Quality Operations Technical Assistance Workgroup Meeting Agenda
Wednesday, September 25, 2024
Via Zoom Link Platform
9:30 a.m. – 11:30 a.m.

I. Announcements — A. Siebert

II. Substance Use Disorder (SUD) (Tabled) — J. Davis/G. Lindsey

III. Recipient Rights (Tabled) — C. Witcher

IV. **QAPIP Effectiveness**

Customer Service

a) NCI Survey — Kiva Redmond

Integrated Health — A. Oliver

b) Antidepressant Medication Management (AMM)

c) Follow-up after hospitalization from Mental Illness (FUH)

d) Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)

e) Diabetes Screening for People with schizophrenia or bipolar disorder who are using antipsychotic medications (SSD)

Quality Improvement

a) MDHHS HSW (1915 C) Waiver Updates — S. Denny
b) Medicaid Claims Verification Updates — D. Dobija
c) BTAC Analysis
- Quarter 3 — F. Nadeem

a) MMBPI Data Analysis — J. Zeller/S. Ganesan
- Quarters 1-2
- Quarter 3 (Preliminary)

b) CE/SE Updates — C. Spight-Mackay

V. Adjournment

Quality Operations Technical Assistance Workgroup Meeting Agenda
Wednesday, September 25, 2024
Via Zoom Link Platform
9:30 a.m. – 11:30 a.m.
Note Taker: DeJa Jackson

1) **Item: Announcements:**
   - Updates were made to the progress notes, aligning with the Medicaid Provider Manual. The inclusion of start and end times for providing community living supports and personal care services is now mandatory.
   - DWIHN achieved provisional certification for the CCBHC demonstration. Full certification is expected by January 2025.

2) **Item: Substance Use Disorder (SUD) – G.Lindsey/ Judy Davis**

Goal: Updates from SUD

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

Discussion		
SUD updates Tabled.		
Provider Feedback	**Assigned To**	**Deadline**
No additional provider feedback was provided.		
Action Items	**Assigned To**	**Deadline**
None		

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

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

Discussion		
ORR Updates Tabled.		
Provider Feedback	**Assigned To**	**Deadline**
No Provider Feedback.		
Action Items	**Assigned To**	**Deadline**
None		

4) Item: QAPIP Effectiveness

Goal: Customer Service

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

Discussion		
Kiva Redmond, Customer Service shared the following information with the workgroup: NCI Survey: • The NCI survey list will be sent to the assigned CRSP's within the next 15-30 days. • Individual updates will be provided to each organization.		
Provider Feedback	**Assigned To**	**Deadline**
None provided		
Action Items	**Assigned To**	**Deadline**
None required.		

4) Item: QAPIP Effectiveness
Goal: Integrated Health

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		
Alicia Oliver shared the following: HEDIS measure 3rd quarter rates and interventions: ○ ***Antidepressant Medication Management***: Acute Phase(6-12 weeks) Current rate:48.79% Goal: 66.93% ○ Antidepressant Medication Management: Continuation Phase(4-9 months) Current rate: 22.40% Goal: 50.71% ○ Effective Interventions: ▪ Regular Monitoring ▪ Medication Management ▪ Psychotherapy ▪ Lifestyle Interventions ▪ Social Support ▪ Crisis Management ▪ Education and resources ○ ***Follow-up After Hospitalization from Mental Illness*** ***30-day FUH ages 6 and older***: 6-17 years: 66.28% Goal: 70% 18-64 years: 53.24% Goal: 58% 65+ year: 45.90% Goal: 58% ○ ***Follow-up After Hospitalization from Mental Illness*** ***7-day FUH ages 6 and older***: 6-17 years: 45.35% Goal:70%		

18-64 years:33.07% Goal: 58% 65+years:22.95% Goal: 58% ○ Current strategies to improve attendance: ▪ Education and Communication ▪ Outreach Systems and Case Managers ▪ Referrals and Coordination ○ ***Adherence to Antipsychotic Medications for Individuals with Schizophrenia*** Current rate: 60.53% Goal: 66.28% ○ Strategies' implemented to improve adherence: ▪ Patient Education ▪ Simplifying Medications Regimens ▪ Support Systems ▪ Technology ▪ Medication Synchronization ▪ Address Barriers ▪ Regular Follow-ups ▪ Behavioral Interventions ▪ Pharmacist Involvement ○ ***Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications*** Current Rate: 52.01% Goal: 80.99% ○ Some effective strategies: ▪ Education and Awareness ▪ Integrated Care Models ▪ Reducing Stigma Please refer to handout "September HEDIS presentation (002).ppt".		
Provider Feedback	**Assigned To**	**Deadline**
None provided.		
Action Items	**Assigned To**	**Deadline**
HEDIS measures will continually be shared with the workgroup as required.	A. Oliver (IHC)	Ongoing

4) Item: QAPIP Effectiveness
Goal: Quality Improvement
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		
Sara Denny, Clinical Specialist Quality Improvement shared the following: MDHHS 2024 Waiver & 1915 (i)SPA 90-day follow up review: • The follow-up review will occur Tuesday November 12th – November 29th, 2024 • This review will be a validation of implementation of CAP responses • DWIHN Quality will send notification to all involved providers by Tuesday October 1st, 2024 • All evidence is due back to Quality by Friday October 11th, 2024 • List of evidence being requested is found in the approved MDHHS CAP responses providers received in July. • Instructions for submission will be found within the notification letter • You can choose to submit all evidence at once, or continuously send documents as you have them ready (as long as they are all submitted by October 11th) Please refer to handout "*MDHHS 2024 Waiver iSPA 90 Day Follow Up Timeline.pptx*".		
Provider Feedback	**Assigned To**	**Deadline**
• Question: Will there be changes to the audit tools for FY25? • Answer: Yes, the tools are being refined for the upcoming fiscal year.		
Action Items	**Assigned To**	**Deadline**
Ongoing MDHHS 2024 Waiver & 1915 (i)SPA updates will be provided to the workgroup as received from MDHHS.	DWIHN Quality Improvement (Monitoring) Team	Ongoing

4) Item: QAPIP Effectiveness
Goal: Quality Improvement

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

Discussion		
Dayna Stevens, Clinical Specialist - Performance Monitor discussed and shared the following: ***Medicaid Claims Verification Updates***: ○ **Why do we verify claims?** ○ To monitor the Network's compliance with MDHHS' requirements for encounters and assure that paid claims, and the associated services rendered, are appropriately documented in the member's case record ○ **Medicaid claims chosen** ○ Twice a year, a statistically sound random sample is generated that complies with the OIG minimum sampling standards (https://oig.hhs.gov/compliance/rat-stats/index.asp ○ **What Happens after claims are reviewed** ○ The process will result in one or more of the following: ▪ Full Compliance letter ▪ CAP request letter ▪ Recoupment of the claim ▪ Referral to compliance for potential Fraud, Waste and Abuse ○ **Preliminary findings Q1.Q2 FY 2024** ○ Records are lacking evidence of a valid IPOS (signed and dated by both the author and the legally responsible individual) ○ Unsigned ○ Verbal Consent ▪ Only acceptable if it is witnessed by someone other than the author of the plan ▪ Must be followed up with a wet signature as soon as possible (with all attempts to obtain the signature documented in the member's record) ○ Obtained Externally ▪ Only acceptable if there is evidence of the wet or electronic signature ○		

○ **Why are we sharing this data? •** ○ CRSPs ▪ Ensure all providers supporting the member have access to a valid IPOS as soon as it is signed by all parties ▪ Ensure all providers supporting the member are trained on that individual's plan as soon as possible ○ Direct service providers ▪ Work with the CRSP to ensure access to a valid IPOS, documenting all efforts to obtain the document ▪ Work with the CRSP to ensure staff are trained on the IPOS, documenting all efforts to do so ▪ Designate staff to train others ▪ Maintain evidence of the initial training with the CRSP ○ **Upcoming changes to the process**: ▪ There will no longer be feedback provided ▪ Beginning with the review of claims for services provided during Quarters 3 and 4 providers will be expected to submit documentation as requested in the initial request letter ▪ There will <u>not</u> be feedback sheets sent, which allowed providers additional opportunities to submit documentation. ○ **Why the change?** ▪ Encourage providers to submit all supporting documentation after the initial response. ▪ Eliminate the time-consuming process of providing feedback, waiting for the response, updating the audit and finalizing the audit and completing the process. • Focus on supporting providers with creating and implementing Corrective Action Plans. ▪ Improved outcomes. Please refer to handout "Medicaid_Claims_PPT_Q1.Q2_FY24.pdf"		
Provider Feedback	**Assigned To**	**Deadline**
None.		
Action Items	**Assigned To**	**Deadline**
Q3 and Q4 analysis will be shared with the workgroup in January or February of 2025.	DWIHN Quality Improvement (Monitoring) Team	February 25, 2025

4) Item: QAPIP Effectiveness
Goal: Quality Improvement
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems **X Quality** ☐ Workforce
NCQA Standard(s)/Element #: QI #1 CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Discussion		
Fareeha Nadeem, **Clinical Specialist Quality Improvement** shared and discussed the the following: Q3 Behavior Treatment Advisory Committee ○ **Background**: ○ The Behavior Treatment Advisory Committee (BTAC) was started in June 2017. ○ The Committee comprises DWIHN Provider Network representatives, DWIHN staff, including Psychologists and Psychiatrists, the Office of Recipient Rights, and members. ○ The Committee reviews the implementation of Behavior Treatment Plan Review Committees (BTPRC) procedures and evaluates each committee's overall effectiveness and corrective action as necessary ○ The charge of this Committee includes random sampling of intrusive and restrictive behavior treatment plans and review for inclusion of the MDHHS Technical Guidelines in the DWIHN Behavior Treatment Policy and Procedures and training. ○ The Committee reviews system-wide trends, behavior plan approvals, disapprovals, and terminations. ○ **Accomplishment**: ○ The Michigan Department of Health and Human Services (MDHHS) has recently completed the 1915 (c) Waiver Review. In FY24, DWIHN/R7 was found to be in continued full compliance for a fifth consecutive year with all the areas of the Administrative Review of B.1: ○ **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 quarterly analysis to address any trends and/or opportunities for quality improvement.		

○ 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 and provide trends from previous quarters, the need for training, and interventions done to minimize the use of restriction ○ **Recommendations**: ○ Continuation of Case Validation Reviews of randomly selected cases as a step towards continuous quality improvement at the PIHP level. ○ To improve the under-reporting of Behavior Treatment beneficiaries' required data, including 911 Calls, Deaths, Emergency Treatment, and Use of Physical Management. Network BTPRC electronic data should be patched into the PIHP PCE system to help underreport Sentinel Events of members on BTPs. ○ Conduct training for network providers on the Technical Requirements of Behavior Treatment Plans. Please refer to handout "QISC BTAC Q3 FY 2024.pdf"		
Provider Feedback	**Assigned To**	**Deadline**
None.		
Action Items	**Assigned To**	**Deadline**
Q4 data and analysis will be shared with the workgroup in January or February of 2025. Ongoing efforts will be noted for underreporting of events as noted.	Quality Improvement Team (Fareeha Nadeem)	February 25, 2025

4) Item: QAPIP Effectiveness
Goal: Quality Improvement
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems **X Quality** ☐ Workforce
NCQA Standard(s)/Element #: QI #4 CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Discussion		
Justin Zeller, Clinical Specialist Quality Improvement shared the following with the workgroup: ***Q1 & 2 MMBPI Data and Q3 (Preliminary)*** Performance Indicators Q3: • PI# 1***(Pre-Admission Screening within 3 hours)*** • All populations for PI#1 have met the MDHHS 95% benchmark ▪ PI#1 Children: 95.01% ▪ PI#1 Adults: 97.85% ▪ PI# 1 Total: Q3 (Preliminary): 97.19% • PI# 2 ***(Access/1st Request Timeliness)*** • Major focus the last couple of years • MDHHS benchmark of 57% began in 2024 • Staffing shortages and lack of available appointments have been the main challenges • Many initiatives and interventions have been implemented. Hoping to continue to see increases above the 57% MDHHS benchmark and beyond ▪ PI#2a MI Child: 59.06% ▪ PI#2a MI Adult: 59.43% ▪ PI#2a IDD Child: 31.50% ▪ PI#2a IDD Adult: 60.77% ▪ PI#2a Total: 55.36%		

Q1 & 2 MMBPI Data and Q3 (Preliminary) • PI # 3 (**Access/1st Service Timeliness)** ▪ 1st Quarter had some challenges with CRSPs billing follow-up services as well as challenges with capacity ▪ Issues appear to have been cleaned up and 3rd Quarter rates are highest rates for a quarter DWIHN has had in years ▪ PI#3 MI Child:93.03% ▪ PI#3 MI Adult: 94.49% ▪ PI#3 IDD Child: 88.90% ▪ PI#3 IDD Adult: 93.50% ▪ PI#3 Total: 93.25% • PI# 4 (**Hospital Discharges Follow-up)** • All populations have consistently been meeting the 95% MDHHS benchmark • Major focus has been the racial disparity rates without including exceptions ▪ PI#4a Child: 98.63% ▪ PI#4a Adult: 97.47% ▪ PI#4a Total: 97.59% • PI # 10 (**Inpatient Recidivism)** • #10 rates have continued to slightly increase this year • Past recidivism initiatives have been restarted to try and decrease the rates • PI#10 child 3rd Quarter hit the highest rate in years. 4th Quarter 2024 is currently in the single digits. ▪ PI#10 Child: 15.69% ▪ PI#10 Adult: 17.61% ▪ PI#10 Total: 17.35% • PI# 2e **(SUD - Expired SUD service requests)** ▪ PI#2e continues to consistently be under the new 68.20% MDHHS benchmark • PI# 4b **(SUD - Detox Discharges Follow-Up)** ▪ PI#4b continues to meet the 95% MDHHS benchmark ▪ PI#4b SUD: 95.38%		
Provider Feedback	**Assigned To**	**Deadline**
No provider feedback.		
Action Items	**Assigned To**	**Deadline**
Q4 and FY2024 Data will be shared with the workgroup in January or February of 2025.	Quality Improvement Team (Justin Zeller)	February 25, 2025

4) Item: QAPIP Effectiveness – Quality Improvement
Goal: CE/SE Updates

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		
Dr. Carla Spight-Mackey shared the following reminders with the workgroup: • The state will begin tracking fall risks in FY25. • Providers are reminded to close out critical and sentinel events before the fiscal year ends.		
Provider Feedback	**Assigned To**	**Deadline**
No Provider feedback.		
Action Items	**Assigned To**	**Deadline**
None required.		

New Business Next Meeting: 10/30/24
Adjournment: 9/25/2024

DETROIT WAYNE INTEGRATED HEALTH NETWORK

800-241-4949

www.dwihn.org

HEDIS measure 3rd quarter rates and Interventions

- Antidepressant Medication Management (AMM)
- Follow up after hospitalization from mental illness (FUH)
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)
- Diabetes Screening for People with schizophrenia or bipolar disorder who are using antipsychotic medications (SSD)

Antidepressant Medication Management: Acute Phase (6-12 weeks) AMM

Measurement Period 3rd quarter	Eligible population	Total compliant	Non-Compliant	Rate	Goal
2024	3946	1807	2139	48.79	66.93

AMM is a measure that ends in April 30 of the current year it restarts May 1 the following year.

Antidepressant Medication Management: Continuation Phase (4-9 months after acute phase)

Measurement Period 3rd quarter	Eligible population	Total compliant	Non-Compliant	Rate	Goal
2024	3946	884	3062	22.40	50.71

AMM is a measure that ends in April 30 current year it restarts May 1 the following year.

Effective Interventions

Regular Monitoring

- Schedule appointments: Regular check-ins with healthcare providers to monitor progress and adjust treatment plans as needed.
- Telehealth Services: Utilizing telehealth for more frequent and accessible follow-ups.

Medication Management

- Adherence Support: Providing reminders and support to ensure clients take their medication as prescribed.
- Side Effect Management: Monitoring and managing any side effects to improve adherence and comfort.

Psychotherapy

- Continued Therapy Sessions: Ongoing therapy sessions to address underlying issues and develop coping strategies.
- Group Therapy: Offering group therapy sessions to provide peer support and reduce feelings of isolation.

Lifestyle Interventions

- Exercise programs: Encouraging regular physical activity, which can improve mood and overall well-being.
- Healthy Eating: Providing nutritional guidance to support mental health.

Social Support

- Support Groups: Connecting clients with support groups for shared experiences and encouragement.
- Family Involvement: Involving family members in the treatment process to provide additional support.

Crisis Management

- Crisis Hotlines: Ensuring clients have access to crisis hotlines for immediate support.
- Safety Plans: Developing safety plans for clients at risk of self-harm or suicide.

Education and resources

- Psychoeducation: Educating clients about depression and its treatment to empower them in their recovery.
- Resource Provision: Providing information on community resources and services that can offer additional support.

Follow up After Hospitalization From Mental Illness

30-day FUH ages 6 and older

Measurement Period 3rd quarter 2024	Eligible population	Total compliant	Non-Compliant	Rate %	Goal %
6-17 3rd quarter	172	114	58	66.28	70
18-64 3rd quarter	1899	1011	888	53.24	58
65+ 3rd quarter	61	28	33	45.90	58

Follow up After Hospitalization From Mental Illness

7- day FUH age 6 and older

Measurement Period 3rd quarter	Eligible population	Total compliant	Non-Compliant	Rate %	Goal %
6-17 3rd quarter	172	78	94	45.35	70
18-64 3rdt quarter	1899	628	1271	33.07	58
65+ 3rd quarter	61	14	47	22.95	58

Current strategies to improve attendance:

Education and Communication:

- Talking openly with patients about the importance of a follow up visit.
- Explaining how these appointments contribute to their overall well-being.
- Encouraging compliance by emphasizing the value of continued treatment.

Outreach Systems and Case Managers:

- Developed outreach systems and assigned case managers.
- Encouraging recently discharged patients to keep follow-up appointments.
- Addressing any barriers they may face such as transportation or social determinants of health.

Referrals and Coordination

- Facilitating referrals to behavioral health specialists.
- Coordinating care to ensure timely follow-up visits
- Ideally, scheduling appointments within 7 days of discharge, but no later than 30 days.

Addressing barriers before discharge and assisting facilities in securing timely follow-up appointments are essential steps in improving attendance.

Adherence to Antipsychotic Medications for Individuals with Schizophrenia
SAA

Measurement 3rd quarter	Eligible population	Total compliant	Non-Compliant	Rate %	Goal %
3rd quarter	4561	2761	1800	60.53	66.28

Strategies implemented to Improve Adherence

1. **Patient Education:** Educating patients about the importance of medication adherence and the potential consequences of non-adherence can empower them to take their medications as prescribed. Educating patients about their medications. Clear communication about the benefits and potential side effects can help patients understand why adherence is crucial.
2. **Simplifying Medications Regimens:** Using long-acting injectable antipsychotics can help improve adherence. Whenever possible, simplify the medication regimen. This can include prescribing combination pills to reduce the number of medications a patient needs to take daily.
3. **Support Systems:** Involving family members or caregivers in the treatment process can provide additional support and encouragement for adherence.
4. **Technology**: Utilizing technology such as reminder apps, automated phone calls, and smart pillboxes can help individuals to remember to take their medications. Implement reminders through phone calls, text messages, or mobile apps to help patients remember to take their medications. Electronic pill dispensers and smart pill bottles can also be useful.

1. **Medication Synchronization**: Align refill dates so that all medications can be picked up at the same time. This reduces the number of trips to the pharmacy and helps patients stay on track.
2. **Address Barriers**: Identify and address barriers to adherence, such as cost, side effects, or complex dosing schedules. Providing financial assistance or alternative medications.
3. **Regular Follow-ups**: Schedule regular follow-up appointments to monitor adherence and address any issues. This also provides an opportunity to reinforce the importance of sticking to the prescribed regimen.
4. **Behavioral Interventions**: Use motivational interviewing and other behavioral techniques to encourage adherence. Setting specific goals and providing positive reinforcement.
5. **Pharmacist Involvement:** Pharmacists play a key role providing medication counseling, conducting medication reviews and helping to manage side effects.

Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications
SSD

Measurement 3rd quarter	Eligible population	Total compliant	Non-Compliant	Rate %	Goal %
3rd quarter	6704	3487	3217	52.01	80.99

Some effective strategies:

1.Education and Awareness:

Patient Education: Providing clear information about the risks of diabetes associated with antipsychotic medications and the importance of regular screening.

Provider Training: Ensuring healthcare providers are aware of the increased diabetes risk and trained to integrate diabetes screening into routine care for patients with severe mental illness.

2.Integrated Care Models:

Collaborative Care: Implementing integrated care models where mental health and primary care providers work together to manage both mental and physical health needs.

Case Management: Utilizing case managers to coordinate care, ensure follow-up on screening, and help patients navigate the healthcare system.

3.Reducing Stigma:

Community Programs: Developed community-based programs to reduce stigma around mental illness and encourage individuals to seek regular medical care.

Support Groups: Creating support groups for individuals with mental illness to share experiences and encourage others to maintain their health/

4.Improving Access to care:

Mobile Health Clinics: Using mobile health clinics to provide screening services in underserved areas.

Telehealth Services: Offering telehealth services to increase access to healthcare providers, especially for those with transportation or mobility issues.

5.Medication Management:

Monitoring Side Effects: Regularly monitoring and managing the side effects of antipsychotic medications to minimize their impact on physical health.

Alternative Medications: Considering alternative medications with a lower risk of metabolic side effects when appropriate.

Questions?

Educational Tools
Resources:
https://dwihn.org/providers-HEDIS

https://dwihn.org/documents/myStrength_Flyer.pdf (self help tool)

https://dwihn.org/access-mymobileapp

MDHHS 2024 Waiver & 1915 (i)SPA 90-day follow up review

- Will occur Tuesday November 12th-Friday November 29th, 2024
- This review will be a validation of implementation of CAP responses
- DWIHN Quality will send notification to all involved providers by Tuesday October 1st, 2024
- All evidence is due back to Quality by Friday October 11th, 2024
- List of evidence being requested is found in the approved MDHHS CAP responses providers received in July
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Detroit Wayne Integrated Health Network
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Your Link to Holistic Healthcare
TOP WORK PLACES 2023
Detroit Free Press

Medicaid Claims Verification Process and Upcoming Changes

Presented by:

DeLisa Marshall
and
Dayna Stevens

DWIHN's Quality Improvement Department

Why do we verify claims?

To monitor the Network's compliance with MDHHS' requirements for encounters and assure that paid claims, and the associated services rendered, are appropriately documented in the member's case record.

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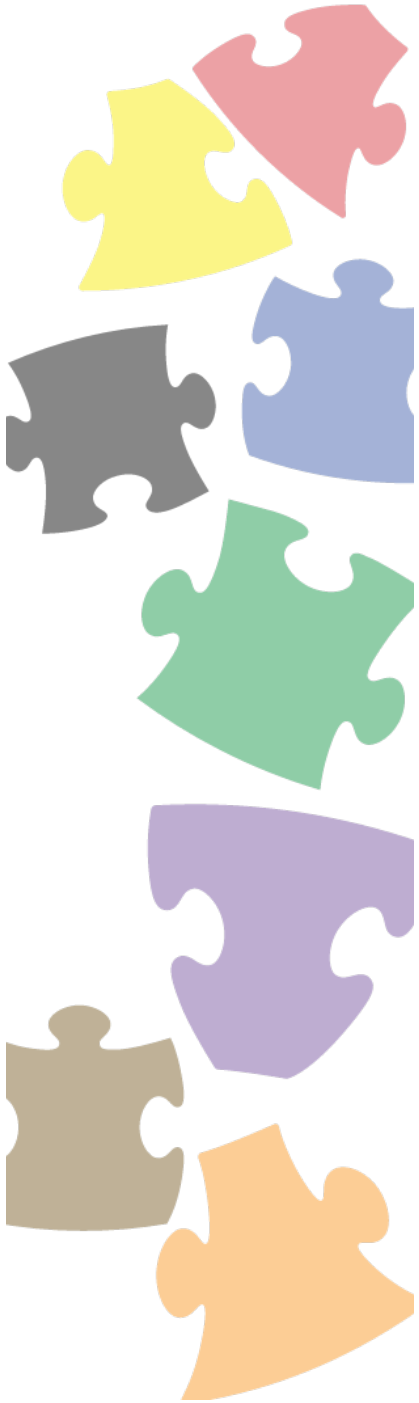
TOP WORK PLACES 2023
Detroit Free Press

Medicaid claims chosen

Twice a year, a statistically sound random sample is generated that complies with the OIG minimum sampling standards (https://oig.hhs.gov/compliance/rat-stats/index.asp)



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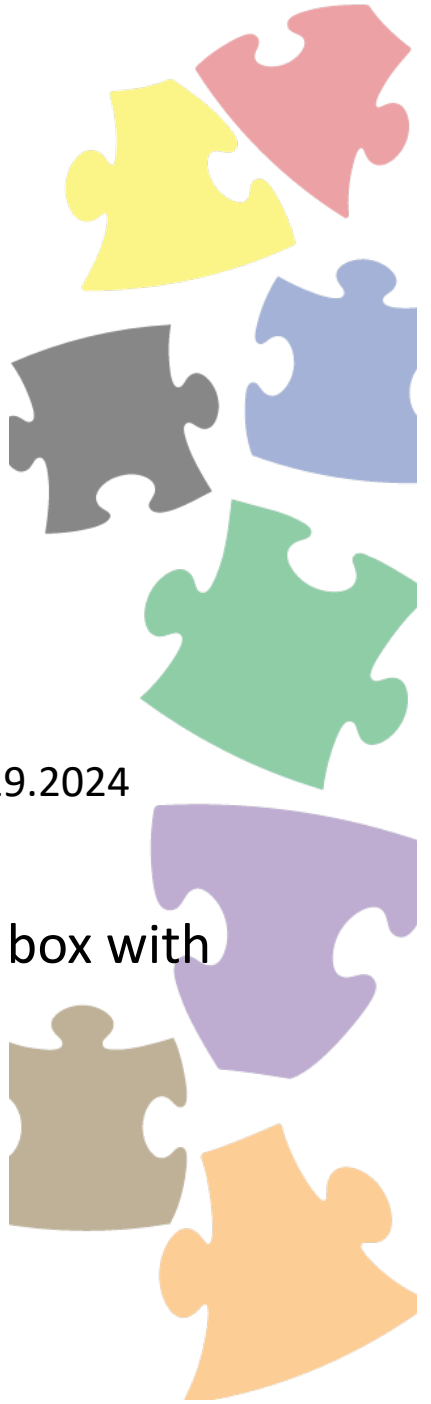
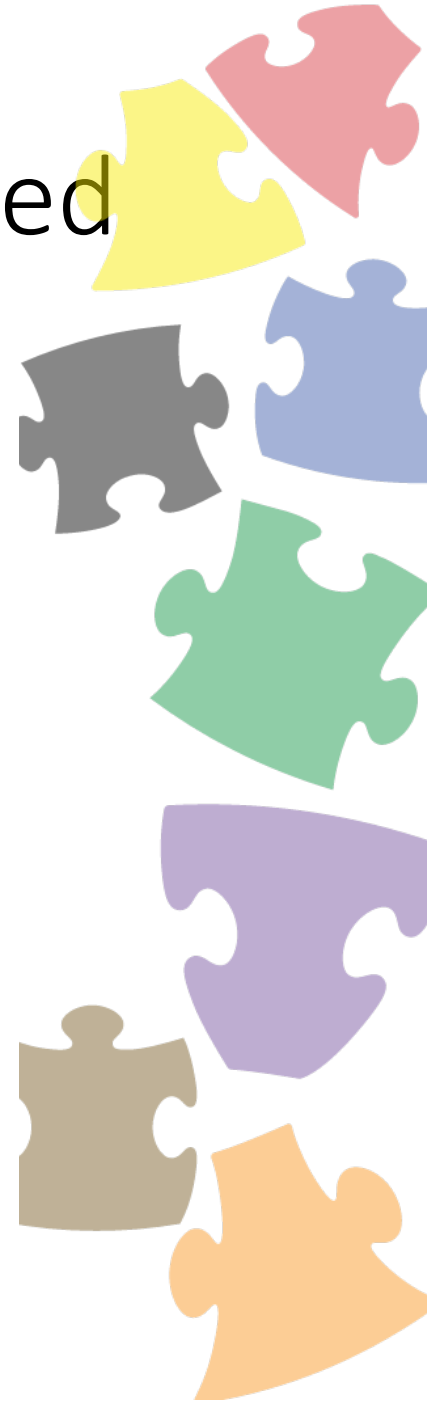
The Initial Request

- Identifies claims randomly chosen for review
- Identifies what documentation is needed to support the claim
- Provides detailed instructions how/when to forward supporting documentation
  - Scan one claim per file (see instructions to ZIP a file)
    - All information for each claim should be Zipped into separate files and labeled by MHWIN#_DOS
      - For example, all supporting documentation for member with MHWIN# 1234 for DOS 02.29.2024 should be labeled: 1234_02.29.2024)
  - Typically, the reviewer will require these files to be sent via MHWIN message box with the following information in the body of the message:
    - Organization name
    - Best contact person
      - Telephone number
      - Email address



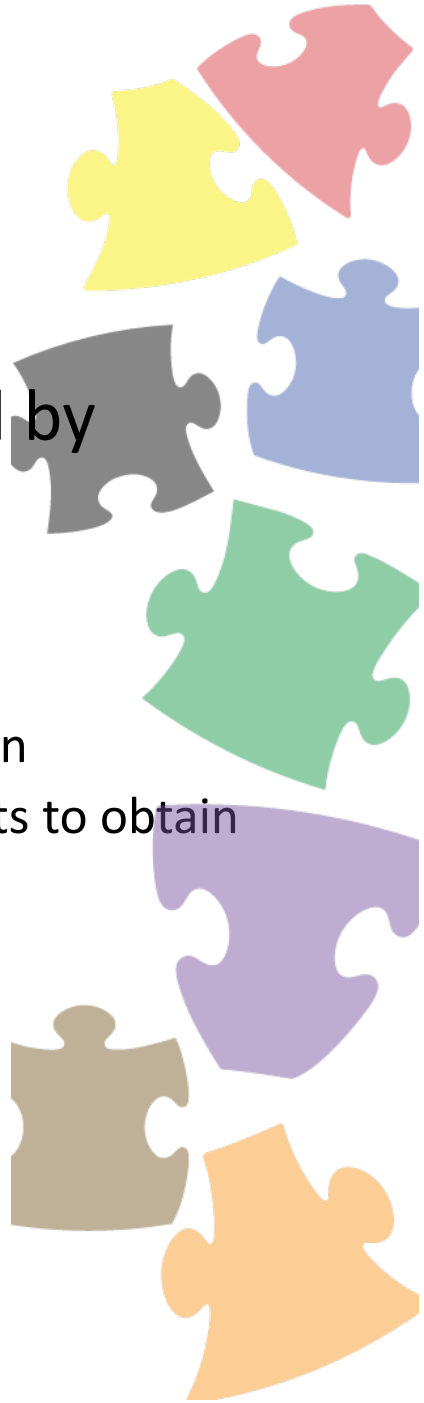
What Happens after claims are reviewed

- The process will result in one or more of the following:
  - Full Compliance letter
  - CAP request letter
  - Recoupment of the claim
  - Referral to compliance for potential Fraud, Waste and Abuse



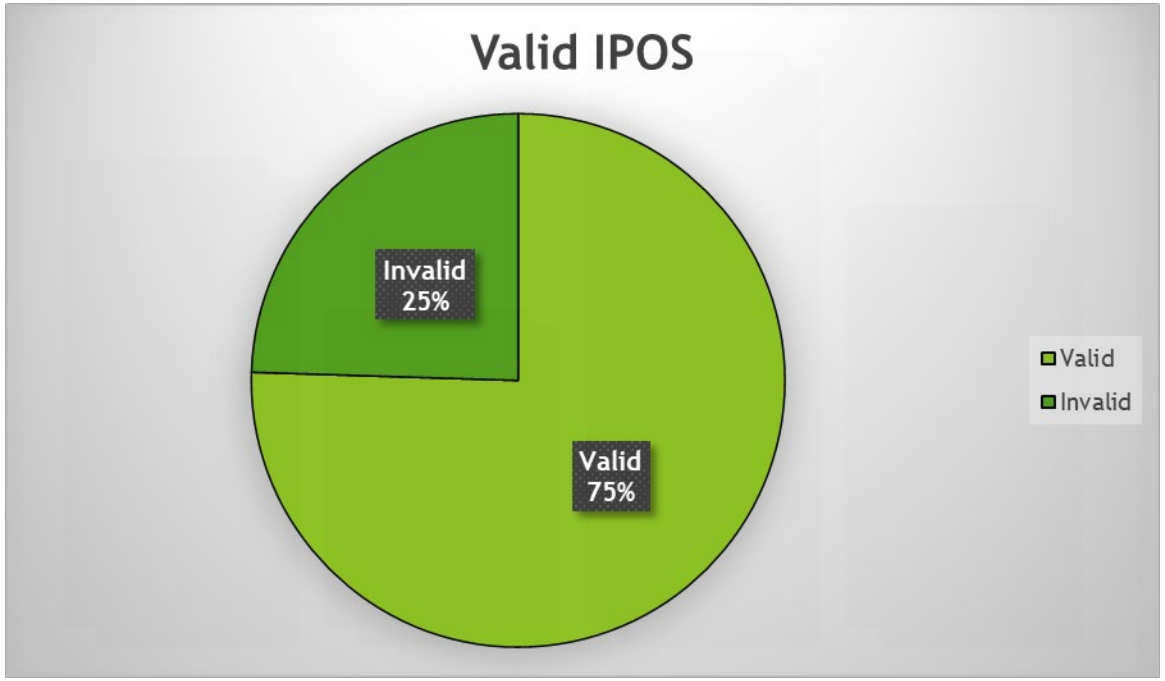
Preliminary findings Q1.Q2 FY 2024

- Records are lacking evidence of a ***valid*** IPOS (signed and dated by both the author and the legally responsible individual)
  - Unsigned
  - Verbal Consent
    - Only acceptable if it is witnessed by someone other than the author of the plan
    - Must be followed up with a wet signature as soon as possible (with all attempts to obtain the signature documented in the member's record)
  - Obtained Externally
    - Only acceptable if there is evidence of the wet or electronic signature



Preliminary findings: **Invalid IPOS**

Of the 665 claims reviewed to date:

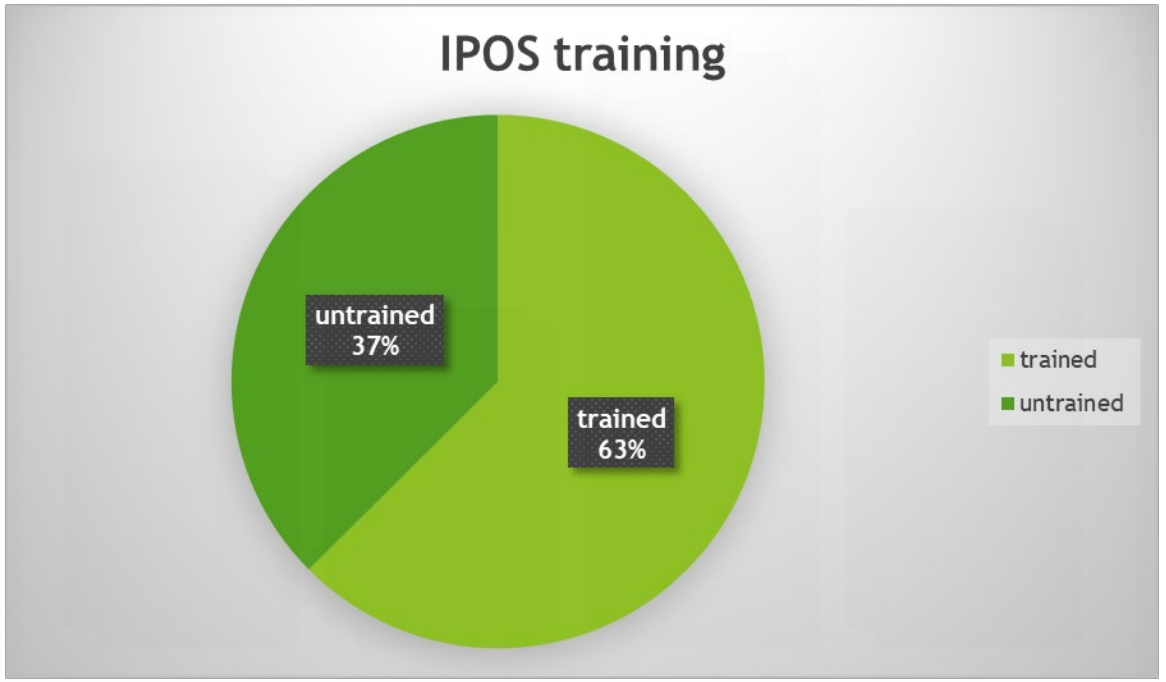


Preliminary findings Q1.Q2 FY 2024

- Staff were not fully qualified on the date of service, often due to not being trained on the member's IPOS
  - No evidence submitted
  - Evidence submitted did not meet minimum requirements:
    - Training not done by the Supports Coordinator/CRSP
      - Train the trainer is OK if there is evidence that staff were initially trained by the SC/CRSP
    - Document is a running log of dated signatures
      - This is only acceptable if the trainer signs and dates each training session
    - The Training document is not filled out in its entirety

Preliminary findings: **Invalid/No IPOS training**

Of the 422 claims reviewed to date for providers of non-professional direct care services:



Why are we sharing this data?

- CRSPs
  - Ensure all providers supporting the member have access to a valid IPOS as soon as it is signed by all parties
  - Ensure all providers supporting the member are trained on that individual's plan as soon as possible
- Direct service providers
  - Work with the CRSP to ensure access to a valid IPOS, documenting all efforts to obtain the document
  - Work with the CRSP to ensure staff are trained on the IPOS, documenting all efforts to do so
    - Designate staff to train others
      - Maintain evidence of the initial training with the CRSP

Upcoming changes to the process

There will no longer be feedback provided

- Beginning with the review of claims for services provided during Quarters 3 and 4
  - providers will be expected to submit documentation as requested in the initial request letter
  - there will not be feedback sheets sent, which allowed providers additional opportunities to submit documentation

Why the change?

- Encourage providers to submit all supporting documentation after the initial response.
- Eliminate the time-consuming process of providing feedback, waiting for the response, updating the audit and finalizing the audit and completing the process.
- Focus on supporting providers with creating and implementing Corrective Action Plans.
- Improved outcomes.

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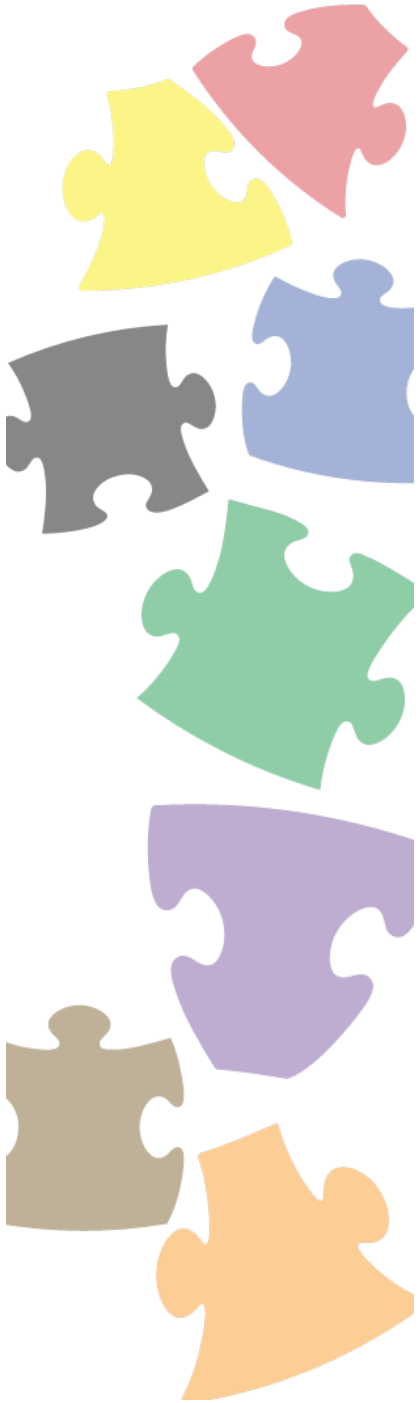

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Behavior Treatment Advisory Committee
Summary of Data Analysis
3rd Quarter 2023-2024

Fareeha Nadeem, MA, LLP. Clinical Specialist, Quality Improvement.

Behavior Treatment Advisory Committee

- ***Background***
- The Behavior Treatment Advisory Committee (BTAC) was started in June 2017.
- The Committee comprises DWIHN Provider Network representatives, DWIHN staff, including Psychologists and Psychiatrists, the Office of Recipient Rights, and members.
- The Committee reviews the implementation of Behavior Treatment Plan Review Committees (BTPRC) procedures and evaluates each committee's overall effectiveness and corrective action as necessary
- The charge of this Committee includes random sampling of intrusive and restrictive behavior treatment plans and review for inclusion of the MDHHS Technical Guidelines in the DWIHN Behavior Treatment Policy and Procedures and training.
- The Committee reviews system-wide trends, behavior plan approvals, disapprovals, and terminations.

ACCOMPLISHMENT

The Michigan Department of Health and Human Services (MDHHS) has recently completed the 1915 (c) Waiver Review. In FY24, DWIHN/R7 was found to be in continued full compliance for **a fifth consecutive year** with all the areas of the Administrative Review of B.1:

"The graphic representation of BTC data supported the understanding of (the) data."

BTPRC DATA

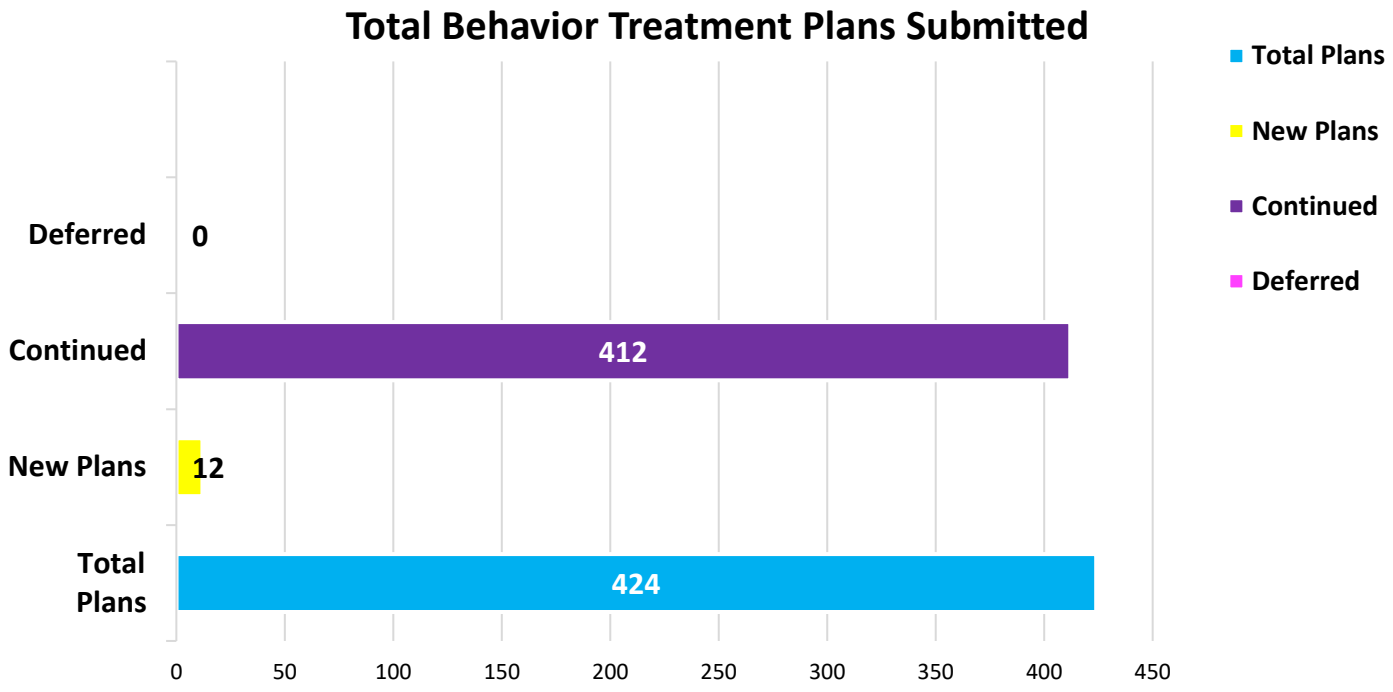
- Network BTPRCs collect, review, and report to DWIHN quarterly, where intrusive and restrictive techniques have been approved for use with individuals and where physical management or 911 calls to law enforcement have been used in an emergency behavioral situation.
- The BTPRC data provides DWIHN an oversight through quarterly analysis to address any trends and/or opportunities for quality improvement.
- 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 and provide trends from previous quarters, the need for training, and interventions done to minimize the use of restrictions.

DATA COLLECTION

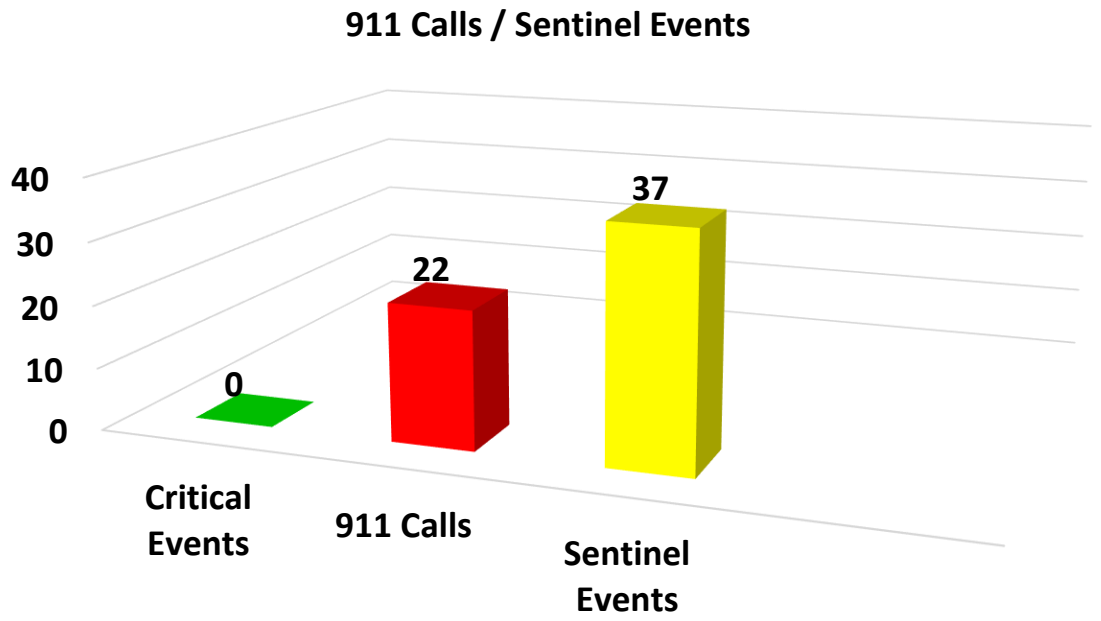
The following BTPRC submitted the data included in this report:

- 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.

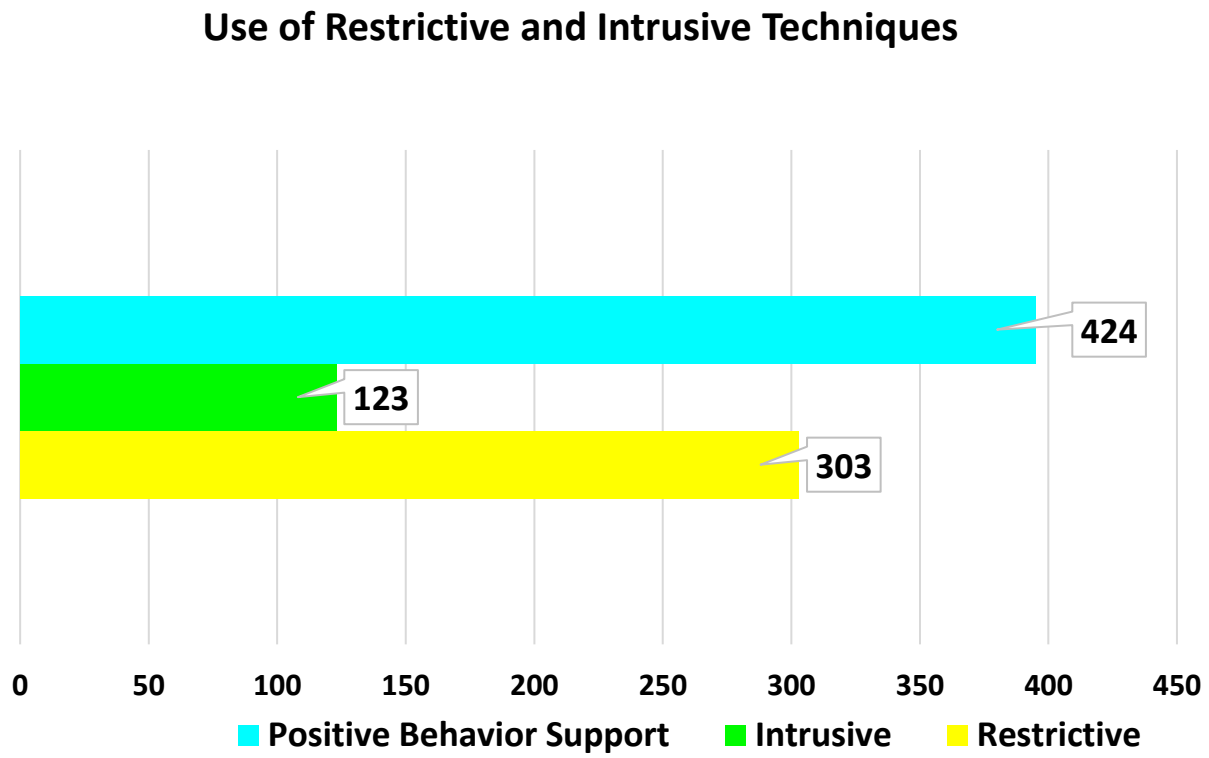
TOTAL BEHAVIOR TREATMENT PLAN SUBMITTED



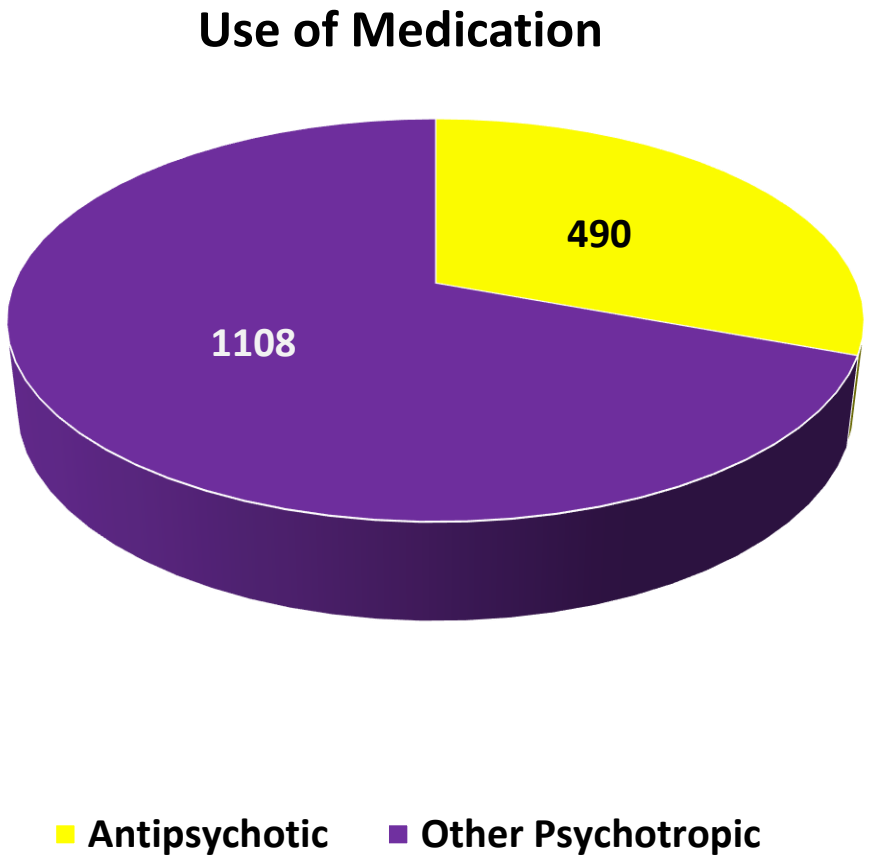
911 CALLS/SENTINEL EVENTS



RESTRICTIVE and INTRUSIVE INTERVENTIONS



REPORTED MEDICATIONS



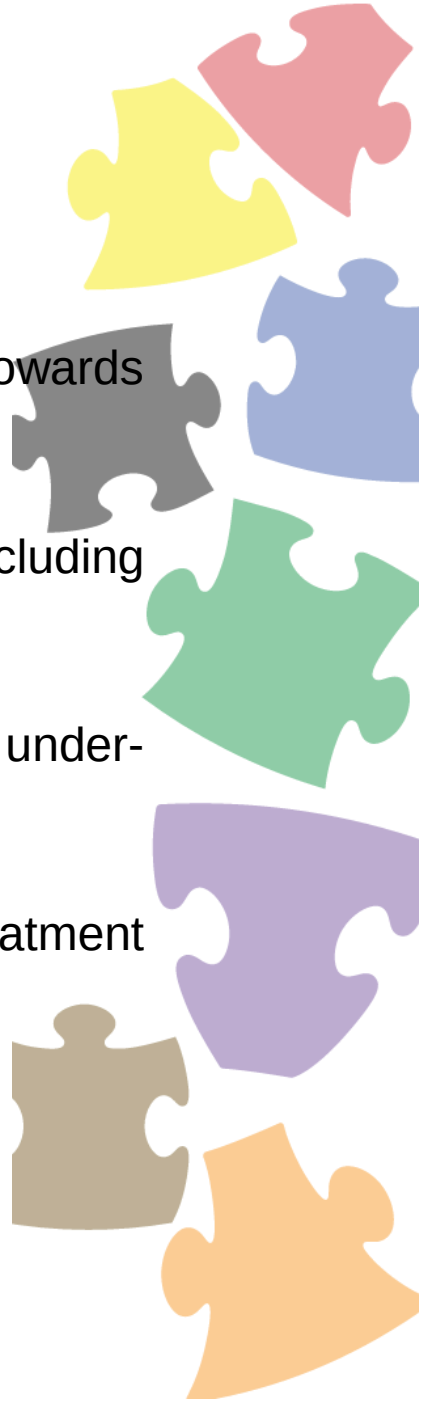
RECOMMENDATIONS

⇒ Continuation of Case Validation Reviews of randomly selected cases as a step towards continuous quality improvement at the PIHP level.

⇒ To improve the under-reporting of Behavior Treatment beneficiaries' required data, including 911 Calls, Deaths, Emergency Treatment, and Use of Physical Management.

⇒ Network BTPRC electronic data should be patched into the PIHP PCE system to help under-report Sentinel Events of members on BTPs.

⇒ Conduct training for network providers on the Technical Requirements of Behavior Treatment Plans.



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Michigan Mission Based Performance Indicator #1

Performance Indicators			
	1st Quarter 2024	2nd Quarter 2024	3rd Quarter 2024 (Preliminary)
PI#1 Children	99.44%	98.80%	95.01%
PI#1 Adults	96.55%	97.23%	97.85%
PI# Total	97.15%	97.55%	97.19%

- For 2024, All populations for PI#1 have met the MDHHS 95% benchmark

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Michigan Mission Based Performance Indicator #2a

	1st Quarter 2024	2nd Quarter 2024	3rd Quarter 2024 (Preliminary)
PI#2a MI Child	30.21%	51.78%	59.06%
PI#2a MI Adult	57.36%	59.68%	59.43%
PI#2a IDD Child	21.78%	27.92%	31.50%
PI#2a IDD Adult	58.41%	63.64%	60.77%
PI#2a Total	47.64%	53.37%	55.36%

- Major focus the last couple of years
- MDHHS benchmark of 57% began in 2024
- Staffing shortages and lack of available appointments have been the main challenges
- Many initiatives and interventions have been implemented. Hoping to continue to see increases above the 57% MDHHS benchmark and beyond.

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Michigan Mission Based Performance Indicator #3

	1st Quarter 2024	2nd Quarter 2024	3rd Quarter 2024 (Preliminary)
PI#3 MI Child	79.70%	90.80%	93.03%
PI#3 MI Adult	90.49%	91.62%	94.49%
PI#3 IDD Child	66.35%	74.31%	88.90%
PI#3 IDD Adult	81.82%	90.91%	93.50%
PI#3 Total	85.22%	88.84%	93.25%

- 1st Quarter had some challenges with CRSPs billing follow-up services as well as challenges with capacity
- Issues appear to have been cleaned up and 3rd Quarter rates are highest rates for a quarter DWIHN has had in years

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Michigan Mission Based Performance Indicator #4a

	1st Quarter 2024	2nd Quarter 2024	3rd Quarter 2024 (Preliminary)
PI#4a Child	97.78%	96.23%	98.63%
PI#4a Adult	98.67%	97.57%	97.47%
PI#4a Total	98.60%	97.48%	97.59%

- All populations have consistently been meeting the 95% MDHHS benchmark
- Major focus has been the racial disparity rates without including exceptions

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Michigan Mission Based Performance Indicator #10

	1st Quarter 2024	2nd Quarter 2024	3rd Quarter 2024 (Preliminary)
PI#10 Child	8.62%	8.82%	15.69%
PI#10 Adult	17.58%	16.65%	17.61%
PI#10 Total	16.79%	15.97%	17.35%

- #10 rates have continued to slightly increase this year
- Past recidivism initiatives have been restarted to try and decrease the rates
- PI#10 child 3rd Quarter hit the highest rate in years. 4th Quarter 2024 is currently in the single digits.

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Michigan Mission Based SUD Performance Indicators

	1st Quarter 2024	2nd Quarter 2024	3rd Quarter 2024 (Preliminary)
PI#2e SUD	64.73%	63.79%	-
PI#4b SUD	97.25%	95.05%	95.38%

- PI#2e continues to consistently be under the new 68.20% MDHHS benchmark
- PI#4b continues to meet the 95% MDHHS benchmark

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