 911 calls, and critical and sentinel events is an opportunity to improve as a system. DWIHN continues to work with network providers to address this issue.
- The network BTPRCs have an electronic health record system that is not patched with the DWIHN PCE system (MHWIN), and that is one of the barriers to improve the under- reporting of 911 calls and other reportable categories of the events.

TRENDS AND PATTERNS Contd'…

- Reporting under the wrong category is one of the barriers. The Behavior Treatment category is live in the Sentinel Events Reporting module in MHWIN to improve the systemic under-reporting of Behavior Treatment beneficiaries' required data, however many of the reportable events are reported in the wrong category.
- In-service on behavior treatment plans by the staff not qualified. The shortage of the clinical staff with MDHHS-required credentials for BTPRC review continues to be challenging.

THANK YOU!

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.

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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.

- **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.

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**

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

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

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?

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.

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%

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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

<u>Barriers Identified:</u> *<u>Initial Diagnostic Evaluation</u>*

- ❑ 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.

<u>Intervention:</u>

- 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

<u>Barriers Identified:</u> *<u>Continued Challenges with Capacity Issues</u>*

- 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.
  - **<u>PROJECTED Intervention: Grant to Build Parent Training into 90-day wait period</u>**
    - 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

12

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

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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.

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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.

- **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

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

<u>As of April 2023 – Improving Practices Leadership Team (IPLT):</u>

- **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**

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?

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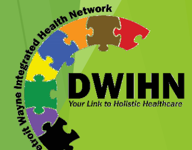
DWIHN Population Assessment and Analysis of Complex Case Management Activities and Resources FY2023

- DWIHN recognizes the importance of analyzing member data to assure that our programs and services meet the diverse needs of the members we serve. The information includes gender, age, primary language spoken, ethnic background, disability designation, residency, and insurance.
- We use this information to create topic and language appropriate materials, establish partnership with other organizations serving ethnic communities, inform our vendors about specific ethnic and cultural needs; and develop competency training for staff.
- This information is gathered annually



75,638

Primary Care Physician

- During FY23, DWIHN provided services to a total of 75,638 members. This is a slight decrease of 201 (.3%) from FY22

- Only 71% of members had an identified Primary Care Physician in 2023. This is an increase from 66% of members in 2022 and from 69% of members in 2021 who had an identified Primary Care Physician. *(Table 1)*

Identified Primary Care Physician

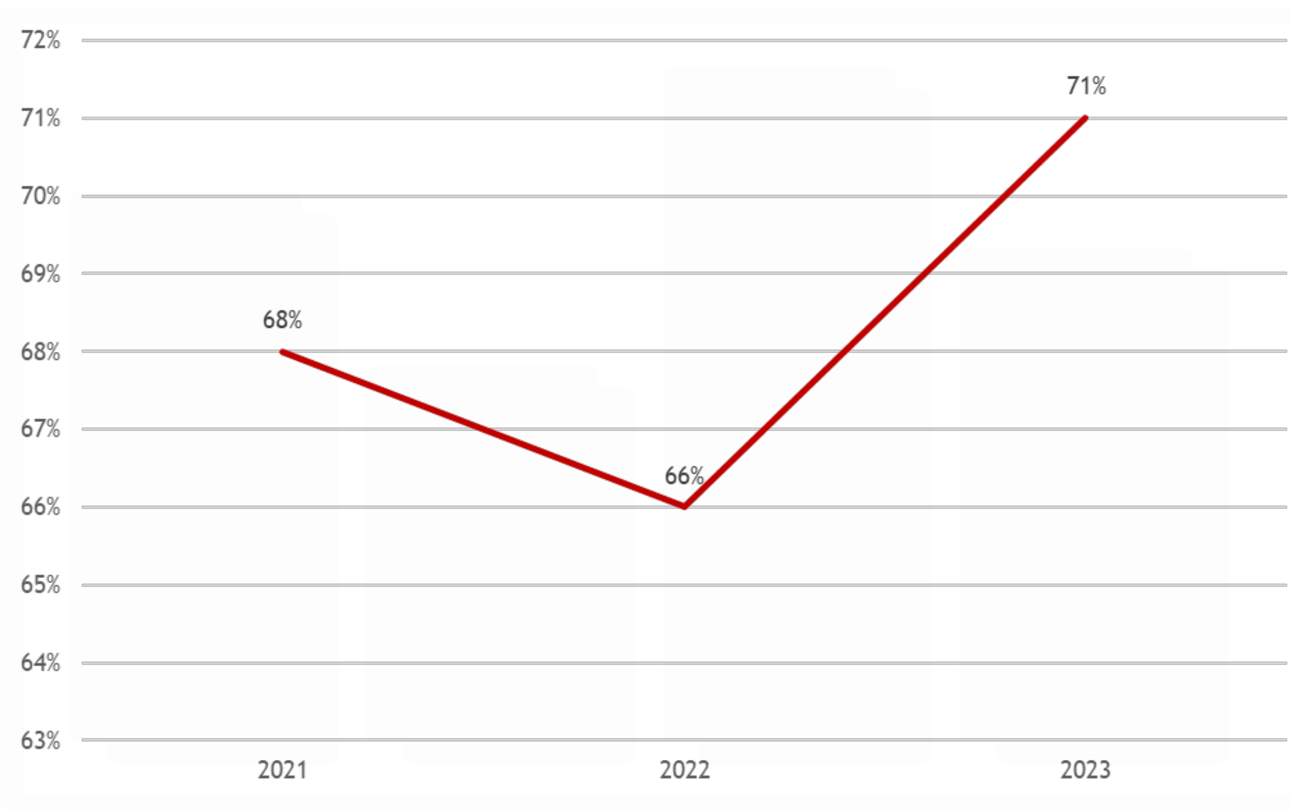


Table 1
* Data derived from Risk Matrix

Gender

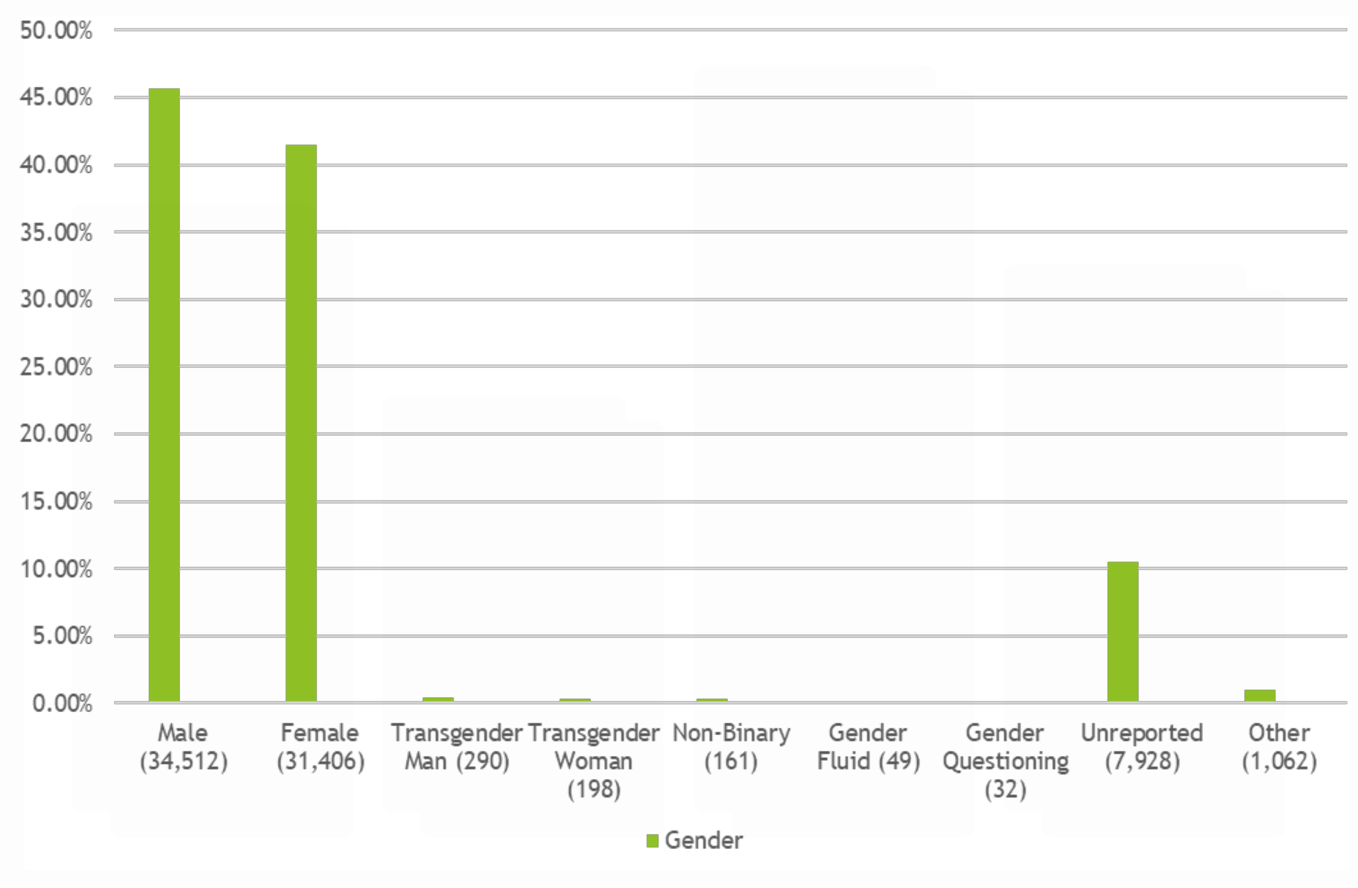


Table 2
* Data derived from Risk Matrix

Age Range

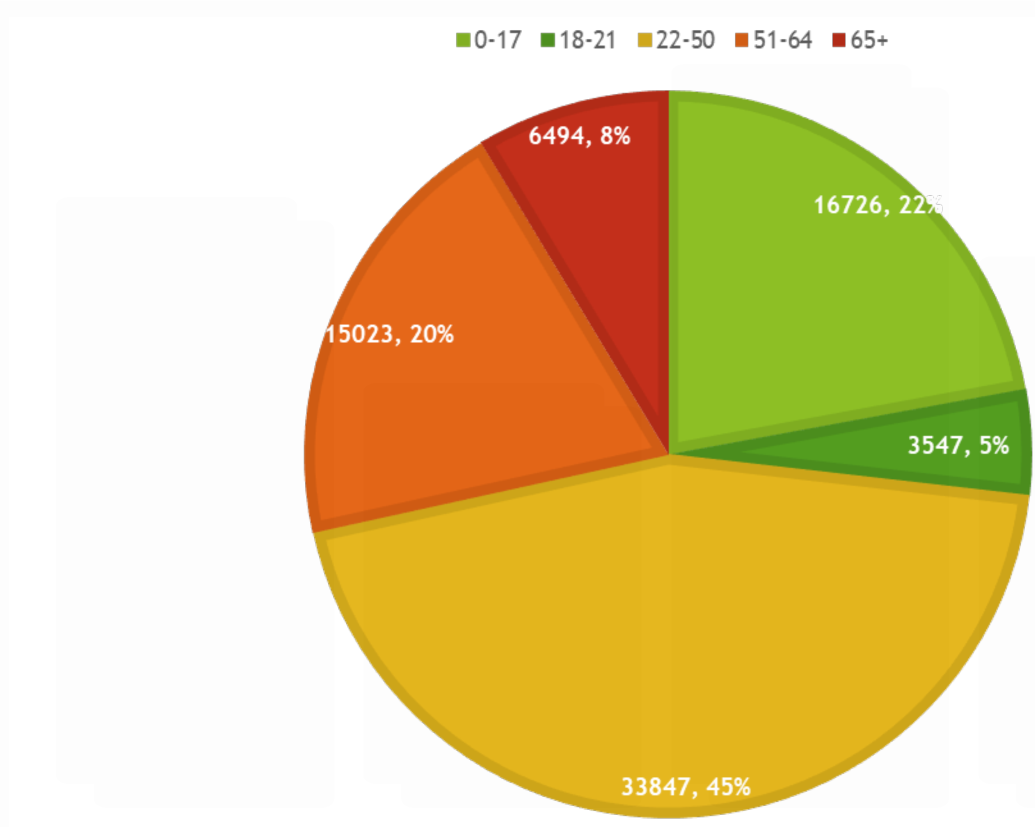


Table 3
*Data derived from Risk Matrix

Ethnic Background

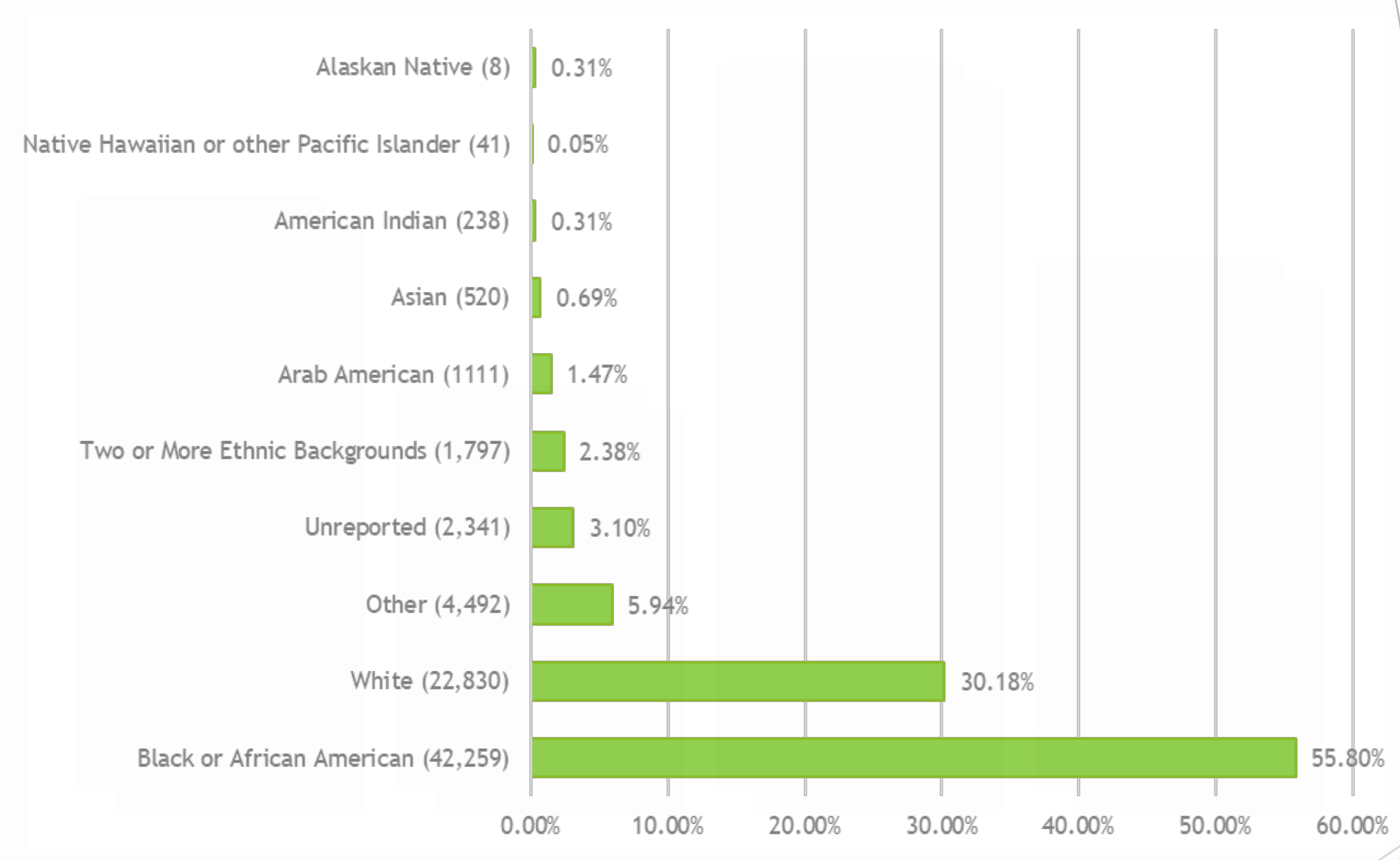


Table 4
*Data derived from Risk Matrix

Primary Language

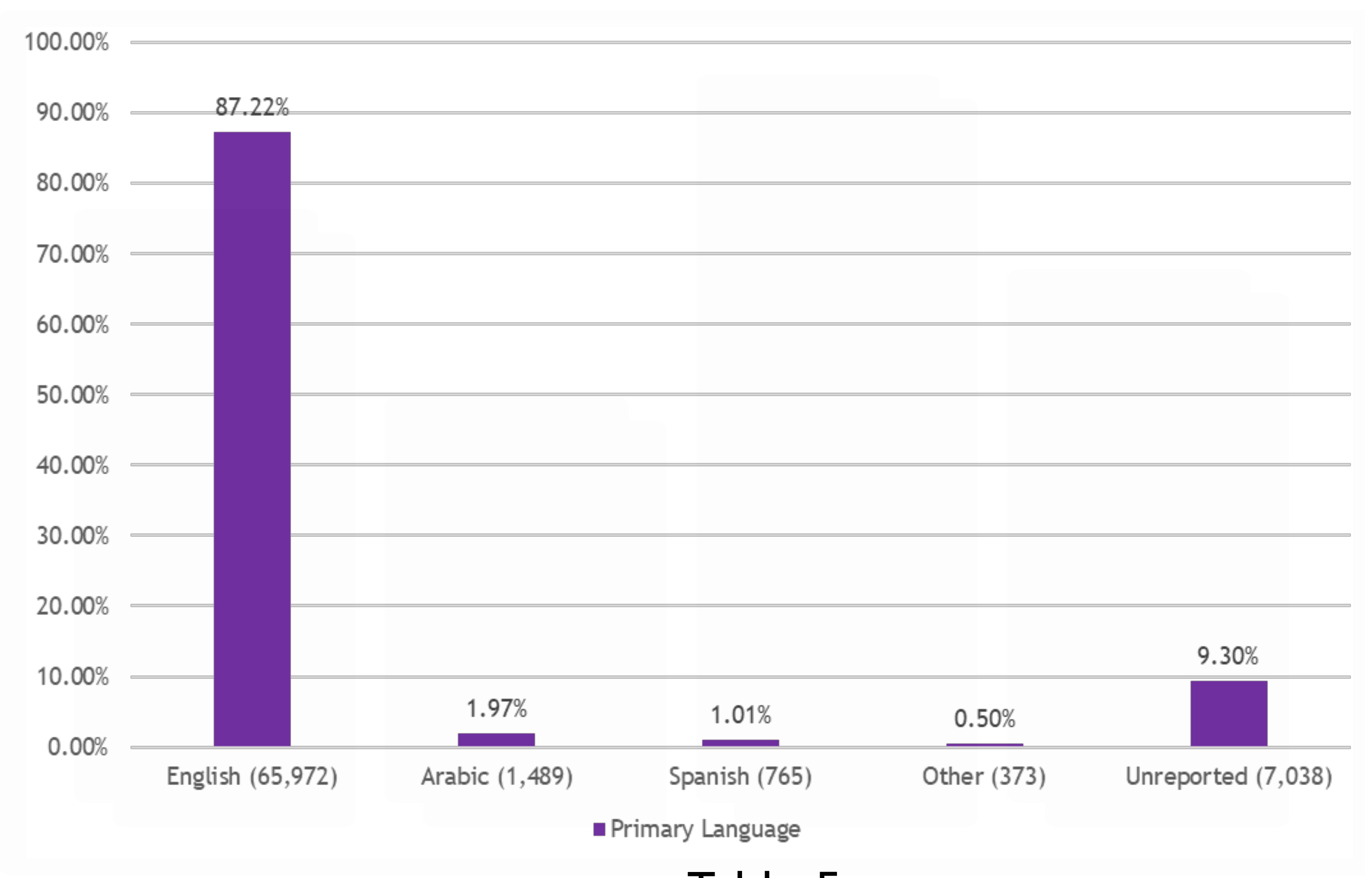


Table 5
*Data derived from Risk Matrix

Disability Designation

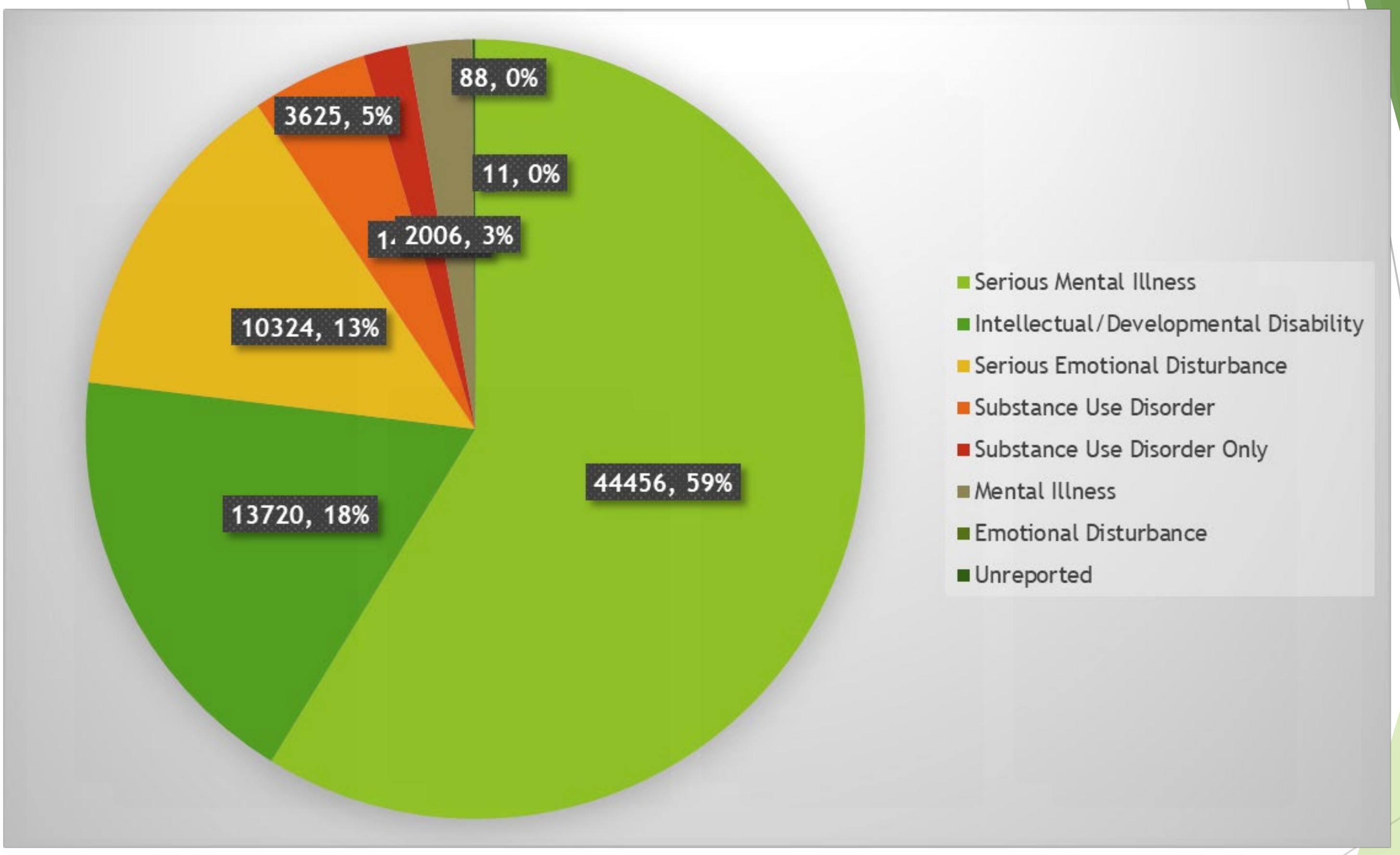


Table 6
*Data derived from Risk Matrix

Residency

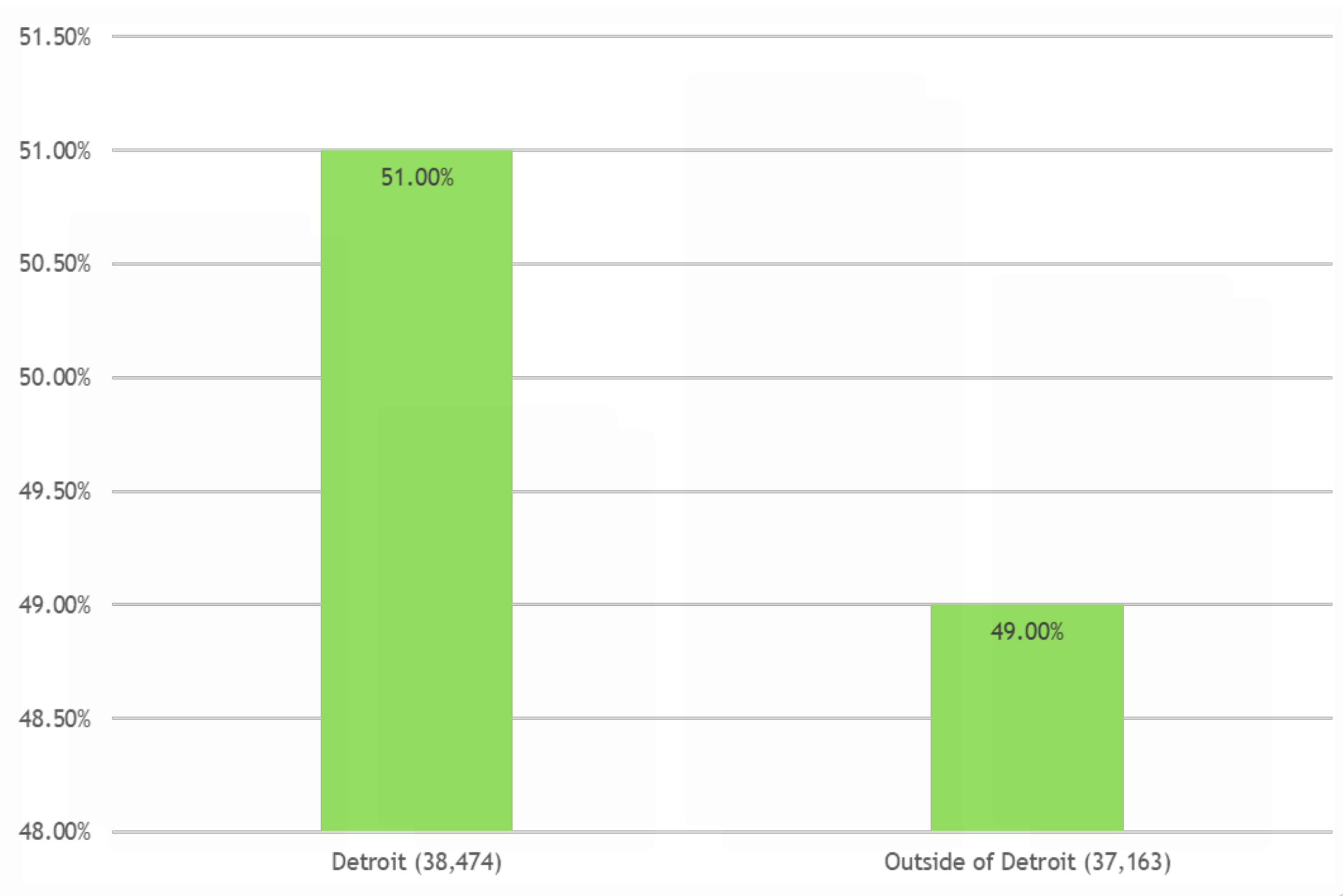


Table 7
*Data derived from Risk Matrix

Insurance

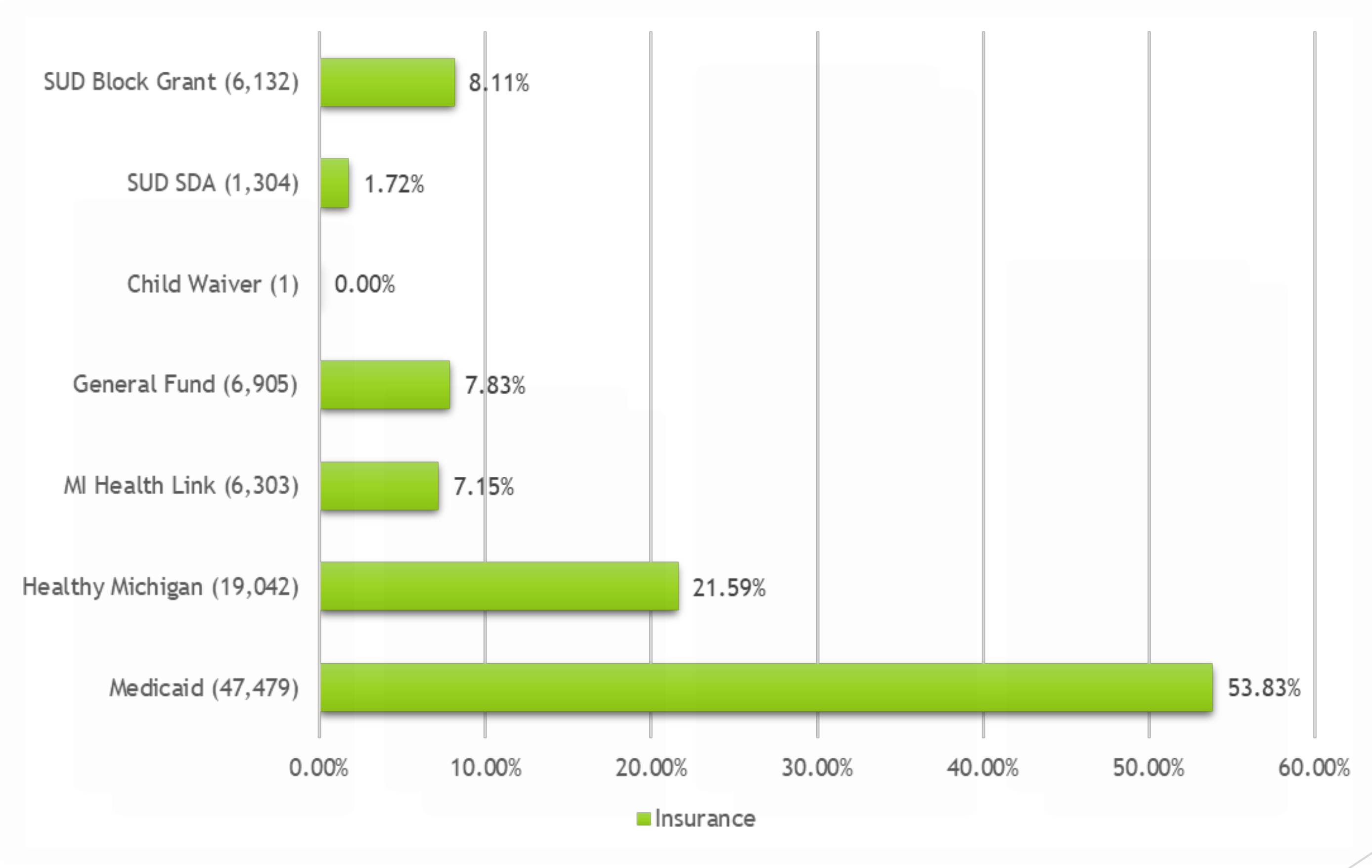


Table 8

*Data derived from Risk Matrix

Unreported Primary Spoken Language

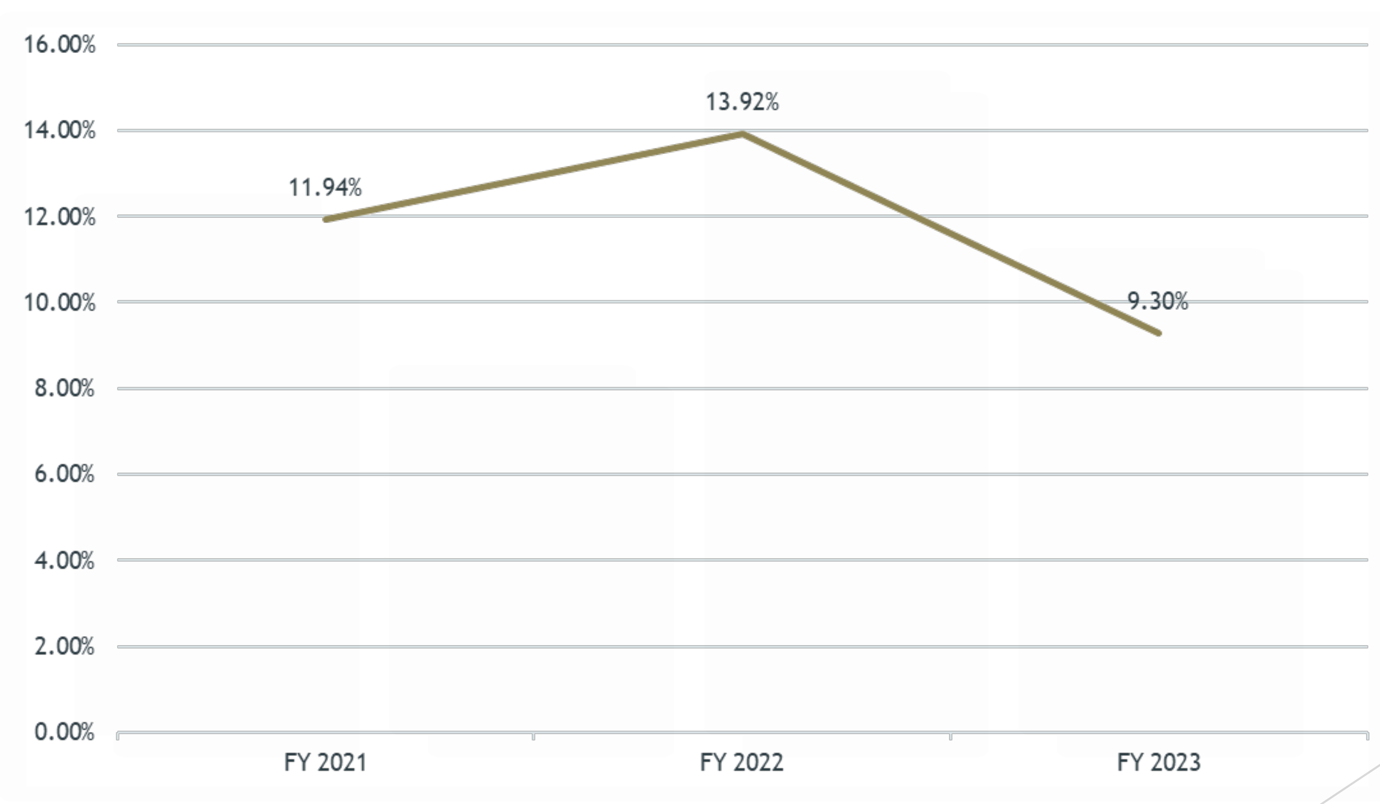


Table 9
*Data derived from Risk Matrix

English Primary Spoken Language

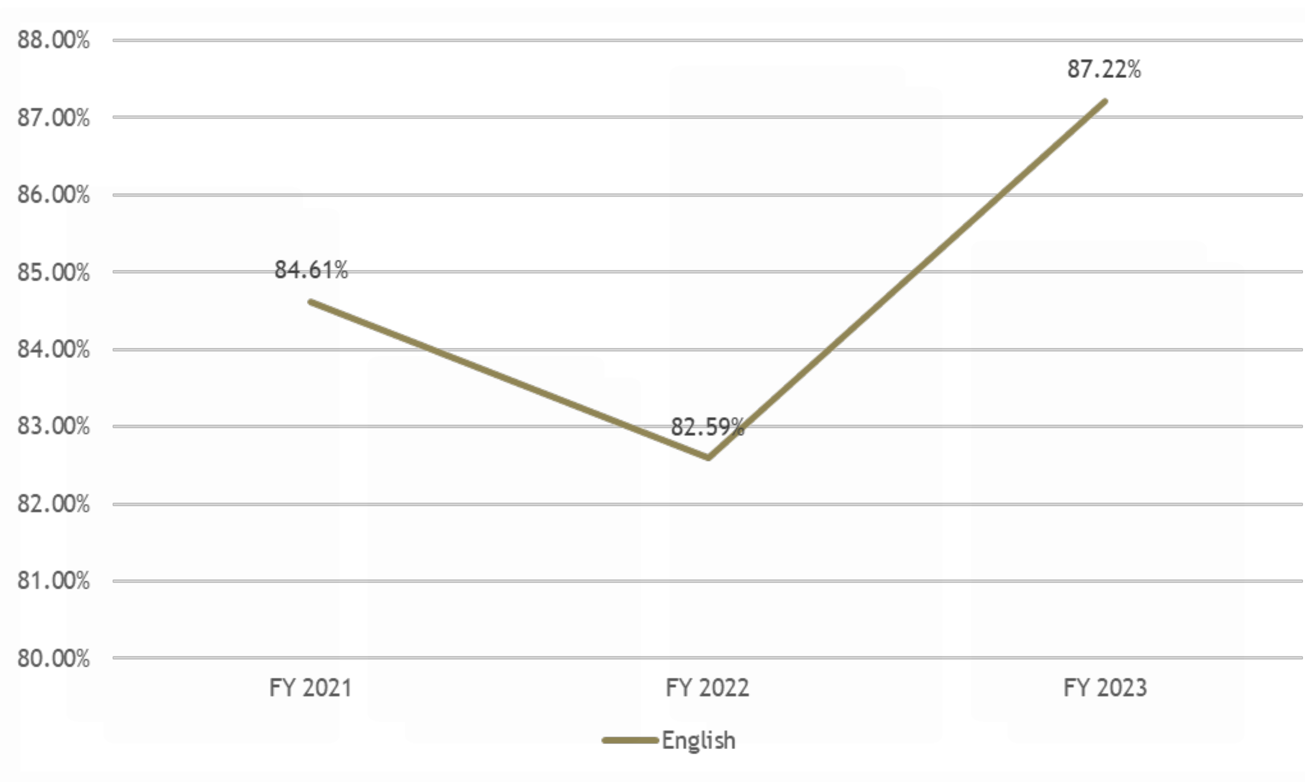


*Table 10
*Data derived from Risk Matrix

Two or more Ethnic Backgrounds

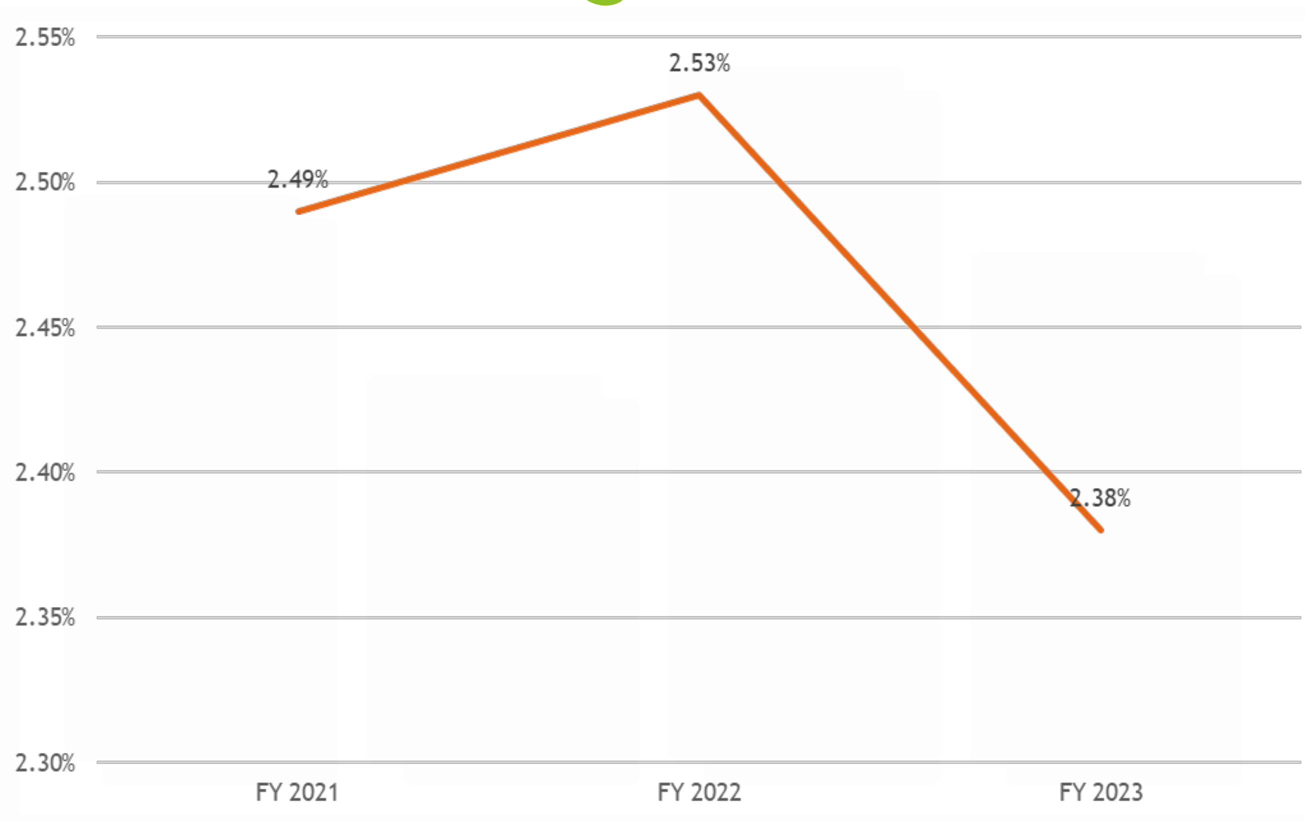


Table 11
*Date derived from Risk Matrix

Top 5 Behavioral Health Diagnosis Children 0-17

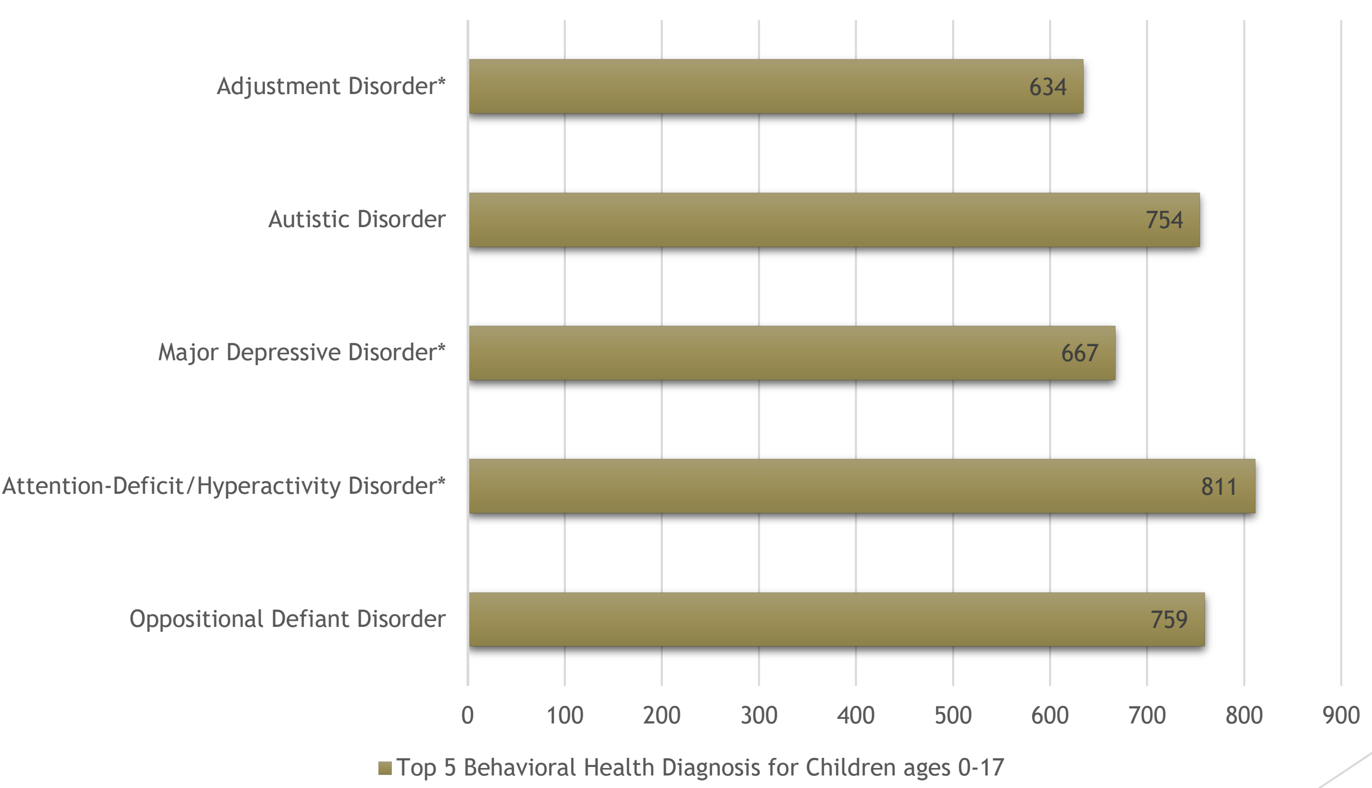


Table 12

**Data pulled from IT/MHWIN

Top 5 Physical Health Diagnosis Children 0-17

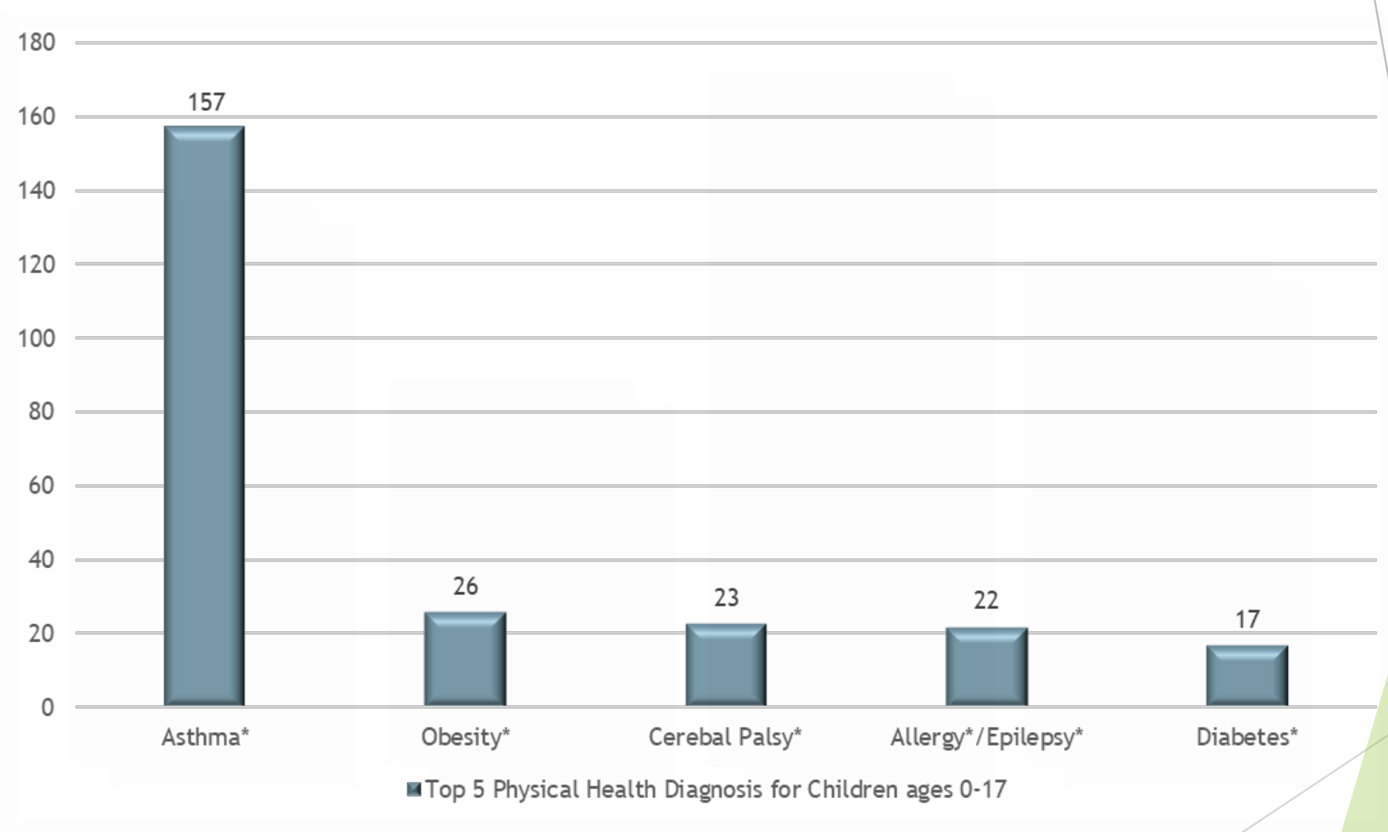


Table 13
**Data pulled from IT/MHWIN

Top 5 Behavioral Health Diagnosis Adults 18+

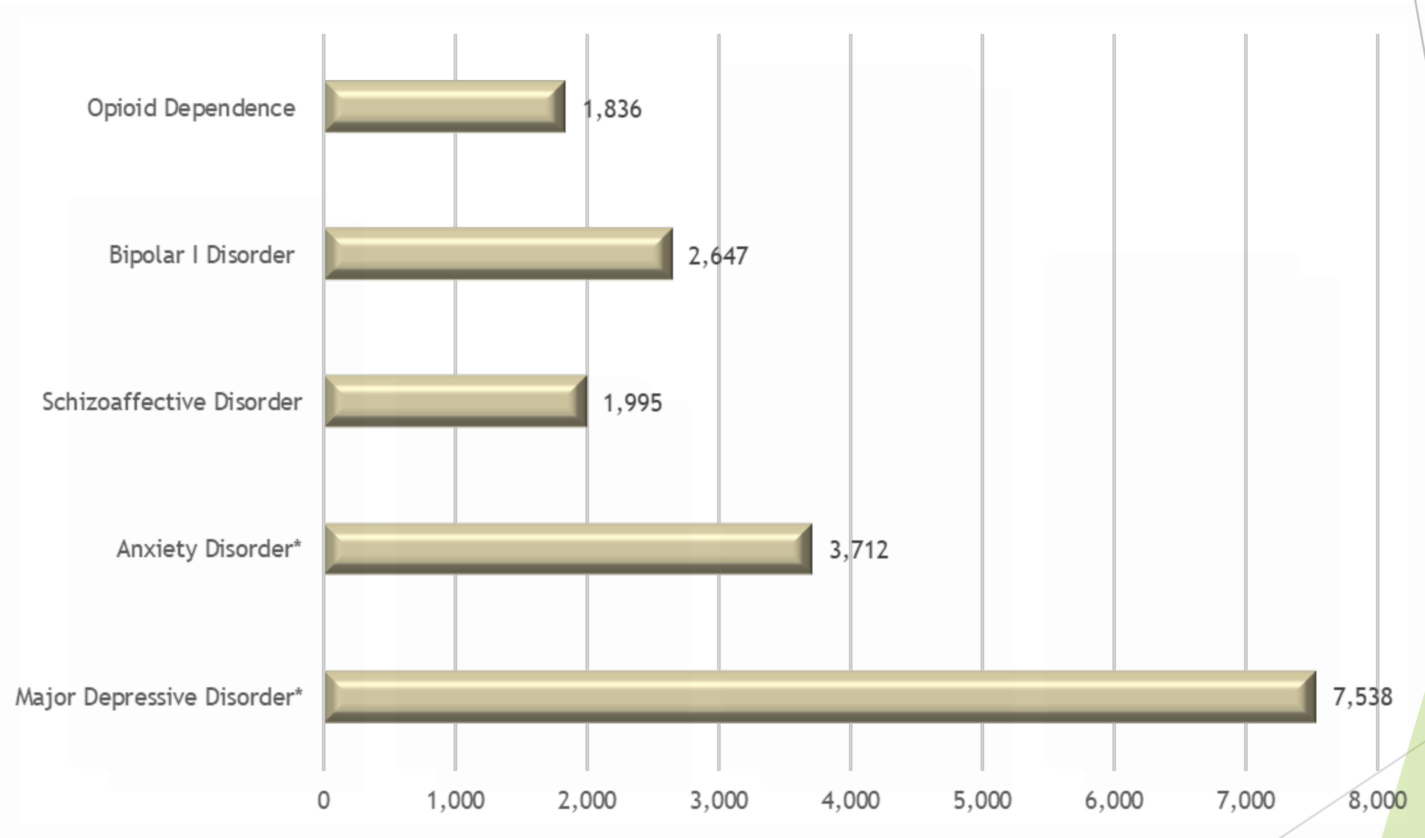


Table 14

**Data pulled from IT/MHWIN

Top SPMI Diagnosis for Adults 18+

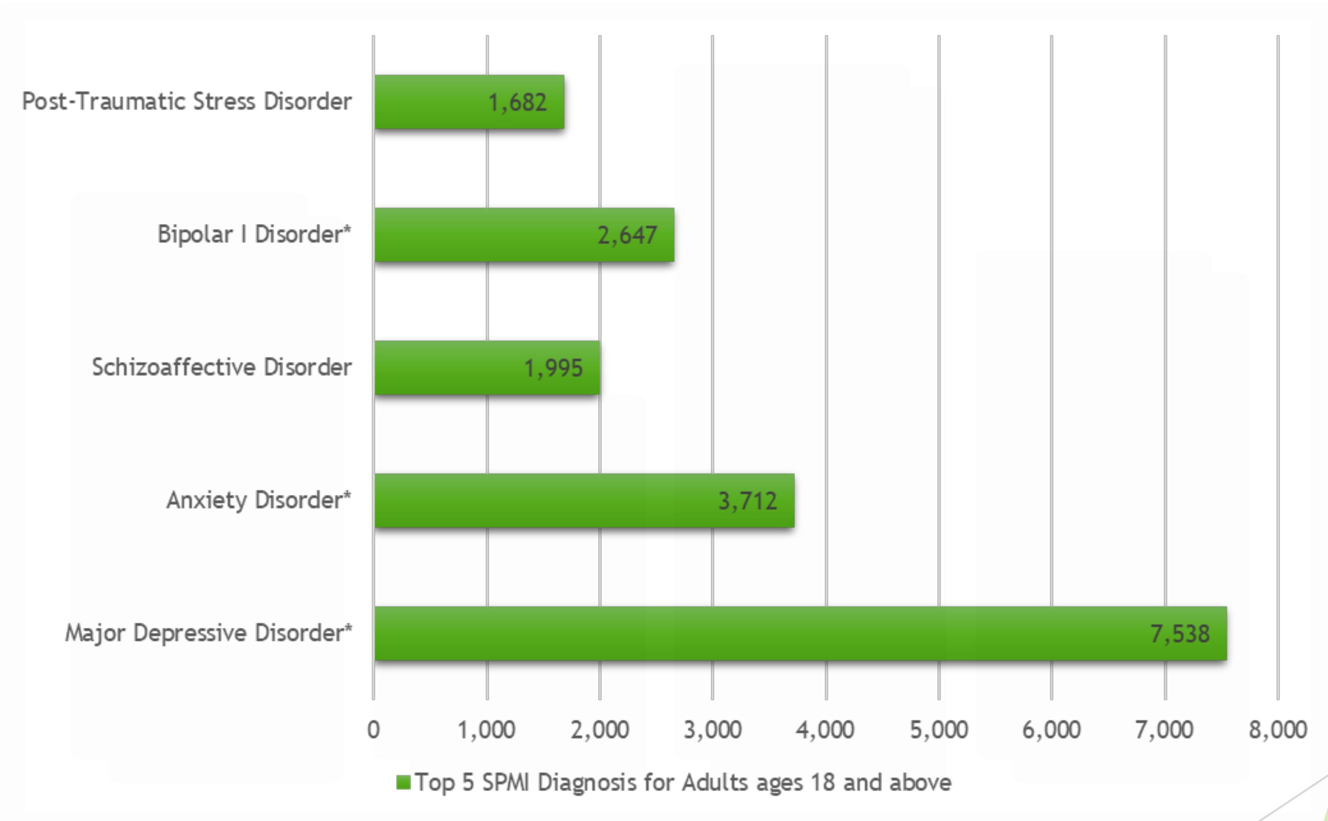


Table 15
**Data pulled from IT/MHWIN

Top 5 Physical Health Diagnosis Adults 18+

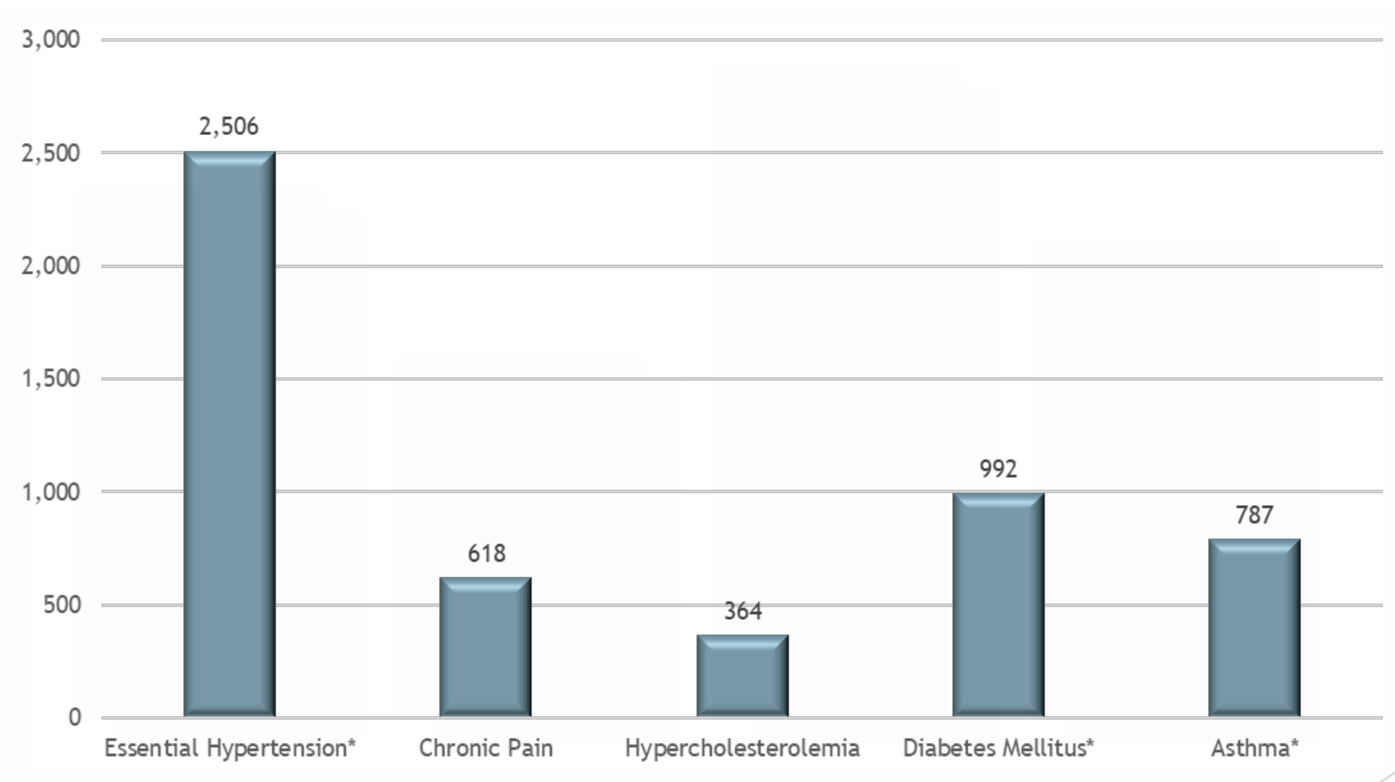


Table 16

**Data pulled from IT/MHWIN

Childrens Behavioral Health comparisons FY23 and FY22

Top 5 Behavioral Dx 2023	Top 5 Behavioral Dx 2022
1. Attention-Deficit/Hyperactivity Disorder	1. Attention-Deficit/Hyperactivity Disorder
2. Oppositional Defiant Disorder	2. Oppositional Defiant Disorder
3. Autistic Disorder	3. Major Depressive Disorder
4. Major Depressive Disorder	4. Adjustment Disorder
5. Adjustment Disorder	5. Autistic Disorder/Mood Disorder

Table 17
**Data pulled from IT/MHWIN

Childrens Physical Health comparisons FY23 and FY22

Top 5 Physical Dx 2023	Top 5 Physical Dx 2022
1. Asthma	1. Asthma
2. Obesity	2. Epilepsy
3. Cerebral Palsy	3. Cerebral Palsy/Obesity
4. Allergy/Epilepsy	4. Allergy
5. Diabetes	5. COPD

Table 18
**Data pulled from IT/MHWIN

Adult Behavioral Health comparisons FY23 and FY22

Top 5 Behavioral Dx 2023	Top 5 Behavioral Dx 2022
1. Major Depressive Disorder	1. Major Depressive Disorder
2. Anxiety Disorder	2. Anxiety Disorder
3. Schizoaffective	3. Bipolar I
4. Bipolar I	4. Schizoaffective
5. Opioid Dependence	5. Schizophrenia

Table 19

**Data pulled from IT/MHWIN

Adult Physical Health comparisons FY23 and FY22

Top 5 Physical Dx 2023	Top 5 Physical Dx 2022
1. Essential Hypertension	1. Essential Hypertension
2. Diabetes Mellitus	2. Diabetes Mellitus
3. Asthma	3. Asthma
4. Chronic Pain	4. Chronic Pain
5. Hypercholesterolemia	5. Obesity

Table 20
**Data pulled from IT/MHWIN

Adult SPMI comparisons FY23 and FY22

SPMI 2023	SPMI 2022
1. Major Depressive Disorder	1. Major Depressive Disorder
2. Anxiety Disorder	2. Anxiety Disorder
3. Bipolar I Disorder	3. Bipolar I Disorder
4. Schizoaffective Disorder	4. Schizoaffective Disorder
5. Post Traumatic Stress Disorder	5. Schizophrenia

Table 21
**Data pulled from IT/MHWIN

Adult SUD Diagnosis

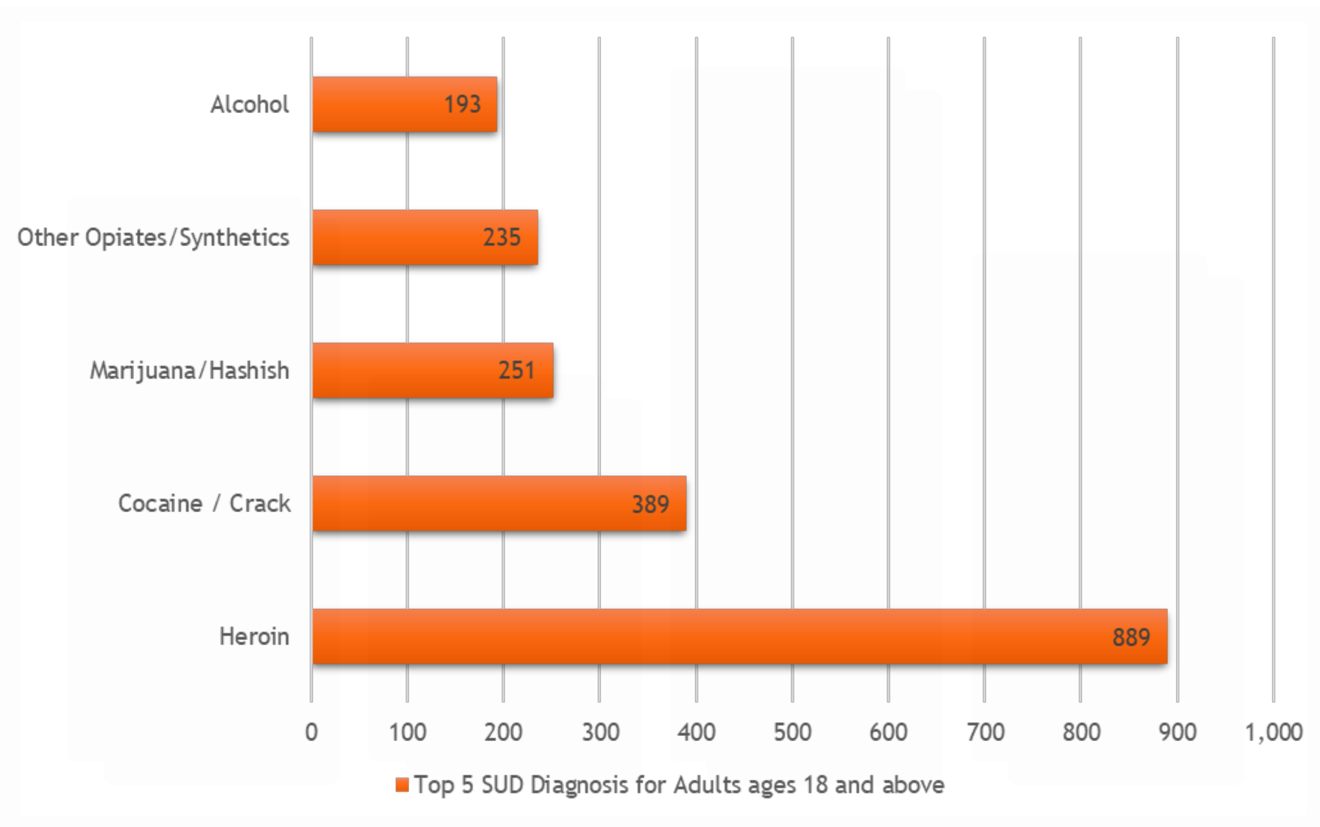


Table 22
**Data pulled from IT/MHWIN

Adult SUD comparisons FY23 and FY22

SUD 2023	SUD 2022
1. Heroin	1. Heroin
2. Cocaine/Crack	2. Cocaine/Crack
3. Marijuana/Hashish	3. Marijuana/Hashish
4. Other Opiates/Synthetics	4. Other Opiates/Synthetics
5. Alcohol	5. Alcohol

Table 23
**Data pulled from IT/MHWIN

MI percentile ranks for Asthma

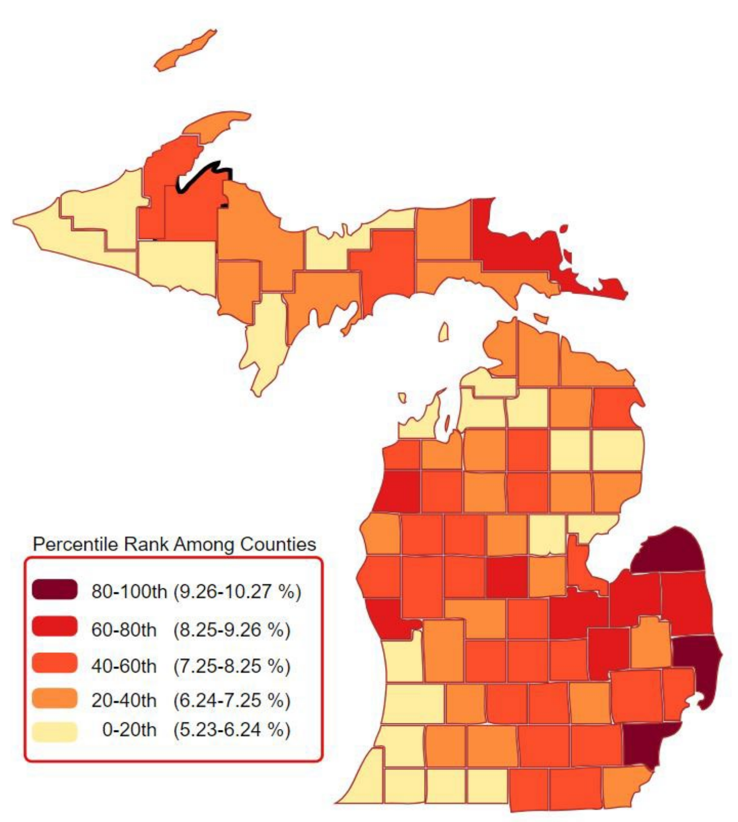


Table 24
**Data pulled from CC360

Asthma Dx per zip code

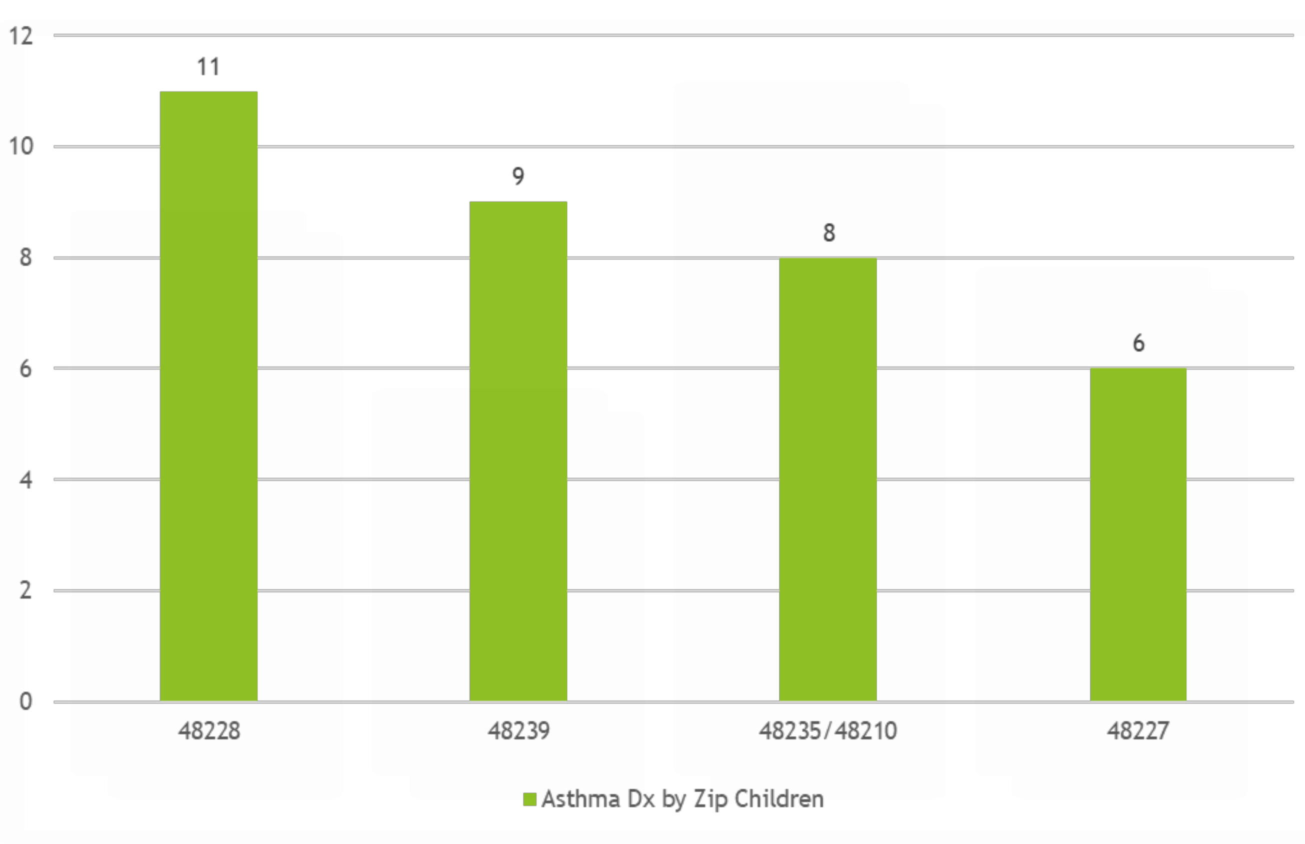


Table 25
**Data pulled from IT/MHWIN

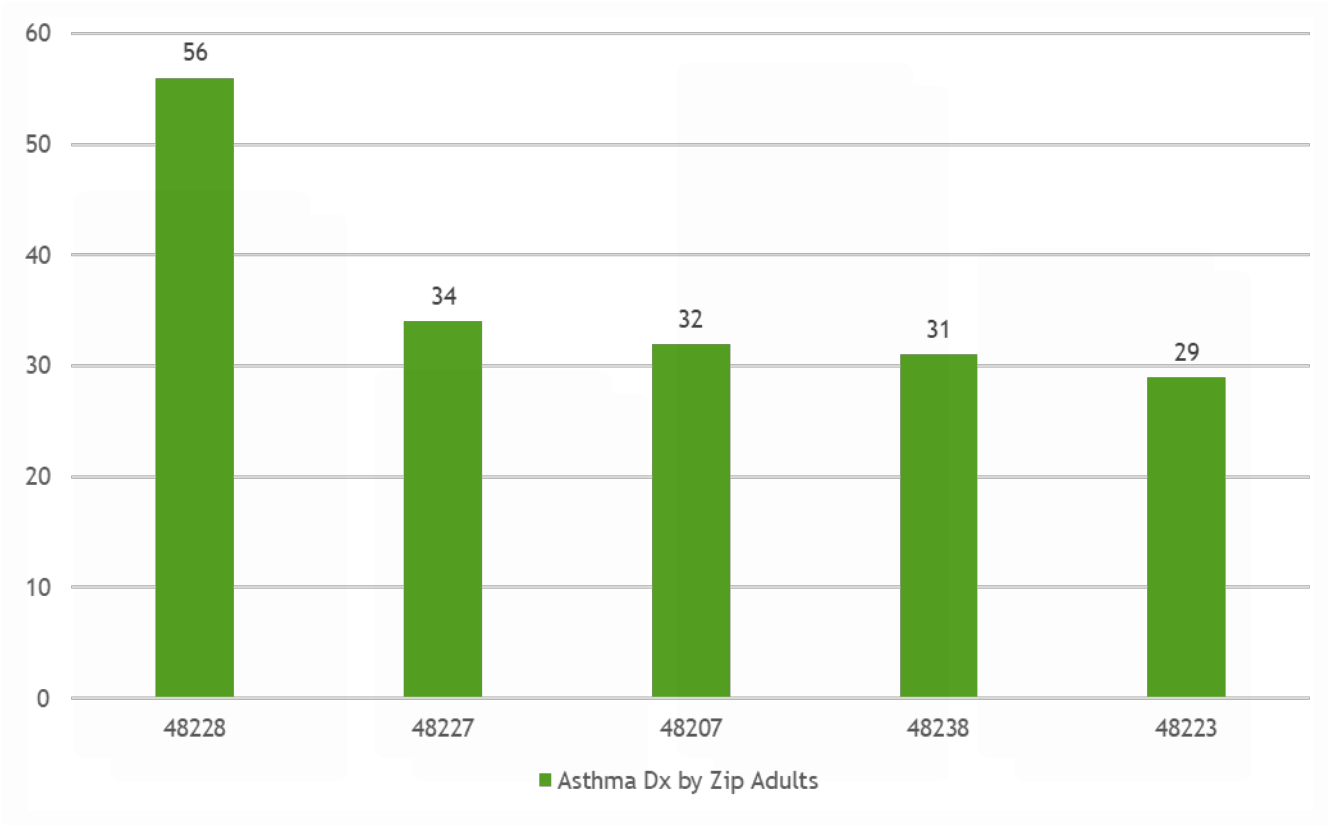


Table 26
**Data pulled from IT/MHWIN

Diagnosis per Plan compared to Statewide

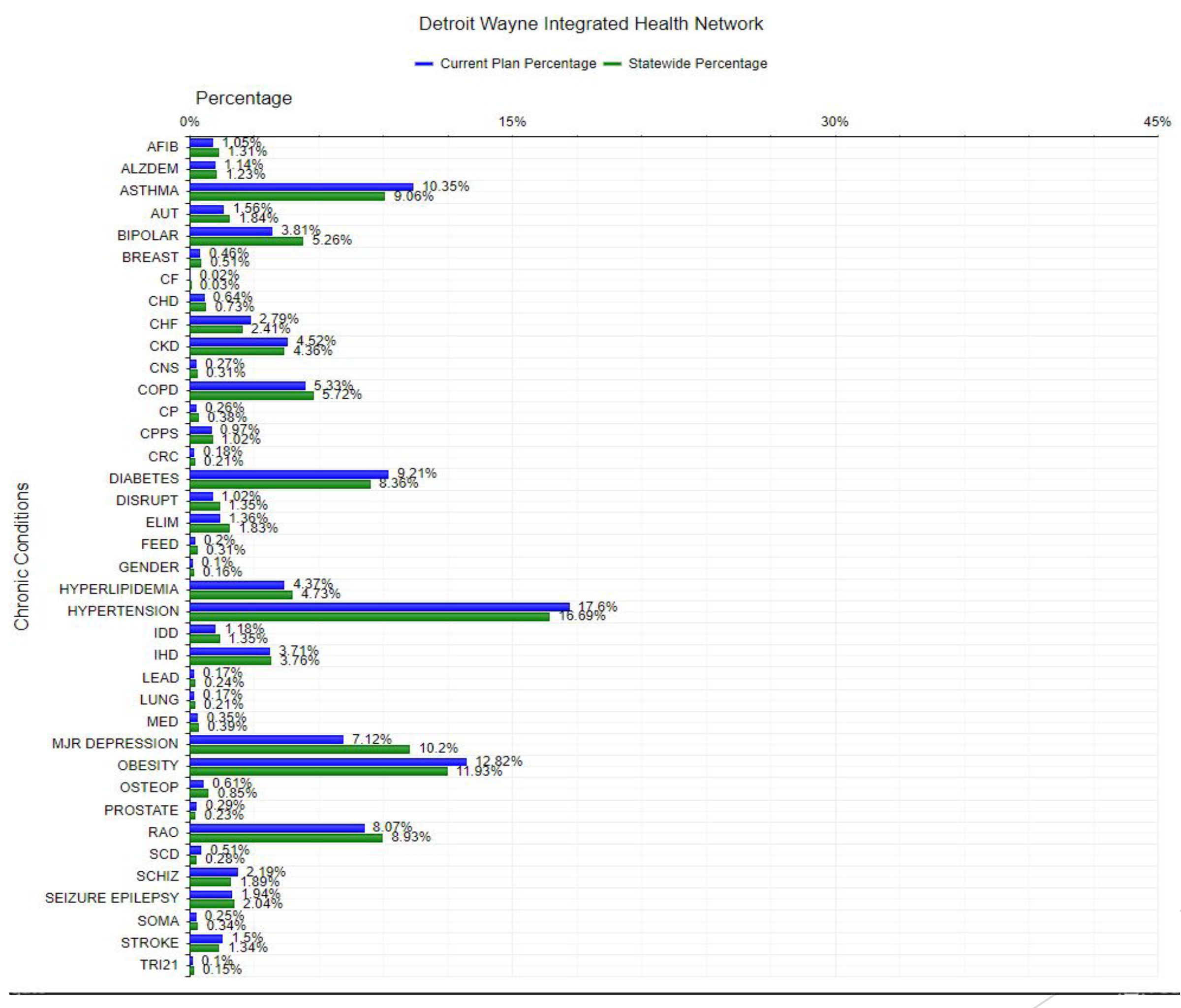


Table 27
**Data derived from CC360

Physical Health Diagnosis and Ethnic Background (Kids)

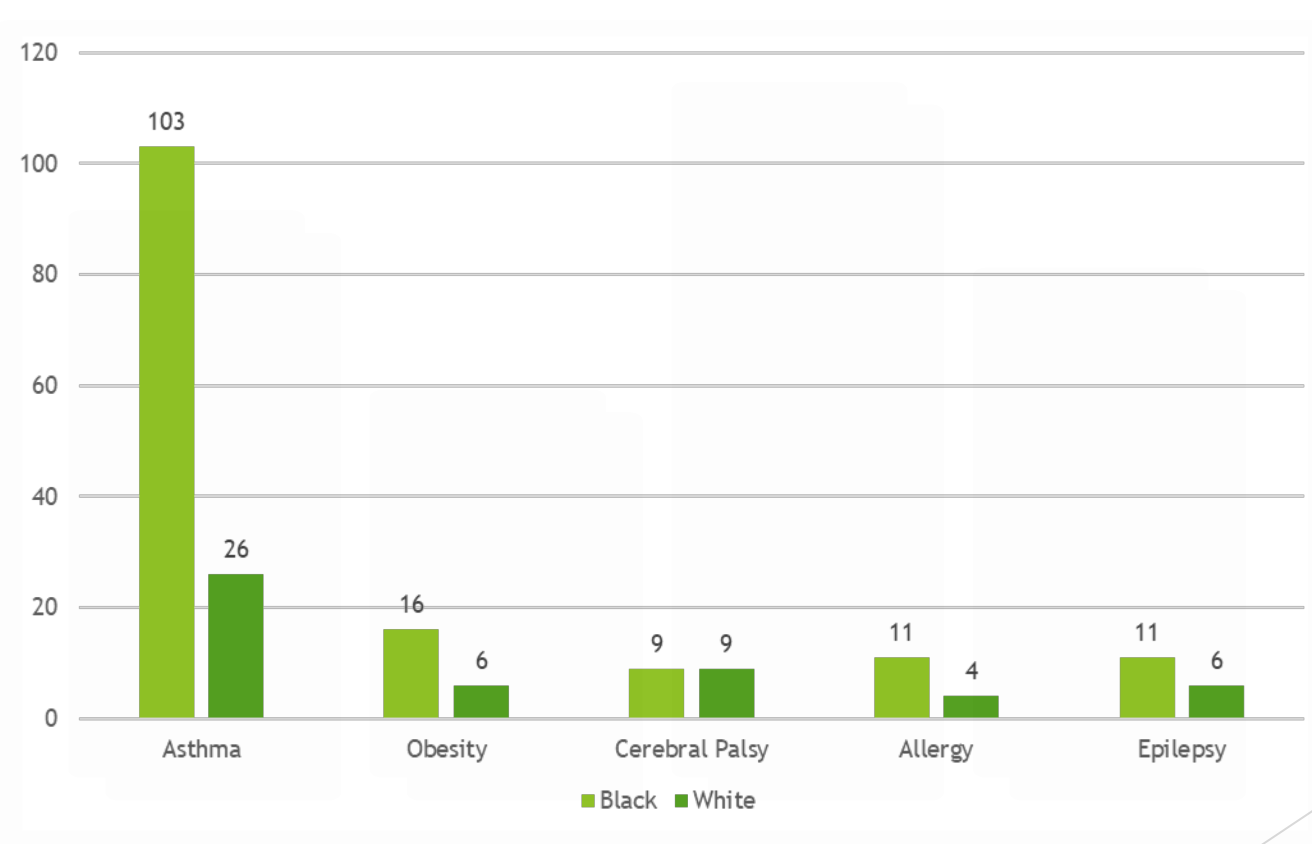


Table 28

** Data pulled from IT/MHWIN

Physical Health Diagnosis and Ethnic Background (18+)

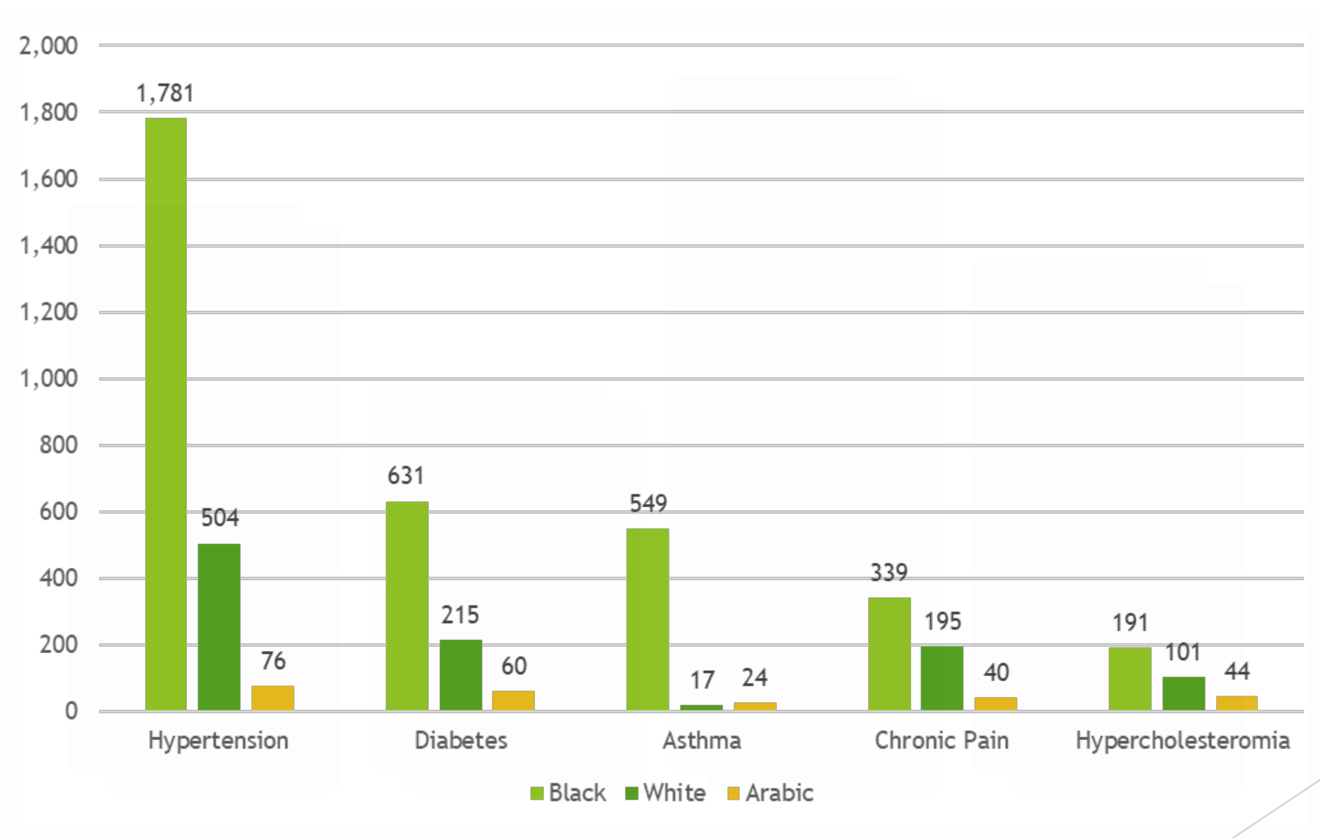


Table 29

*Data pulled from IT/MHWIN

Social Determinants of Health

Length of Life

Premature death

(years of potential life lost before age 75)

Quality of Life

Self-reported health status

Percent of low birthweight newborns

Health Behaviors

- Tobacco use
- Diet & exercise
- Alcohol & drug use
- Sexual activity

Clinical Care

- Access to care
- Quality of care

Social and Economic Factors

- Education
- Employment & income
- Family & social support
- Community safety

Physical Environment

- Air & water quality
- Housing & transit

Table 30

**Data derived from 2023 County Health Rankings Report by Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute

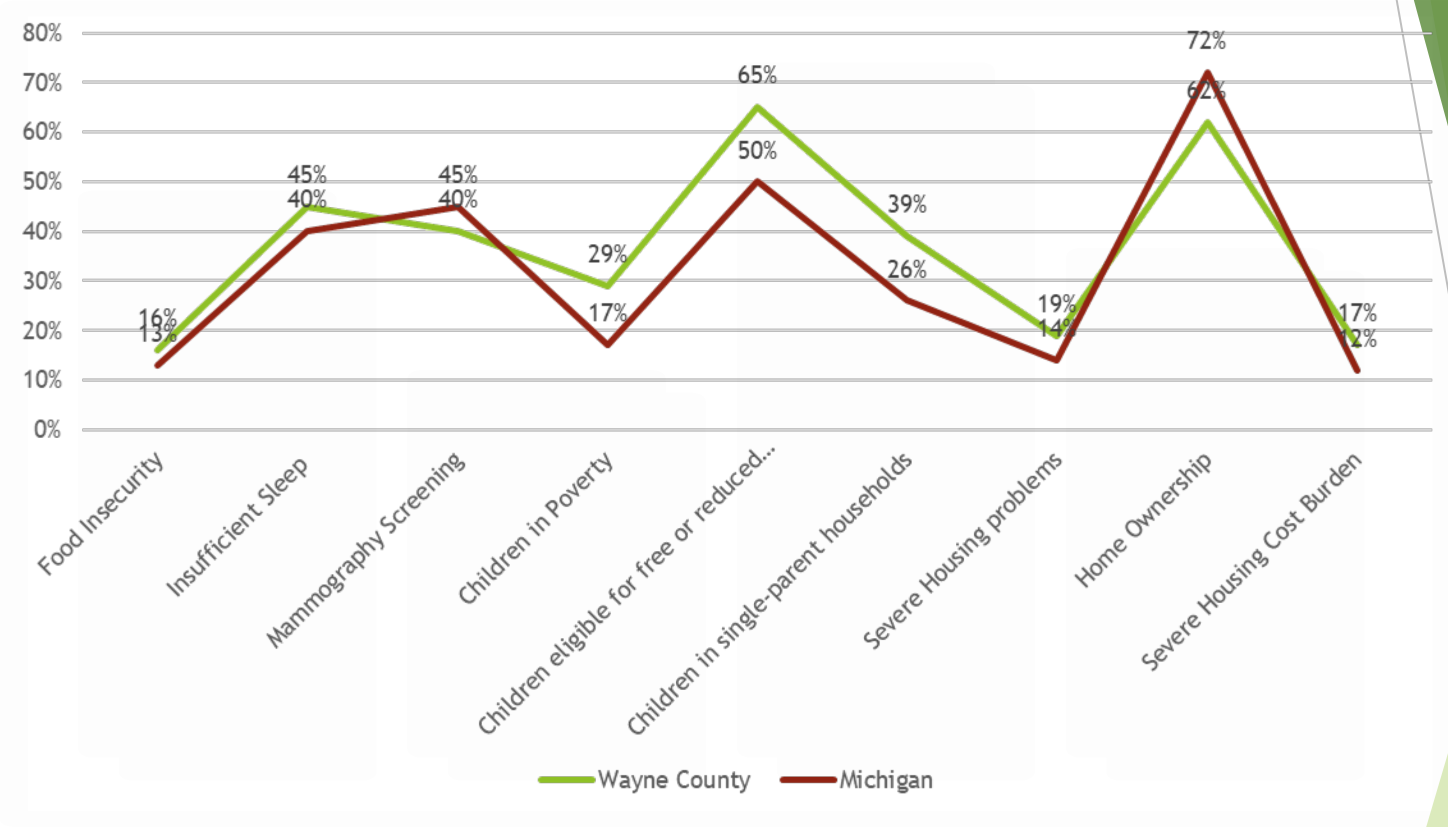


Table 30
**Data derived from 2023 County Health Rankings Report by Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute

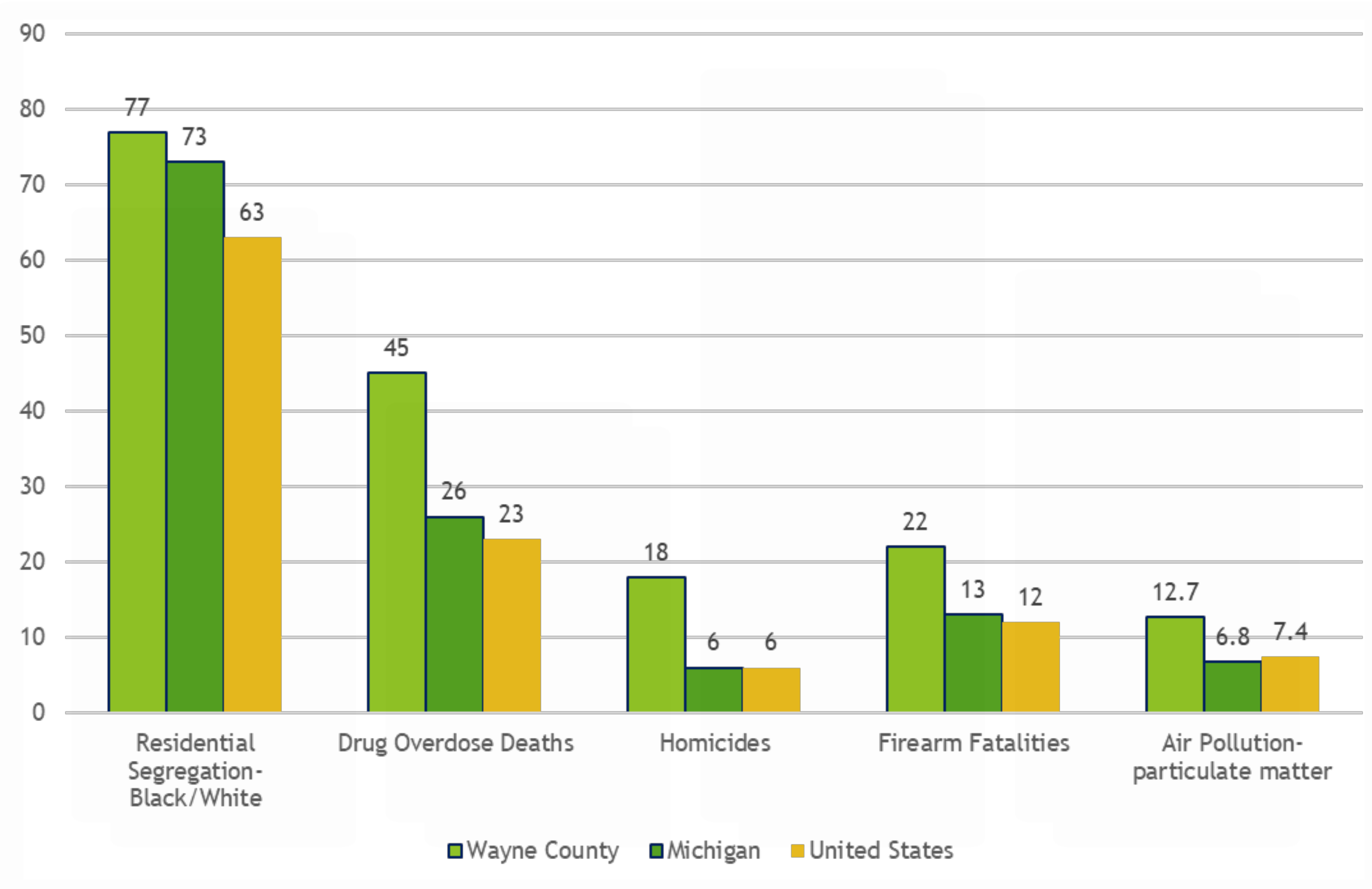


Table 30

**Data derived from 2023 County Health Rankings Report by Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute

Analysis of Complex Case Management Activities and Resources

- DWIHN utilizes the information included in the above Population Assessment to review and update complex case management activities and resources to ensure that member needs are addressed.
- Some of the areas of focus for CCM includes ensuring members are connected with PCP’s, insurance coverage, and are connected to culturally competent resources and materials.
- CCM utilizes the top diagnosis from this report to update eligibility criteria for CCM program. Based on FY23 report no changes have been made to CCM eligibility criteria for children and adults.

- During FY24 CCM will focus on trainings that includes material on autism, interventions with families with young children, childhood obesity, depression in children and adolescents, African American gay & lesbian adolescent development, sexual awareness for children and adults with mental illness or intellectual/developmental disabilities, and gender identity/expression in children and youth

- During FY23, 63 members were in enrolled in Complex Case Management Services
- The CCM team currently consists of a Clinical Specialist and 2 Complex Case Managers. Our current staffing ratios are adequate to meet the needs of the population
- CCM works closely with the Clinical Specialist OBRA/PASSR nurse to have an increased understanding of member medical conditions as well having a Registered Nurse available to work on member cases as needed

- Wayne county residents experience social determinants of health at a higher rate than the rest of the State of Michigan
- CCM's are knowledgeable of community resources to address member needs including transportation, food, housing, utilities, dental services, health care and etc to match member needs with the most appropriate resources and follow up to ensure members are connected

- With the increasing population of members aged 65 and over, we have partnered with the Area of Aging to learn more about services available to our members
- These services include in-home help, personal emergency response systems, adult day services, respite care, transportation, creating safe plans and working with members/families to understand long term care options

- Another population that has been identified as needing more supports/interventions are African American members and attendance with follow up after hospitalization appointments (FUH)

- 28% Caucasian Members Hospitalized in which 50% attended FUH appointments
- 1% of Hispanic Members Hospitalized in which 60% attended FUH appointments
- 61% of African American Members Hospitalized in which 28% attended FUH

- The Integrated Care Department (under which Care Coordinators function) has partnered with the Quality Improvement Department on the Reducing Ethnic Disparity with African American Members 7-day FUH project
- Care Coordinators perform transition of care activities and incorporate interventions with given priority to African American members in efforts to reduce this disparity

- Prior to discharge, hospital social workers are contacted to ensure discharge plans are appropriate
- Members are contacted post discharge to receive verbal reminders of scheduled FUH appointment and address any barriers for appointment attendance
- CRSP's are contacted for FUH verification and if missed, CCM's reach out to members in attempts to reschedule
- In attempts to make sure that we are meeting the need of our population and to increase engagement, DWIHN will also be including Practitioner race and ethnicity in the Provider Directory

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Complex Case Management Evaluation FY23

- The ultimate goals of DWMHA's/DWIHN's Complex Case Management (CCM) Program are to:
- Improve medical and/or behavioral health concerns and increase overall functional status as well as improve overall quality of life as evidenced by a 10% improvement in PHQ scores and/or a 10% improvement in WHO-DAS scores at CCM closure.
- To provide early intervention for members appropriate for Complex Case Management to prevent recurrent crisis or unnecessary hospitalizations as evidenced by 10% reduction in Emergency Department (ED) utilization and/or 10% reduction hospital admissions from 90 days prior to receiving CCM services to 90 days after receiving CCM services.
- Increased participation in out-patient treatment as evidenced by a 10% increase in out-patient behavioral health services from 90 days prior to receiving CCM services to 90 days after receiving CCM services.
- Assist members to access community resources and obtain a better understanding of the physical and/or behavioral health conditions as evidenced by improved compliance with behavioral health and physical health appointments and decrease in ED visits and/or inpatient admissions.
- 80% or greater member satisfaction scores for members who have received CCM services.

PHQ Scores

- Depression symptoms were measured using the Patient Health Questionnaire (PHQ-9) for adults and Patient Health Questionnaire- Adolescent (PHQ-A) for children under 18
- This assessment is embedded in the CCM assessments and are completed upon the start of CCM services and every 30 days thereafter until CCM services end
- The higher the score on the PHQ-9/PHQ-A, the greater the symptoms of depression are present
- A decrease in PHQ score indicates an improvement in symptoms of depression

- Members baseline scores ranged from 0 to 12, with an average score of 4.92
- Members participating in CCM demonstrated an overall improvement in their PHQ scores, and the improvement increased the longer that the members participated in CCM services
- Average PHQ scores improved 24% from baseline at 30 days, 28% at 60 days and 28% at 90 days of receiving CCM services

PHQ Scores

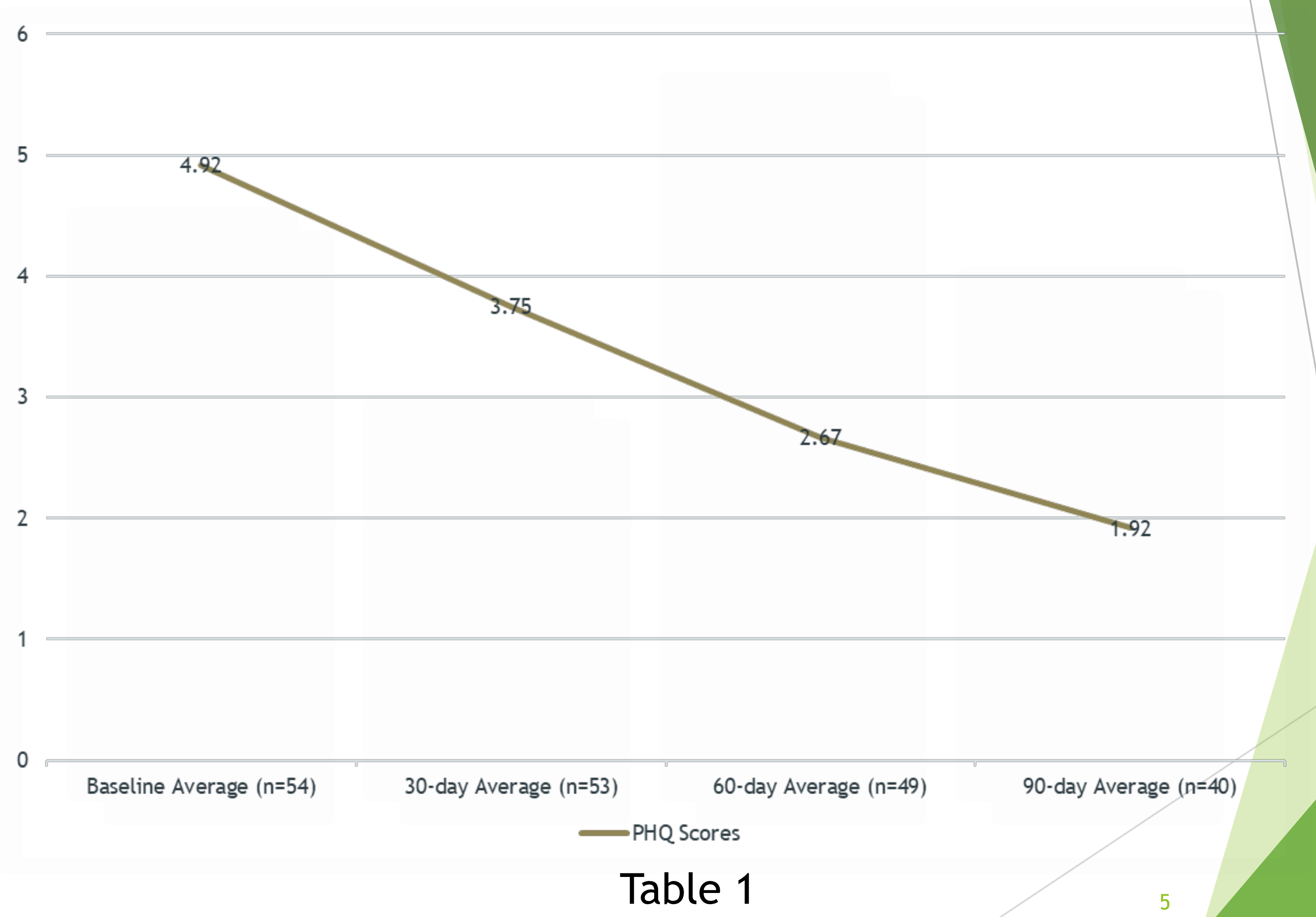

Table 1

WHO-DAS Scores

- The WHO-DAS assessment is embedded in the CCM assessment and is completed when the assessment is completed at the start of CCM services and every 30 days thereafter until CCM services end
- The higher the score on the WHO-DAS, the greater the level of disability. A decrease in WHO-DAS score indicates an improvement in level of disability
- WHO-DAS scores were gathered from the CCM assessments that were completed at the start of CCM services and at 30, 60, and 90 days after starting CCM services

- Members WHO-DAS baseline scores ranged from 1 to 32, with an average score of 6.23
- Members participating in CCM services demonstrated overall improvement in their WHO-DAS scores, and the improvement increased the longer that the members participated in CCM services
- Average WHO-DAS scores improved 18% from baseline at 30 days, 29% at 60 days and .5% at 90 days of participating in CCM services

WHO-DAS Scores

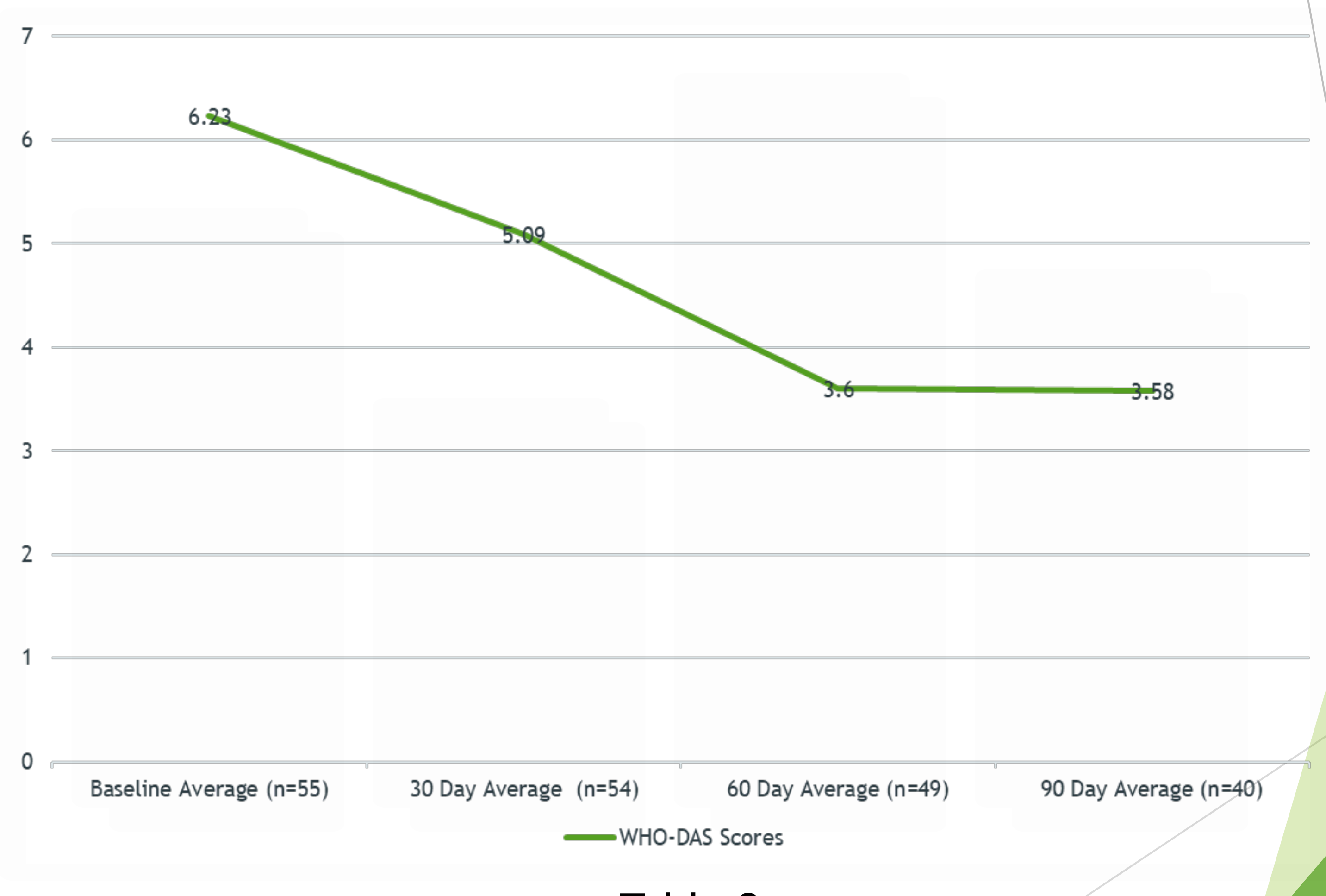

Table 2

Emergency Department Utilization

- DWIHN analyzed member Admission, Discharge and Transfer (ADT) alerts and DWIHN claims data to measure utilization of Emergency Department 90 days prior to participating in CCM services and 90 days after starting CCM services
- Members participating in CCM services showed an average 9% reduction in Emergency Department utilization from 90 days prior to 90 days after starting CCM services.
- Members had an average of 2.7 Emergency Department visits during the 90 days prior to receiving CCM services and had an average of 2.47 Emergency Department visits during the 90 days after starting CCM services

ED Visits

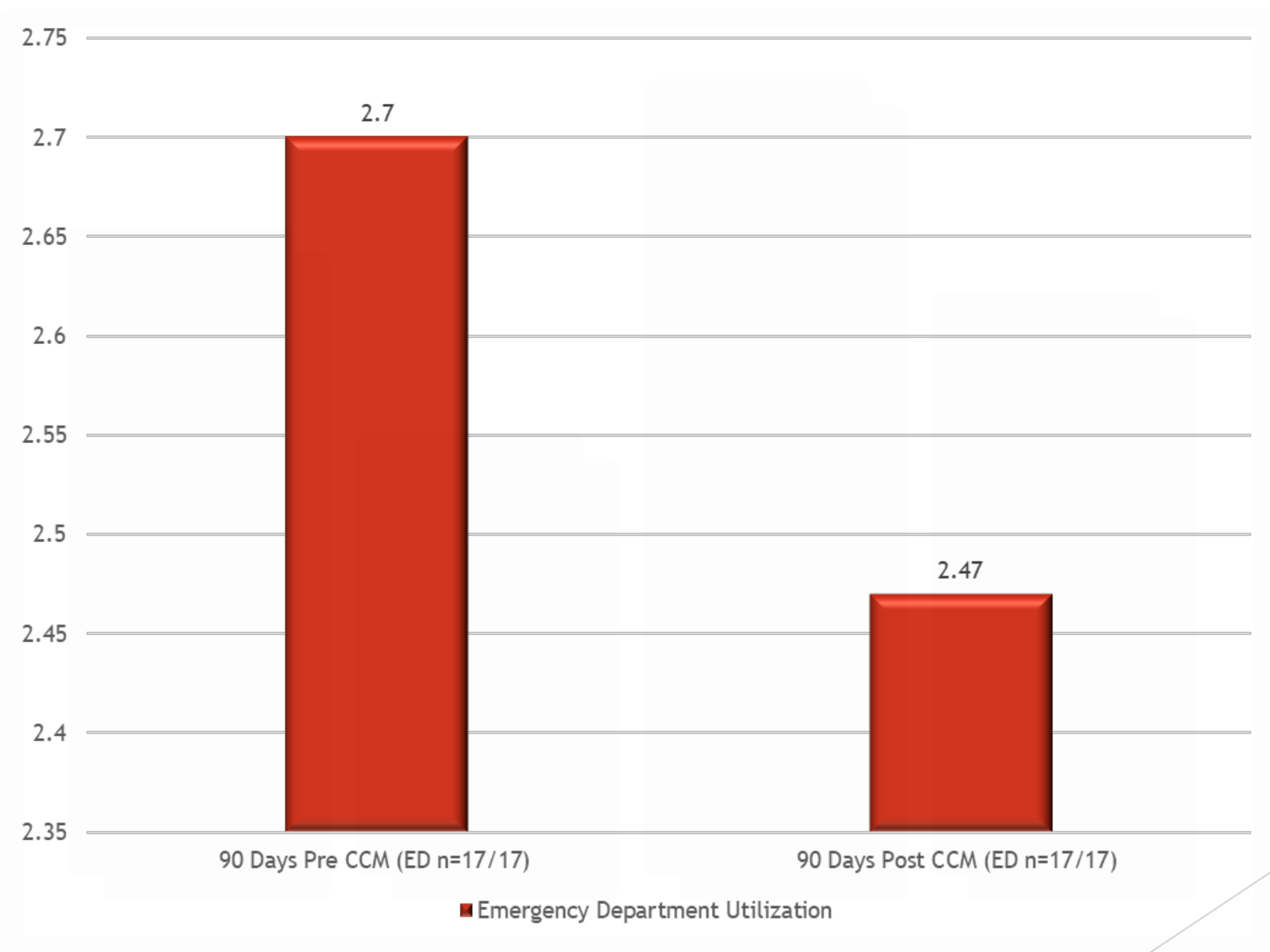

Table 3

Hospital Admissions

- Only 1 member experienced a hospitalization within 90 days of starting CCM services. Inpatient admits could not be evaluated for FY23 as a goal due to only one CCM member being hospitalized.
- We will continue to monitor and evaluate for FY24

Utilization of Out-patient Services

- DWIHN analyzed members claims data for out-patient behavioral health service utilization 90 days prior to participating in CCM services and 90 days after starting CCM services.

- The average number of out-patient behavioral health services during the 90 days prior to CCM services was 6.86 and the average number of out-patient behavioral health services after starting CCM services was 9.48, which amounts to a 38% increase in out-patient services utilization

Outpatient Service Utilization

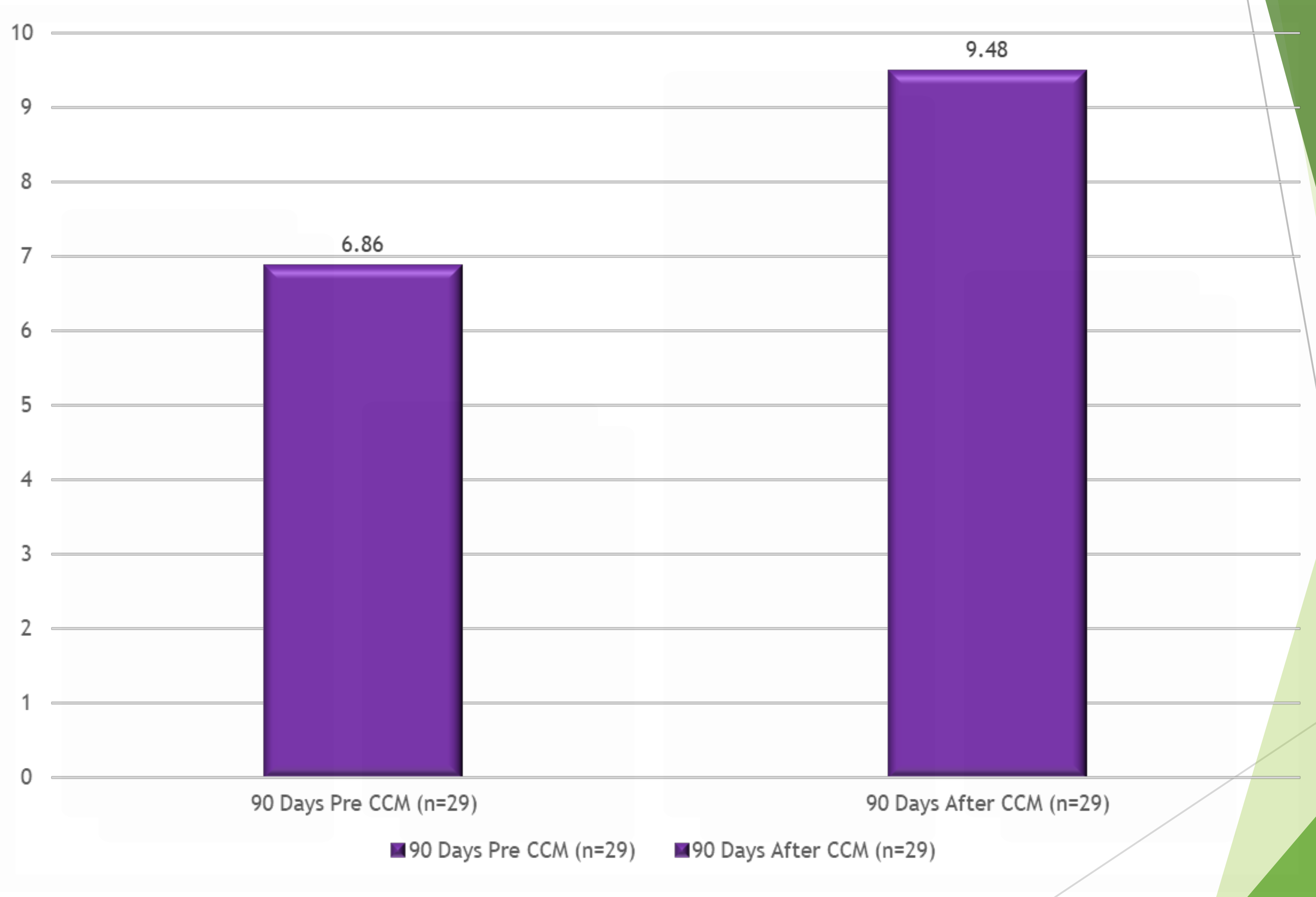

Table 4

Outpatient Utilization within 60 days

- DWIHN also measured the number of members who attended two out-patient behavioral health services within 60 days of starting CCM services.
- Of the 44 members that were available to participate in 2 out-patient services after starting CCM services, 41 members (93%) attended two out-patient behavioral health services within 60 days of starting CCM services.

Outpatient Utilization post 60 days

- DWIHN measures the number of members who attended two out-patient behavioral health services within 60 days of the closure CCM services.

- Of the 36 members that were available to participate in 2 out-patient services after ending CCM services, 26 members (72%) attended two out-patient behavioral health services within 60 days of CCM case closure.

Satisfaction Surveys

- Satisfaction surveys were offered to members upon closure of Complex Case Management services. Members were informed that completion of the Survey was not mandatory, but that they were encouraged to complete the Survey to provide feedback regarding their experience receiving CCM services.

- Out of 44 members had Complex Case Management services closed during FY2022, 39 (88%) Satisfaction Surveys were completed and returned.

CCM Satisfaction Survey Questions

- *1. The Care Coordinator helped me understand the plan of care?*
- *2. The Care Coordinator assisted and supported me to get the care I needed?*
- *3. The Care Coordinator was attentive and helped me work through my problems?*
- *4. The Care Coordinator treated me with courtesy and respect?*
- *5. The Care Coordinator helped me eliminate barriers to connect me with Behavioral and Medical Health and Community Resources?*
- *6. I am satisfied with the Complex Case Management program?*

CCM Satisfaction Survey Responses

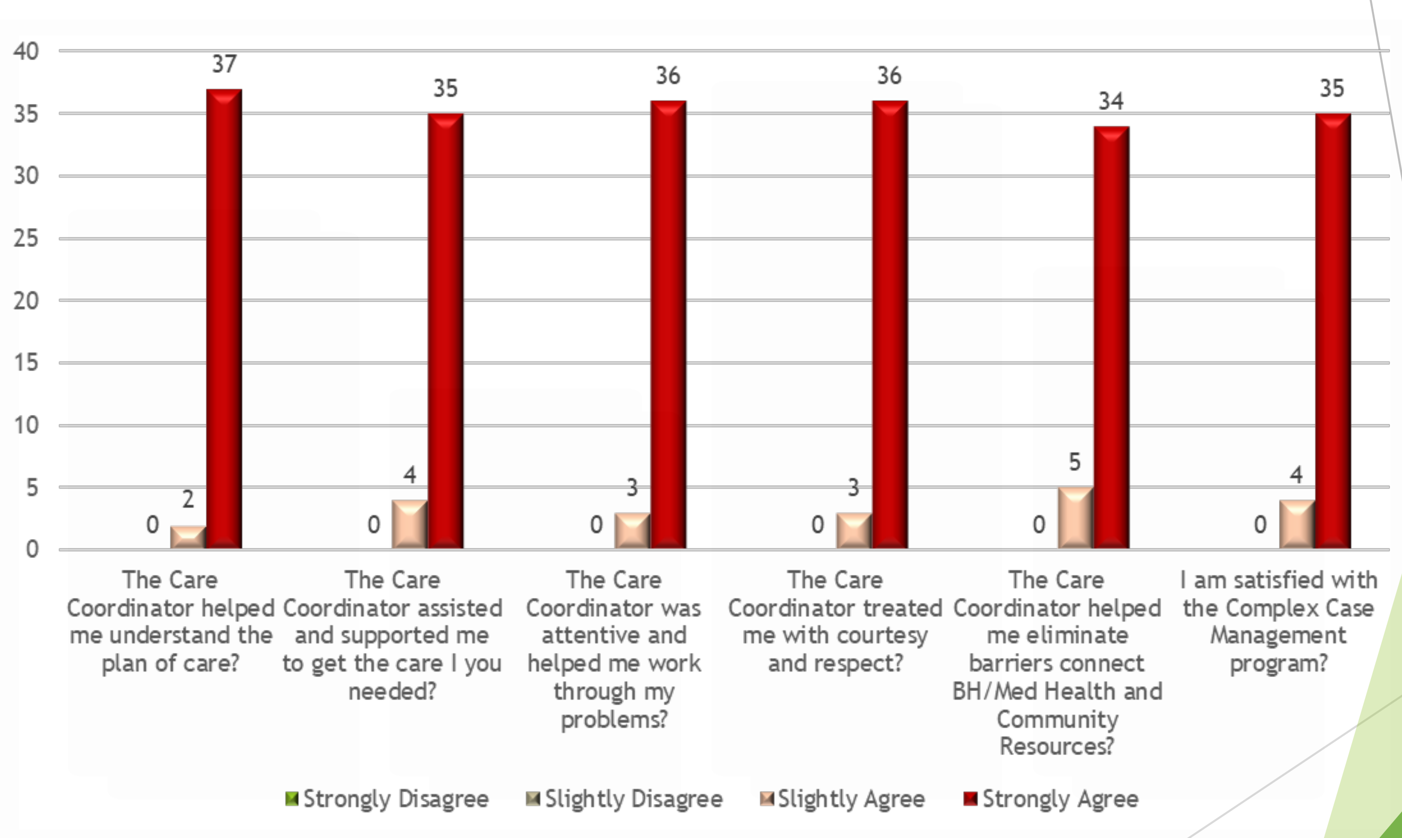

Table 5

	Q1	Q2	Q3	Q4	Q5	Q6
Strongly Agree	95%	90%	92%	92%	87%	90%
Slightly Agree	5%	10%	8%	8%	13%	10%
Slightly Disagree	0%	0%	0%	0%	0%	0%
Strongly Disagree	0%	0%	0%	0%	0%	0%

Table 6

Member Comments

- *“Lenette always treated me with respect and kept my need met. I’m happy to be apart of this program because of her. Thank you!”*
- *“COVID was a barrier to getting follow through services. Complex Case Management was a great support.”*
- *“Lenette has truly been a Godsend and a blessing to me. She is compassionate and non-judgmental. She is also consistent and dependable. Thank you for allowing her to help me. I still have a long way to go, but now I know I can go on”*
- *“Scherie helped me overcome barriers and scheduling appointments. Encouraged me with taking medications and attending appointments with PCP and Detroit Recovery Project”*
- *“I wish Scherie could be my Daughter’s Case Manager forever. She really helped her get the services she needed.”*
- *“Scherie was a good help. She listened to my problems”*

- *“Lenette has been great with my son and helped out whenever she could.”*
- *“Thank you for your assistance with our pursuit of the MI Choice Waiver.”*
- *“Always responsive and tried very hard.”*
- *“Lenette was a very nice lady.”*
- *“Scherie was just really cheerful and has a really good disposition. You can tell that she cares a lot and that she’s sincere.”*
- *“I was very satisfied; she was nice and patient and made me feel accomplished. She (Scherie) also relieved a lot of stress because my anxiety and depression get the best of me, but she helped me tackle each problem full force. I appreciate her having my back.”*
- *“The Care Coordinator (Scherie) has been very helpful towards me and helpful for the things I need. I am very thankful and hope there are more helpers like her.”*
- *“I like the fact that I received a weekly phone call checking in with me”*
- *“Scherie did an excellent job and went above and beyond to help with all the needs that we had”*
- *“Scherie was fantastic! I talked to her every week and sometimes even more.”*

Comparison to Previous Reviews

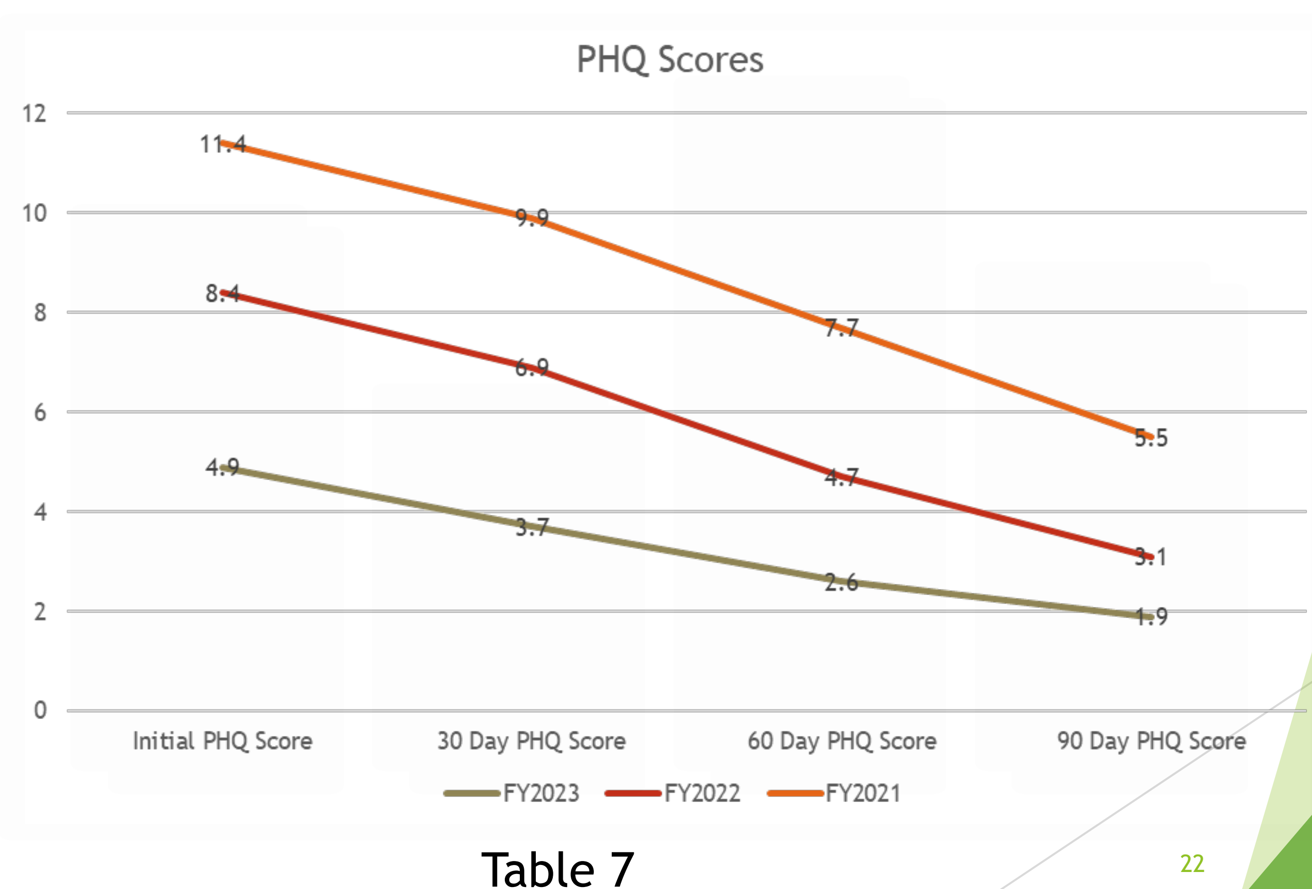

Table 7

WHO-DAS

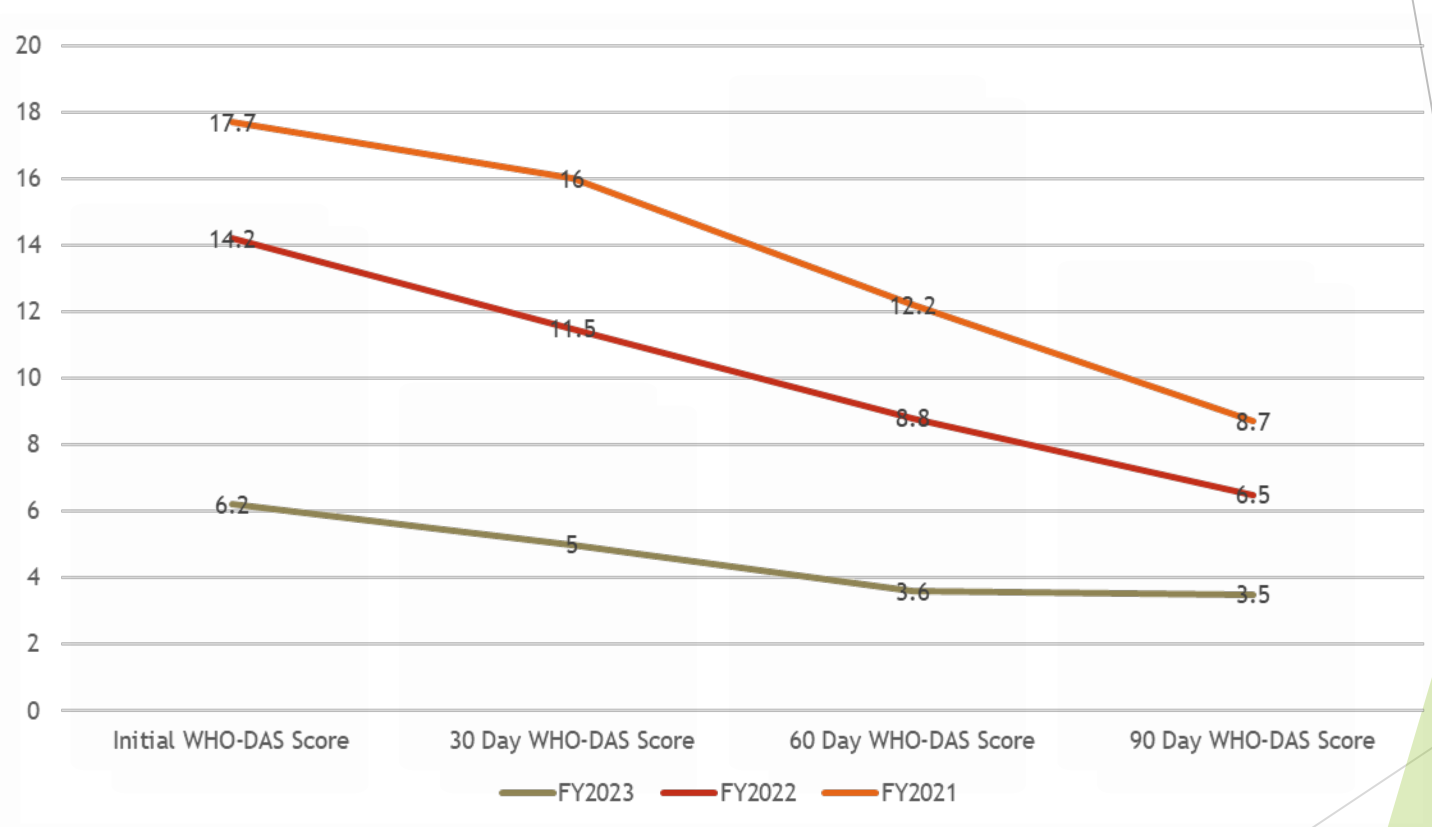

Table 8

PHQ and WHO-DAS Goals Met

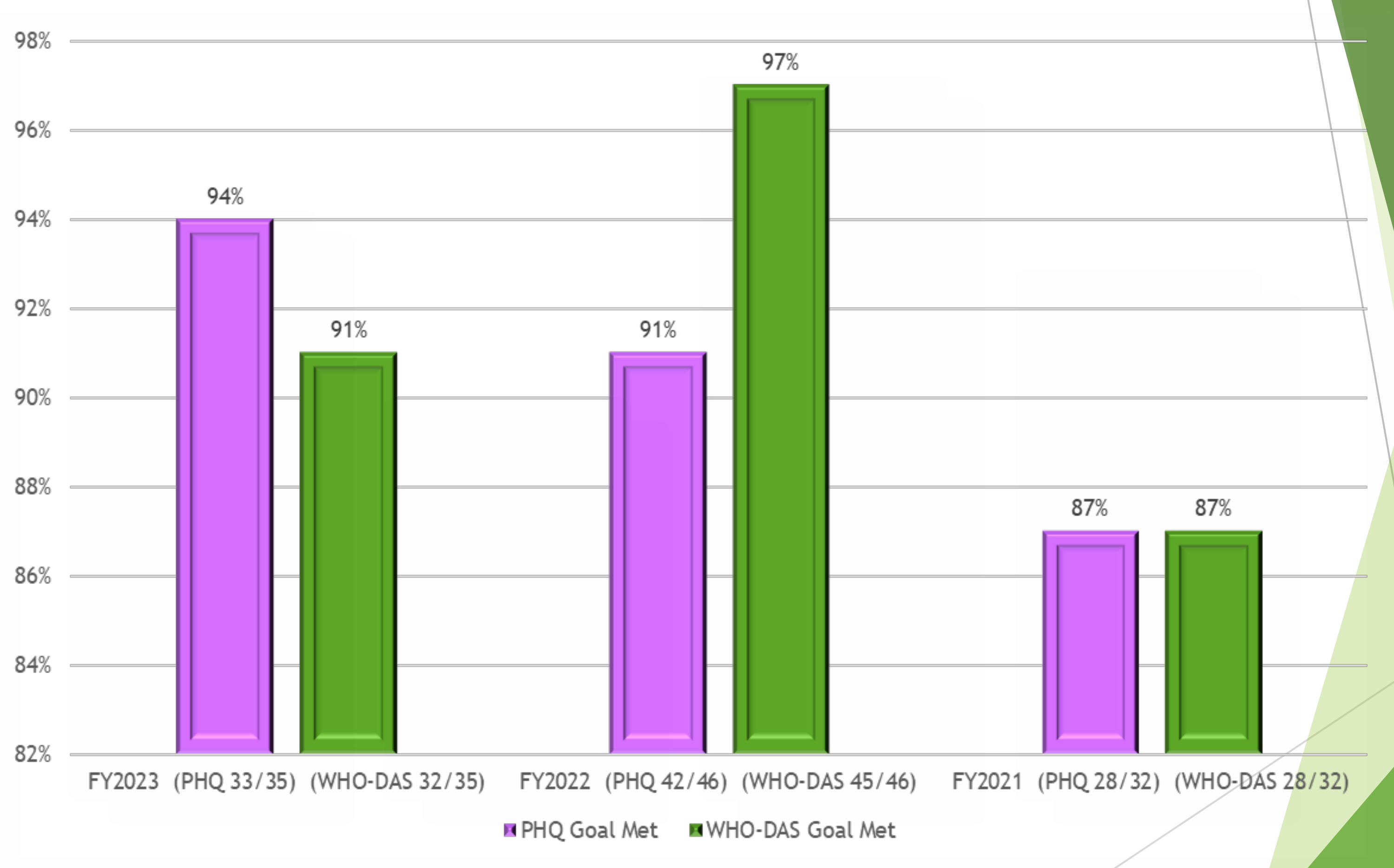

Table 9

Emergency Department Utilization Goals Met

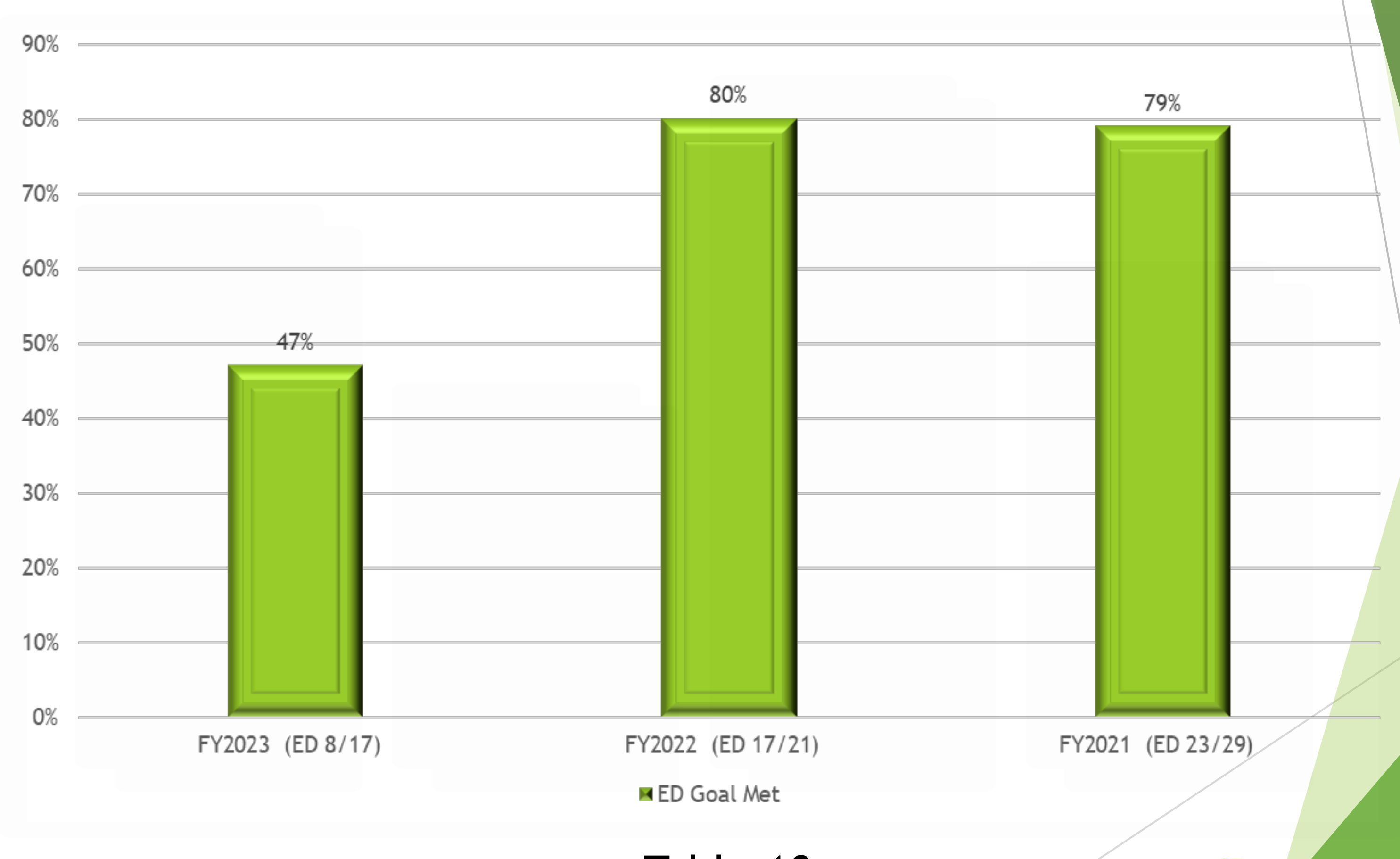

Table 10

Out-patient Behavioral Services

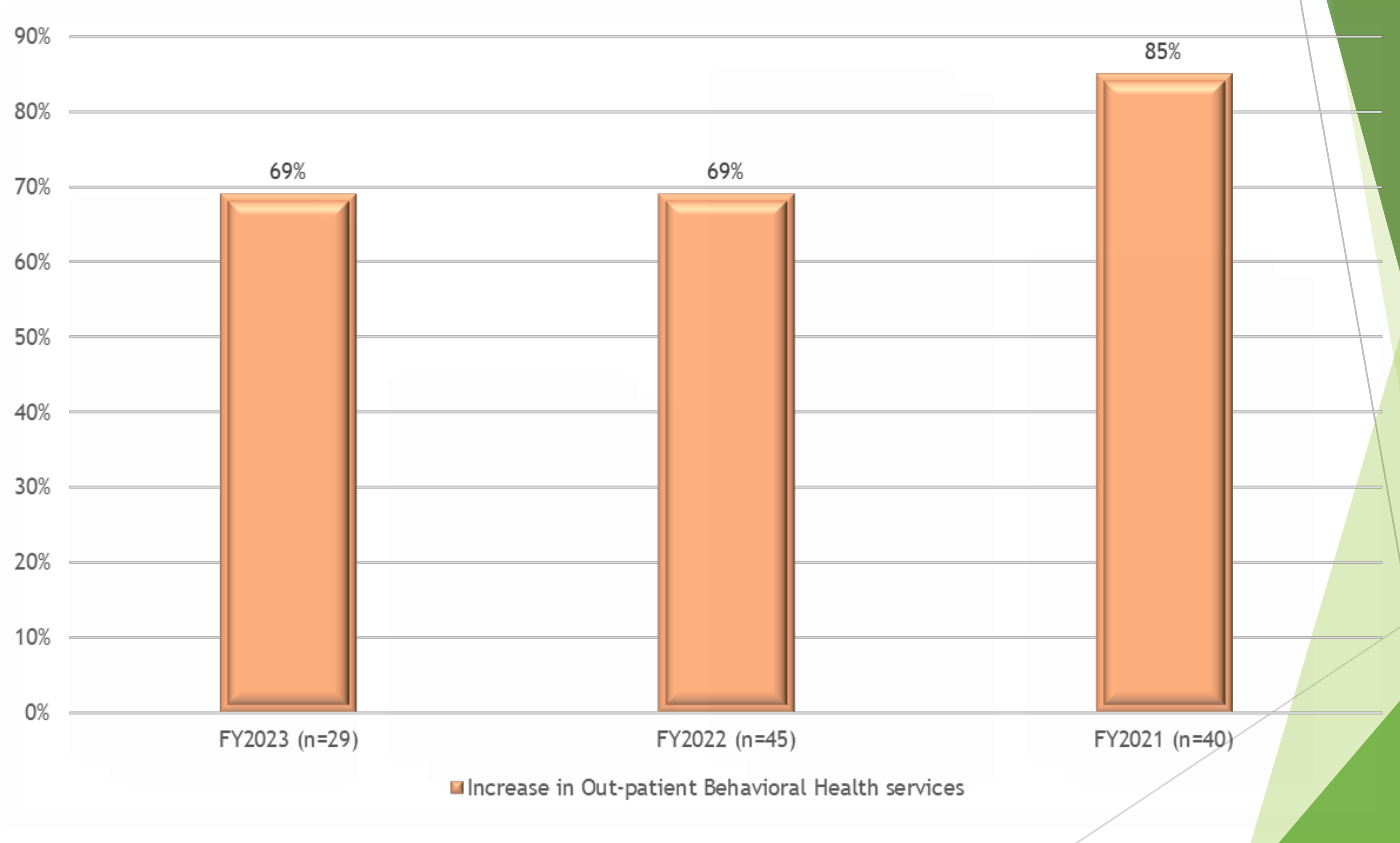

Table 11

Attended 2 Out-Patient BH appointments within 60 days

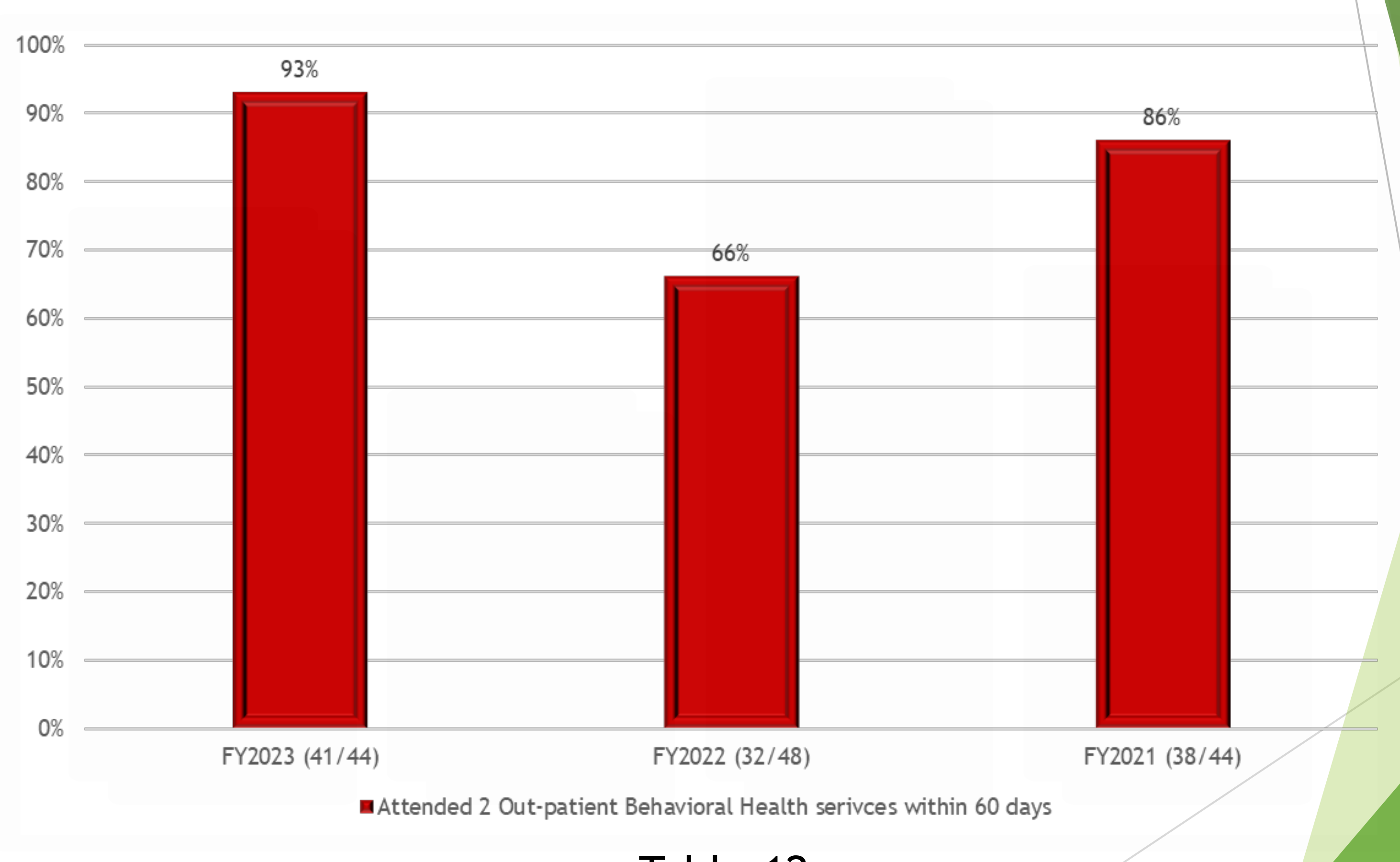

Table 12

Attended 2 Out-Patient BH appointments within 60 days after CCM closure

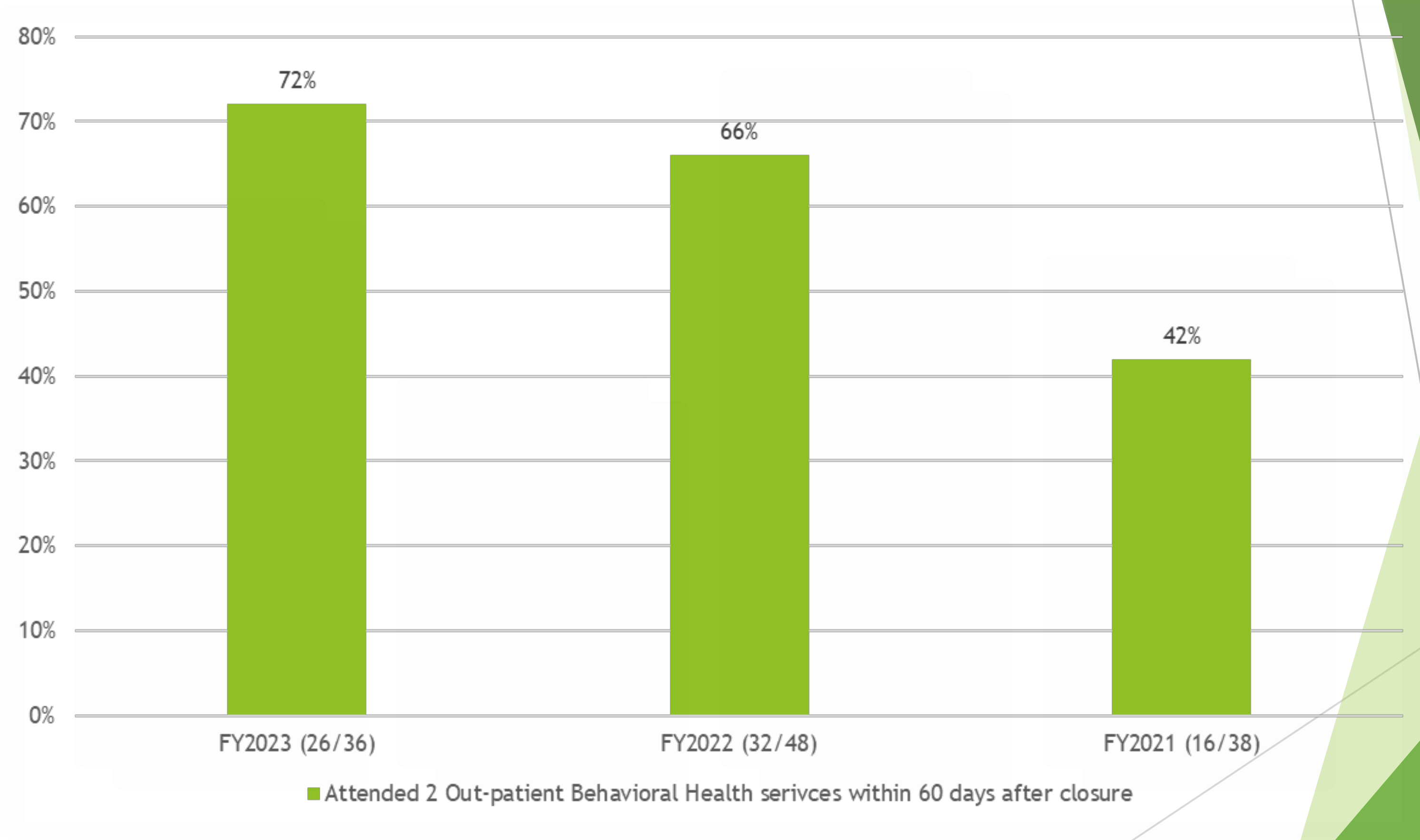

Table 13

Rates of Satisfaction

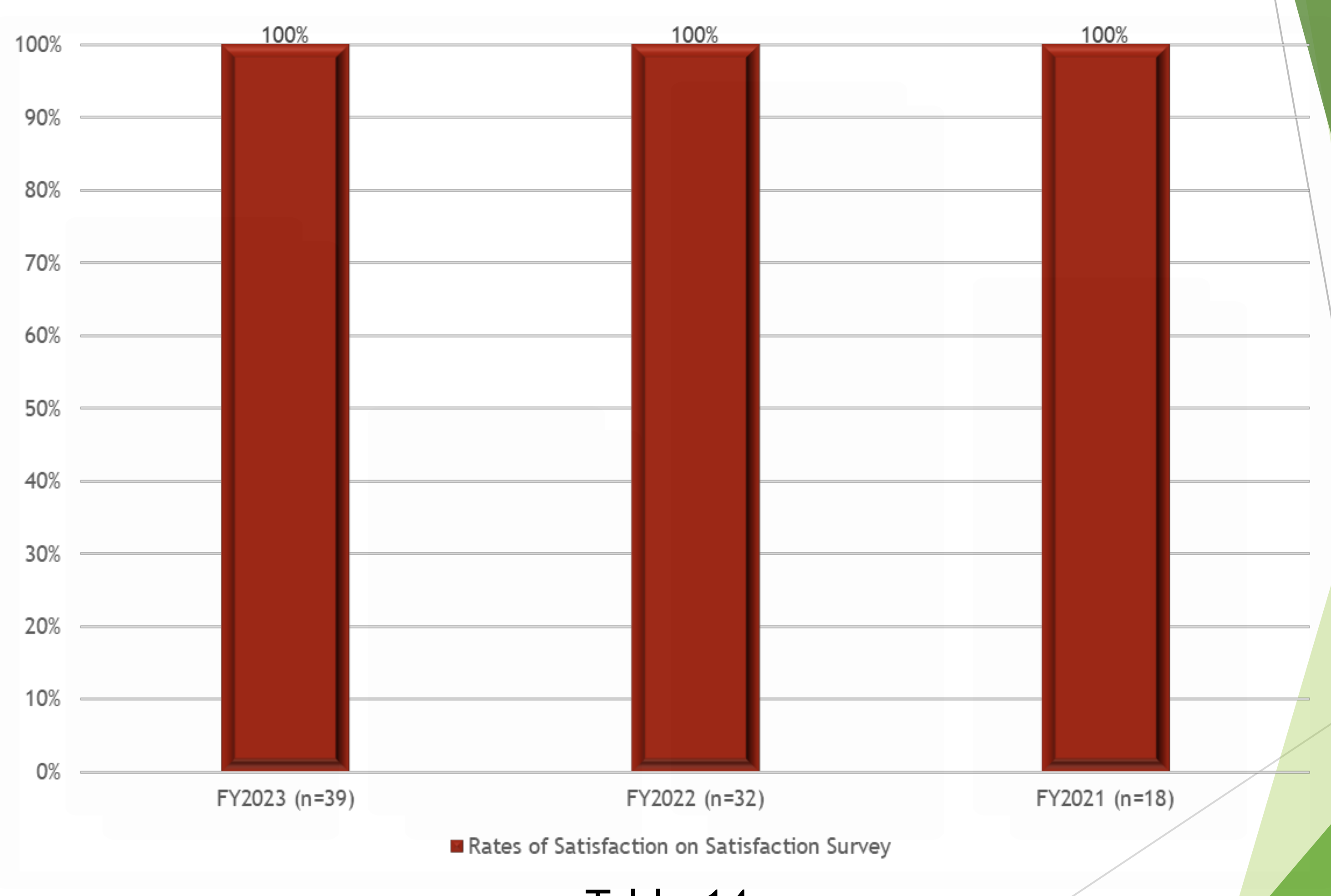

Table 14

Areas of Improvement

- Emergency Department Utilization
- Increase in FUH appointment attendance (primary focus on African American Members)
- Increase in outpatient attendance
- Connecting members to Primary Care Physicians

Detroit Wayne Integrated Health Network

Customer Service
2022/2023
Fiscal Year End Report

QISC Meeting
January 30, 2024

Michele A. Vasconcellos MSA,
Director, Customer Service

Reception/Switchboard & Customer Service Call Center

	FY 22/23		FY 21/22	
	Number of Calls	Abandonment Rate Standard <5%	Number of Calls	Abandonment Rate Standard <5%
Reception/ Switchboard	15,503	1.3%	23,029	0.8%

	FY 22/23		FY 21/22	
	Number of Calls	Abandonment Rate Standard <5%	Number of Calls	Abandonment Rate Standard <5%
DWIHN Customer Service Call Center	6,634	4.6%	12,140	11.1%

Significant Activities:

•In comparing the Fiscal years 21/22 and 22/23, the number of calls continues to vary from year to year that come into the switchboard area, with an abandonment rate well below 5%.

• During the Fiscal Year 22/23, the Call Center has shown a significant improvement from the previous Fiscal Year relative to the abandonment rate (<5%), which is attributed to the repositioning of staff during PTO requests and staff working together as a team to make sure we have adequate staffing during requested time off as well as the call volume has decreased.

Family Support Subsidy

	FY 22/23	FY 21/22
Family Subsidy Calls	7,701	6,783
Applications Received	1404	1238
Family Support Subsidy Applications Processed	847	958

Significant Activity:

The Unit worked on the planning of a new phone queue that will allow for more efficient monitoring, tracking and follow-up on calls.

Grievance Activity:

Complaint and Grievance Related Communications

	FY 22/23	FY21/22
Complaint/Grievance	2,953	788

Grievance Processed

Grievances	FY22/23	FY21/22
Grievances Received	123	92
Grievances Resolved	105	81

- **Significant Activity:**
- The trending grievance pattern for the top grievance categories for FY 22/23 were: **Interpersonal, Access to Services Delivery of Services and Interpersonal.**
- There has been 1 request for a DWIHN State Fair Hearings in FY22/23. It was also withdrawn. **There have consistently been no State Fair Hearings for MI Health Link members for several fiscal years.**
- The MI Health Link Program had 0 Grievances and State Fair Hearings in FY22/23 compared to 1 in 21/22.
- **Accomplishments:**
- Several grievance training sessions and technical assistance continued to be provided for several CRSP providers and their new staff in FY22/23.
- Customer Service continues to address those CRSP who are attempting to circumvent the mandated grievance process by addressing their issues internally and not reporting to DWIHN. The Grievance Team completed 2 SUD site visits on 12/18/23 to talk with members regarding their experience at those two facilities ensuring that they were aware of the grievance process if needed.

Appeals Activity

Appeals Communications

**Communications include emails and phone calls to resolve appeals.*

	FY 22/23	FY 21/22
Appeals Communications Received	757	595

Appeals Filed

	FY 22/23	FY 21/22
Appeals Received	51	38
Appeals Resolved	48	33

Significant Activity:

Several appeals training sessions and technical assistance continued to be provided during the Fiscal Year for several CRSP providers and their new staff.

Via the Customer Service Quarterly Service Provider meetings, DWIHN continues to address all updates and concerns particularly on the topic of Grievances and Appeals and promotes technical assistance to CRSP to ensure compliance with Due Process standards.

Advance and Adequate Notices

Notice Group	FY 22/23 Advance Notices	FY 22/23 Adequate Notices	FY 21/22 Advance Notices	FY 21/22 Adequate Notices
MI	17,792	3,815	12,730	3,613
ABA	1,126	258	761	641
SUD	1,042	89	610	310
IDD	3,297	892	2,289	710
Overall Total	23,257	5,054	16,390	5,274

Significant Activity:

Adequate and Advance Notices that are generated as part of the Appeals process by the CRSP are monitored by Customer Service via random audits to ensure that processes are being followed and members are provided timely access to their ability to appeals.

Adequate Notice: Written statement advising beneficiary of a decision to deny or limit Medicaid services requested. Notice is provided to the Member/Enrollee Beneficiary **on the same date the action takes effect or at the time of signing on the individual plan of service or master treatment plan.**

Advance Notice: Written statement advising the beneficiary of a decision to reduce, suspend, or terminate services currently provided. Notice to be **mailed at least 10 calendar days prior to the effective date of the notice**.

Mediation and State Fair Hearings

Mediation

In September 2021, MDHHS formed a partnership with the Oakland Mediation Center to implement Behavioral Health Mediation. To date, DWIHN has participated in two (2) successful mediations. There was one mediation conference in 2022 and one in 2023.

State Fair Hearings

For FY ‘22, there were 3 State Fair Hearings. 1 CMH/PIHP decision overturned by the Michigan Office of Administrative Hearing and Rules and 2 upheld the CMH/PIHP decision. For FY ‘23, there were no State Fair Hearings held.

Quality and Performance Monitoring

- Customer Service's Quality and Performance Monitoring division continued to conduct Clinically Responsible Service Providers (CRSP) audits to ensure compliance standards were addressed and maintained in the areas of Customer Service, Grievances, Appeals and Enrollee Rights. Applicable Plans of correction were addressed with network providers.

- Quarterly Customer CRSP Service Provider virtual meetings were held to ensure providers were advised of updates and the importance of Customer Service mandated standards.

- Customer Service was also responsible for updating and maintaining all member materials i.e., Member Handbook, Provider Directory, and member brochures.

Member Engagement and Experience

Significant Activity:

- Customer Service Member Engagement division continued to find safe new ways to connect with members and remediate the risk of misinformation, social isolation, and non-engagement.

- In-person Monthly Member Engagement Meetings resumed and were hosted at Clubhouses and Drop-in Centers whereby attendance gradually increased.

- DWIHN's Constituent Voice (CV) Member Committee meetings were held to discuss, plan, and make recommendations on initiatives that supported member education and engagement. Their outreach initiatives included engaging Adult Foster Care (AFC) homes to keep residents informed about services and support. The CV committee also worked collaboratively with the Member Engagement division to host the annual Reaching for the Stars Award Ceremony. There were seven "Dreams Come True" awardees.

Member Engagement

- Member Engagement hosted a Guardianship Forum, in which 100 participants engaged in dialogue related to alternatives to guardianship. In addition, DWIHN was well represented at the Annual Walk-A-Mile In My Shoes event in Lansing, Michigan at the States' Capital. Over 300 Detroit Wayne participants attended. DWIHN's very own Peer Agent, Dwight Harris was the moderator for the event.

- DWIHN was proud to have one of its CV members, Shelley Nelson, be honored at the Community Mental Health Association of Michigan (CMHAM) Recipient Right conference with the Cookie Gant Award for her advocacy efforts in Wayne County. In addition, Detroit Wayne was presented with the Community Partnership award at the Annual Fall CMHAM conference for the excellent work that the DWIHN CV Committee had done over the past year. Michael Shaw and Michael Squirewell accepted the award on DWIHN's behalf.

Member Experience

- The Customer Services' Member Experience team conducted a variety of member experience-related surveys i.e. On-Line Provider Directory User Friendliness, Follow-up Appointment Visits Post Hospital Discharge, Peer Workforce, Peer Liaison, Long Term Support Services, National Core Indicator and in partnership with Wayne State University Center for Urban Studies, the ECHO Adult, and Children surveys.

- The Persons Point of View member newsletters continued to be published quarterly and enjoyed by many.