Quality Operations Technical Advisory Workgroup
October 30, 2024
9:30-11:30 a.m.
Zoom
Phone # 877.853.5247 Toll-Free
Meeting ID: Meeting ID: 872 8272 5026

I. Announcements — A. Siebert
- Staff Announcements
  - Jasmine Siffre
  - Andrea Guilbault

II. Substance Use Disorder — J. Davis

III. Recipient Rights — C. Witcher

IV. **QAPIP Effectiveness**

DWIHN Policy Review
- Infant and Early Childhood Mental Health Services — C. Phipps
- CAFAS-PECFAS-DECA Procedure — C. Phipps
  - Children Readmission Analysis — C. Phipps
- Children Diagnostic Treatment Services Program Policy — M. Hampton

Quality Improvement
a) MDHHS CAP — D. Dobija
   - Evidence of remediation
b) Medicaid Claims Verification Review Q3 & Q4 — D. Dobija
   - Submission of Evidence
c) Technical Requirements of BTPRC 2025 — F. Nadeem
d) Adult Readmission Analysis — A. McGhee

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

1) **Item: Announcements:**
   - Crisis service updates: Launching a new pre-admission review service on November 1, 2024. The service will centralize dispatch requests through DWIHN for a smoother workflow.
   - Over 350 adults and 80 youth have been admitted to the crisis center since it's inception and more than 80% of the adult omission has been voluntary.
   - New hires within the organization: James White has been voted as the organization's new President and CEO. There is not an official start date, but there will be a special board meeting scheduled for today.
   - New additions to the Quality Team: Jasmine Siffre and Andrea Guilbault.

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		
Judy Davis, Director of SUD, shared the following updates: • The importance of timely discharge processes to prevent compliance issues. • Utilization of PA 2 funds from alcohol sales and penalties to support treatment services. • Emphasis on community alcohol abuse awareness as alcohol remains the leading substance issue. • Yoga Therapy initiative expanded to the broader provider network.		
Provider Feedback	**Assigned To**	**Deadline**
No additional provider feedback was provided.		
Action Items	**Assigned To**	**Deadline**
None required.		

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

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

Discussion		
Chad Witcher, Prevention Manager ORR**,** shared the following ORR Updates: • Annual Rights Report: Increased complaints but fewer substantiations, reflecting better access to rights resolution mechanisms. • Key reminder that training schedules are adjusted for the holidays.		
Provider Feedback	**Assigned To**	**Deadline**
No additional provider feedback was provided.		
Action Items	**Assigned To**	**Deadline**
None required		

4) Item: QAPIP Effectiveness
Goal: DWIHN Policy Review

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

Discussion		
Cassandra Phipps, Director of Children Initiatives, shared the following updates: *Infant and Early Childhood Mental Health Services Policy:* • Policy aligned with Michigan Medicaid Manual to integrate home-based services requirements. • Inclusion of the MichiCAN screener and DECA tools to assess eligibility for children with SED and IDD. • Expansion of grants for providers to support mental health services. • Providers encouraged to submit requests for the infant and early childhood consultation grant by October 31, 2024. • Staff serving children ages 0-5 must undergo DECA training. • A caseload maximum of 12 full cases (with up to 3 additional transitional cases). *CAFAS-PECFAS-DECA Procedure:* • Updates made to comply with CMS requirements for certain services such as: SED waiver, CLS, Respite, and Family training. • Providers must maintain CAFAS-PECFAS certification and continue using older codes (H0031 and Modifiers). *Recidivism Analysis (Child):* *What is Hospital Recidivism:* • When a member experiences more than 1 psychiatric hospitalization within 30 days of being discharged from the previous psychiatric hospital encounter within a 90-day period. • The goal for hospital recidivism for children/youth to remain below 15%. *Data:* • Year 2023: 781 children were hospitalized and 497 completed post hospital visits (63.64%). • MDHHS set a goal of 70%. • Year 2024 (as of June 2024): 367 children were hospitalized and 233 completed post hospital visit (63.49%).		

Barriers Identified: • *Crisis Screening Trends* • *Crisis Plans* • *Hospital Discharge Planning with Providers and Hospitals* • *FY24-Q3 the Hospital Recidivism increased above 15% - Youth not connected to CMH services.* *Interventions Implemented:* • *Updated hospital discharge bulletin to include specific billing codes for home-based and wraparound discharge planning.* • *Crisis clinical review forms to ensure early discharge planning.* • *Enhanced coordination between crisis screeners and CRSPs to reduce rehospitalization.* *Crisis plan compliance improved to 78% for SED providers and 81% for IDD providers in FY24-Q3.*		
Provider Feedback	**Assigned To**	**Deadline**
Questions: 1. Who is responsible for completing MichiCAN screeners for children under 6 when cases are referred through ACCESS? Answers: 1. Providers handle screenings.		
Action Items	**Assigned To**	**Deadline**
None required.		

4) Item: QAPIP Effectiveness
Goal: DWIHN Policy Review

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

Discussion		
Monica Hampton, Children's Initiatives Coordinator, shared the following: *Children Diagnostic Treatment Services Program Policy*: It is the policy of Detroit Wayne Integrated Health Network (DWIHN) that the Provider Network and any subcontractors, and direct contractors that provide services to children, adolescents, and their families will meet the standards for the Children's Diagnostic Treatment Services Program Policy. • Combined Children's diagnostic and promoting SED Youth policies. • Added changes for Intensive Care Coordination with Wraparound (ICC-W) • Concerns about ICC-W requirement for facilitators to complete treatment plans, which may be challenging for some agencies.		
Provider Feedback	**Assigned To**	**Deadline**
No additional provider feedback was provided		
Action Items	**Assigned To**	**Deadline**
None required.		

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		
Danielle Dobija, QI Administrator, shared the following: MDHHS CAP: • Ongoing submissions for MDHHS Waiver and ISPA review corrections. • Medicaid Claims Verification review and analysis for Quarter 3 and 4 reviews require submissions to MDHHS by December 31.		
Provider Feedback	**Assigned To**	**Deadline**
Questions: 1. Providers expressed concerns about tight timelines and high volume of file requests. Answers: 1. April Siebert, Director of QI committed to revisiting the process for better efficiency for requesting Medicaid Claims Verification cases and submitting to providers.		
Action Items	**Assigned To**	**Deadline**
Revisit process for Medicaid Claims Verification request from providers.	QI (Danielle Dobija and April Siebert)	March 31, 2025

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		
Fareeha Nadeem, Clinical Specialist, shared the following: Technical Requirement for Behavioral Treatment Plans include any limitations of the recipient's rights, any intrusive treatment techniques, or any use of psychoactive drugs for behavior control purposes shall be reviewed and approved by the Behavior Treatment Plan Review Committee (BTPRC). Technical Requirements of the BTPRC 2025. • Minimum terminology changes in the BTBPRC standards. • Training will be provided in November; details to follow. Please see handout "Technical_Requirement_for_Behavioral_Treatment_Plans.pdf" for more information.		
Provider Feedback	**Assigned To**	**Deadline**
No additional provider feedback was provided		
Action Items	**Assigned To**	**Deadline**
Training dates for BTAC Technical Requirement will be provided. Training from MDHHS will occur in November 2025.	QI (Fareeha Nadeem)	November 30, 2024

4) Item: QAPIP Effectiveness
Goal: Quality Improvement

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

Angel McGhee, Data Analyst, shared the following data/analysis with the workgroup:
Recidivism Analysis (Adult):
 	
Key Trends:
• FY24-Q4 adult recidivism: 16.68% (a significant drop from 23% in 2019).
• Decreased inpatient admissions by 144 cases between Q2 and Q3.
Data:
• Follow-up after Hospitalization (30 days):
  ○ Ages 18-64: Increased from 46.72% in 2023 to 53.46% in 2024.
  ○ Ages 65+: Increased from 30.61% in 2023 to 41.67% in 2024.
• MDHHS set a goal of 58%.
Barriers:
• Members are overwhelmed with information at discharge. They have several people telling them appointment dates. There are many reminder calls coming from various people.
• Incorrect Contact Information
• Members are not made aware of their 30-day follow-up appt.
• Transportation
Interventions:
• Resumed Recidivism Workgroup to address ongoing gaps and barriers.
• Expanded ACT providers' after-hours services by 20%, reducing hospital stays and Medicaid costs.
• Adjusted re-engagement policies to ensure timely discharge documentation.
Please see handout "Adult Recidivism PP - QISC and QOTAW.pptx" for more information.		

Provider Feedback	**Assigned To**	**Deadline**
No additional provider feedback was provided		
Action Items	**Assigned To**	**Deadline**
None required.		

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Behavioral and Physical Health and Aging Services Administration

TECHNICAL REQUIREMENT FOR BEHAVIOR TREATMENT PLANS and BEHAVIOR TREATMENT PLAN REVIEW COMMITTEES

Application:

Prepaid Inpatient Health Plans (PIHPs)
Community Mental Health Services Programs (CMHSPs)
Public mental health service providers

Preamble

The Michigan Department of Health and Human Services (MDHHS) requires that all public mental health agencies protect and promote the dignity and respect of all individuals receiving public mental health services. All public mental health agencies shall have policies and procedures for intervening with an individual receiving public mental health services who exhibits aggressive, self-injurious or other challenging behaviors that place the individual or others at imminent risk of physical harm. These policies and procedures shall include protocols for using the least intrusive and restrictive interventions for unprecedented and unpredicted crisis or emergency occurrences of such behaviors. For all non-emergent or continuing occurrences of these behaviors, the public mental health service agency will conduct appropriate assessments and evaluations to determine the conditions that might be the cause of the behaviors.

The MDHHS will not tolerate violence perpetrated on the individuals served by the public mental health system in the name of intervening when individuals exhibit potentially harmful behaviors. Any individual receiving public mental health services has the right to be free from any form of physical management, restraint or seclusion used as a means of coercion, discipline, retaliation, or for the convenience of staff.

I. POLICY

Any limitations of the recipient's rights, any intrusive treatment techniques, or any use of psychoactive drugs for behavior control purposes shall be reviewed and approved by the Behavior Treatment Plan Review Committee (BTPRC).

Any limitations of the recipient's rights, any intrusive treatment techniques, or any use of psychoactive drugs where the target behavior is due to active symptoms of a substantiated serious mental illness or serious emotional disturbance as defined in Sec. 100d of PA 258 of 1974 does not require review and approval by the BTPRC.

All limitations on recipient's rights shall be justified, time-limited, and clearly documented in the Individual Plan of Service (IPOS). Documentation shall be included that describes attempts that have been made to avoid limitations, as well as what systematic actions will be taken as part of the IPOS to ameliorate (improve) or eliminate the need for the limitations on recipient rights in the future.

Please reference the Home and Community Based Services (HCBS) chapter in the Medicaid Provider Manual for additional IPOS documentation requirements related to limitations.

II. BEHAVIOR TREATMENT PLAN (BTP) STANDARDS

1) If it is determined through assessment and evaluation that an individual may benefit from an individualized BTP for the purpose of treating, managing, controlling, or extinguishing predictable or continuing behaviors that are seriously aggressive, self-injurious, or that place the individual or others at risk of harm, the public mental health agency shall develop a BTP that meets the following criteria:

    a) Employs positive behavior supports and interventions using applied behavior analysis (ABA) or other evidence-based practices, including specific interventions designed to develop functional abilities in major life activities, as the first and preferred approaches. Per MCL 333.18253 (the public health code) an individual shall not engage in the practice of applied behavior analysis or practice as an assistant behavior analyst unless licensed or otherwise authorized under this article.
    b) Considers other kinds of behavior treatment interventions that are supported by peer-reviewed literature or practice guidelines in conjunction with behavior supports and interventions if positive behavior supports and interventions are documented to be unsuccessful.
    c) As a last resort, when there is documented evidence that neither positive behavior supports nor other kinds of less restrictive interventions were successful, proposes interventions that place limitations on the individual's rights, intrusive treatment techniques or the use of psychoactive drugs. These interventions, described herein, shall be reviewed, and approved by the Behavior Treatment Plan Review Committee (BTPRC) prior to implementation.

2) The person-centered planning process used in the development of an individualized written plan of services will identify when a behavior treatment plan needs to be developed and where there is documentation that functional behavior assessments as defined in this policy have been conducted to rule out physical, medical, or environmental causes of the target behavior. If any limitations on rights or intrusive techniques are utilized there is documented evidence that there have been unsuccessful attempts, using positive behavioral supports and interventions, to prevent or address the target behavior.

3) Behavior Treatment Plans must be developed through the person-centered planning process and written consent must be given by the individual, or his/her guardian on his/her behalf if one has been appointed, or the parent with legal custody of a minor prior to the implementation of the behavior treatment plan that includes limiting or intrusive interventions. Behavior Treatment Plans are not effective or ethical if developed without consent or understanding of the participant.

4) The use of physical management, aversive techniques, restraint, seclusion or requesting involvement of law enforcement are prohibited from being included in the BTP and shall be disapproved by the BTPRC. Although emergency interventions are prohibited from inclusion as a component or step in any BTP, the BTP may note that should interventions outlined in the plan fail to reduce the imminent risk of serious or non-serious physical harm to the individual or others, approved emergency interventions may be implemented.

5) Utilization of physical management, restraint, seclusion or requesting law enforcement in an emergency may be evidence of treatment/supports failure. Should use occur more than three (3) times within a 30-day period, the individual's written IPOS must be revisited through the person-centered planning process and modified accordingly, if needed.

6) Behavior Treatment Plans that are forwarded to the BTPRC for review shall be accompanied by:

    a) Results of assessments performed to rule out relevant physical, medical, and environmental causes of the challenging behavior.
    b) A functional behavior assessment as defined in this policy.
    c) Results of inquiries about any medical, psychological, or other factors that might put the individual subjected to limiting or intrusive techniques at high risk of death, injury, or trauma.
    d) Documented evidence of the kinds of positive behavioral supports or interventions, including their amount, scope and duration that have been used to ameliorate (improve) the behavior within the last 12 months, and have proved to be unsuccessful.
    e) Documented evidence of continued efforts to find other options.
    f) Practice guidelines that support the proposed use of limiting or intrusive techniques.
    g) References to peer reviewed literature should be included on new procedures, and where the intervention has limited or no support in the literature, why the BTP is the best option available. Citing of common procedures that are well researched and utilized within most BTPs is not required.
    h) The plan for monitoring and staff training to assure consistent implementation and documentation of the intervention(s). The BTP must include who will provide the training and how it will be monitored for fidelity and modifications if needed.

7) Physical management, restraint, seclusion, and requests for involvement of law enforcement, permitted for intervention in emergencies only, are considered critical incidents that must be managed and reported according to the QAPIP standards and must be evaluated by the PIHPs QAPIP or the CMHSPs QIP, and be available for MDHHS review. Any injury or death that occurs from the use of any BTP, physical management, restraint or seclusion is considered a sentinel event.

III. BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE STANDARDS

1) The purpose of the BTPRC is to review and approve or disapprove any BTP that propose to use limiting or intrusive interventions, as defined in section IV. The BTPRC shall incorporate the standards herein, including those for its composition and functions.

    a) Each CMHSP shall have a BTPRC to review and approve or disapprove any BTP that proposes to use limiting or intrusive interventions. A psychiatric hospital or psychiatric unit, licensed under 1974 PA 258, MCL 330.1137, that receives public funds under contract with the CMHSP and does not have its own BTPRC must also have access to and use of the services of the CMHSP BTPRC regarding a BTP for an individual receiving services from that CMHSP. If the CMHSP delegates the functions of the BTPRC to a contracted mental health service provider, the CMHSP must monitor that BTPRC to assure compliance with these standards.
    b) The BTPRC shall be comprised of at least three (3) individuals, one (1) of whom shall be a licensed behavior analyst, and/or licensed psychologist, if the behavior analysis services provided by the psychologist are within their education, training, and experience; and at least one member shall be a physician/psychiatrist as defined in the Mental Health Code at MCL 330.1100c(10). A representative of the Office of Recipient Rights shall participate on the BTPRC as ex-officio, non-voting member in order to provide consultation and technical assistance to the BTPRC.
    c) The BTPRC shall meet as often as needed, based upon the individual's needs.
    d) Each BTPRC must establish a mechanism for the expedited review of proposed BTP in emergent situations. "Expedited" means the plan is reviewed and approved by members of the BTPRC within **48 hours**. Expedited plan reviews may be requested when, based on data presented by the author of the BTP it requires immediate implementation. The BTPRC Chair may receive, review, and approve such plans on behalf of the BTPRC. The Recipient Rights Office must be informed of the proposed BTP to assure that any potential rights issues are addressed prior to implementation. Upon approval, the BTP may be implemented. All BTPs approved in this manner must be subject to full review at the next regular meeting of the BTPRC.

e) The BTPRC shall keep all its meeting minutes, and clearly delineate the actions of the BTPRC.
f) A BTPRC member who has prepared a BTP to be reviewed by the BTPRC shall recuse themselves from the final decision-making.

2) The functions of the BTPRC shall be to:

a) Disapprove any plan that proposes to use aversive techniques, physical management, seclusion or restraint.
b) Expeditiously review, in light of current peer reviewed literature or practice guidelines, all BTPs proposing to utilize limiting or intrusive techniques.
c) Determine whether causal analysis of the behavior has been performed; whether positive behavior supports and interventions have been adequately pursued; and, where these have not occurred, disapprove any proposed BTP utilizing limiting or intrusive techniques.
d) For each approved BTP, set and document a date to re-examine the continuing need for the approved procedures. This review shall occur at a frequency that is clinically indicated for the individual's condition, or when the individual requests the review as determined through the person-centered planning process. BTPs with limiting or intrusive interventions require minimally a quarterly review.
e) Assure that the causal analysis has ruled out any known medical, psychological or other factors that the individual has, which might put him/her at high risk of death, injury or trauma if subjected to limiting or intrusive techniques.
f) Once a decision to approve a BTP has been made by the BTPRC and consent has been obtained from the individual, the legal guardian, the parent of a minor or a designated patient advocate, the BTP becomes part of the individual's written IPOS. The individual, legal guardian, parent of a minor child, or designated patient advocate has the right to request a review of the written IPOS, including the right to request that person-centered planning be re-convened, in order to revisit the plan. The only exception for consent is when the individual has been adjudicated pursuant to the provisions of section 469a, 472a, 473, 515, 518, or 519 of the Mental Health Code.
g) On a quarterly basis track and analyze the use of all physical management, restraint, seclusion, and involvement of law enforcement for emergencies as well as:
    i) Dates and numbers of interventions used.
    ii) The settings (e.g., individual's home or work) where behaviors and interventions occurred.
    iii) Observations about any events, settings, or factors that may have caused the behavior.
    iv) Behaviors that initiated the techniques.
    v) Documentation of the analysis performed to determine the cause of the behaviors that precipitated the intervention.

vi) Description of positive behavior supports used.
vii) Behaviors that resulted in termination of the interventions.
viii) Length of time of each intervention.
ix) Staff development and training and supervisory guidance to reduce the use of these interventions.
x) Review and modification or development, if needed, of the individual's BTP.

h) In addition, the BTPRC may:
i) Advise and recommend to the agency the need for specific staff or home-specific training in positive behavior supports, other evidence based and strength-based models, and other individual-specific non-violent interventions.
ii) Advise and recommend to the agency acceptable physical management techniques to be used in emergency or crisis situations.
iii) Advise and recommend to the agency acceptable physical management techniques to be used in emergency or crisis situations.
iv) At its discretion, review other formally developed behavior treatment plans, including positive behavior supports and interventions.
v) Advise the agency regarding administrative and other policies affecting behavior treatment plans and evidence-based practices.
vi) Provide specific case consultation as requested by staff of the agency.
vii) Serve another service entity (e.g., subcontractor) by agreement with involved parties.

IV. DEFINITIONS

Term	Definition
Applied Behavior Analysis (ABA)	A set of research-based strategies used to increase opportunities for an enhanced quality of life and decrease seriously aggressive, self-injurious or other targeted behaviors that place the individual or others at risk of physical harm by conducting a functional assessment and teaching new skills and making changes in a person's environment. Positive behavior support combines valued outcomes, behavioral, and biomedical science, validated procedures; and systems change to enhance quality of life and reduce behaviors such as self-injury, aggression, and property destruction Positive Behavior Supports are most effective when they are implemented across all environments, such as home, school, work, and in the community.
Anatomical support	Body positioning or a physical support ordered by a physical or occupational therapist for the purpose of maintaining or improving a recipient's physical functioning.

Aversive techniques	Techniques that require the deliberate infliction of unpleasant stimulus (a stimulus that would be unpleasant and may often generate physically painful responses in the average person or would have a specific unpleasant effect on a particular person) by staff to a recipient to achieve the management, control of the target behavior. Examples of such techniques include electric shock, foul odors, loud noises, mouthwash, water mist or other noxious substance to cons equate target behavior or to accomplish a negative association with a target behavior. Note: Clinical techniques and practices established in the peer reviewed literature that are prescribed in the behavior treatment plan and that are voluntary and self-administered (e.g. exposure therapy for anxiety, taking a prescription medication to help quit smoking) are not considered aversive techniques for the purposed of this technical requirement.
Bodily function	The usual action of any region or organ of the body.
Emotional harm	Impaired psychological functioning, growth, or development of a significant nature as evidenced by observable physical symptomatology or as determined by a mental health professional.
Consent	A written agreement signed by the individual, the parent of a minor, or an individual's legal representative with authority to execute consent, or a verbal agreement of an individual that is witnessed and documented by someone other than the service provider.
Facility	A residential facility for the care or treatment of individuals with serious mental illness, serious emotional disturbance, or developmental disability that is either a state facility or a licensed facility. Facility includes a preadmission screening unit established under section 409 that is operating a crisis stabilization unit.
Functional Behavior Assessment (FBA)	An FBA is a process to identify target behavior and develop a plan to encourage positive behavior. The FBA process must be completed by an LBA or qualified psychologist and typically consists of the following steps: Define the target behavior Gather and analyze the information Identify causal factors or reasons for the behavior Develop a hypothesis of the behavior Test the hypothesis Create a plan of action A physical examination may be necessary to identify biological or medical factors related to the target behavior. The FBA should integrate medical conclusions and recommendations. This assessment provides insight into the function of a behavior, rather than just focusing on the target behavior itself so that a new behavior or skill will be developed to provide the same function or meet the identified need of the recipient. Functional assessments should also identify situations and events that precede positive adaptive behavior to provide more information for a positive behavior support plan.
Emergency Interventions	Emergency interventions can only be implemented in a crisis situation when all other supports and interventions fail to reduce the imminent risk of harm. Each agency shall have protocols specifying what emergency interventions and physical management techniques are approved for use. All interventions must comply with chapter 7 of the mental health code and associate administrative rules.
Imminent Risk	An event/action that is about to occur that will likely result in the serious physical harm of oneself or others.

Individualized Plan of Service (IPOS or plan)	A written plan that specifies the goal-oriented treatment or training services, including rehabilitation or habilitation services, which are to be developed with and provided for a recipient.
Intrusive Techniques	Those techniques that encroach upon the bodily integrity or the personal space of the individual for the purpose of achieving management or control, of an aggressive, self-injurious or other behavior that places the individual or others at risk of physical harm. Examples of such techniques include the use of a medication or drug when it is used to manage or control an individual's behavior or restrict the individual's freedom of movement and is not a standard treatment or dosage for the individual's condition. Use of intrusive techniques as defined here requires the review and approval by the BTPRC.
Limiting Techniques	Those techniques which, when implemented, will result in the limitation of the individual's rights as specified in the Michigan Mental Health Code and the federal Balanced Budget Act. Examples of such techniques as limiting are prohibiting communication with others when that communication would be harmful to the individual; access to personal property when that access would be harmful to the individual; or any limitation of the freedom of movement of an individual for behavioral control purposes. Use of any intrusive techniques for behavior control purposes requires the review and approval of the BTPRC.
Medical and dental procedures restraints	The use of mechanical restraint or drug-induced restraint ordered by a physician or dentist to render the individual quiescent for medical or dental procedures. Medical restraint shall only be used as specified in the individual written plan of service for medical or dental procedures.
Person-centered planning	A process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honors the individual's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires.
Physical management	A technique used by staff as an emergency intervention to restrict the movement of a recipient by direct physical contact to prevent the recipient from seriously harming himself, herself, or others. Note: Physical management shall only be used on an emergency basis when the situation places the individual or others at imminent risk of serious physical harm. To ensure the safety of each consumer and staff each agency shall designate emergency physical management techniques to be utilized during emergency situations.
Practice or Treatment Guidelines	Guidelines published by professional organizations such as the American Psychiatric Association (APA), or the federal government.
Prone immobilization	Physical management of an individual in a face down (prone) position, usually on the floor, where force is applied to his or her body in a manner that prevents him or her from moving out of the prone position for the purpose of control. Note: **PRONE IMMOBILIZATION IS PROHIBITED UNDER ANY CIRCUMSTANCES**
Protective device	A device or physical barrier to prevent the recipient from causing serious self-injury associated with documented and frequent incidents of the behavior. A protective device as defined in this subdivision and incorporated in written individual plan of service shall not be considered a restraint as defined in below. Use of protective devices/physical barriers to prevent a recipient from causing serious self-injury associated with documented and/or frequent incidents of behavior requires BTPRC

	review and approval. (See Section II. Behavior Treatment Plan Standards, for all required elements)
Provider	The MDHHS, each CMHSP, each licensed hospital, each psychiatric unit, and each psychiatric partial hospitalization program licensed under section 137 of the act, their employees, volunteers, and contractual agents.
Psychotropic drug	Any medication administered for the treatment or amelioration of disorders of thought, mood, or behavior.
Request for Law Enforcement Intervention	Calling 911 and requesting law enforcement assistance as a result of an individual exhibiting seriously aggressive, self-injurious or other behavior that places the individual or others at risk of physical harm. Law enforcement should be called for assistance **only when**: caregivers are unable to remove other individuals from the hazardous situation to assure their safety and protection, safe implementation of physical management is impractical, and/or approved physical management techniques have been attempted but have been unsuccessful in reducing or eliminating the imminent risk of harm to the individual or others
Restraint	The use of physical devise to restrict an individual's movement. Restraint does not include the use of a device primarily intended to provide anatomical support
Seclusion	The temporary placement of a recipient in a room, alone, where egress is prevented by any means. Note: Seclusion is prohibited except in a hospital operated by the department, a hospital licensed by the department, or a licensed child caring institution licensed under 1973 PA 116, MCL 722.111 to 722.128.
Serious emotional disturbance	A diagnosable mental, behavioral, or emotional disorder affecting a minor that exists or has existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association and approved by the department and that has resulted in functional impairment that substantially interferes with or limits the minor's role or functioning in family, school, or community activities. The following disorders are included only if they occur in conjunction with another diagnosable serious emotional disturbance: (a) A substance use disorder. (b) A developmental disorder. (c) "V" codes in the Diagnostic and Statistical Manual of Mental Disorders.
Serious mental illness	A diagnosable mental, behavioral, or emotional disorder affecting an adult that exists or has existed within the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association and approved by the MDHHS and that has resulted in functional impairment that substantially interferes with or limits 1 or more major life activities. Serious mental illness includes dementia with delusions, dementia with depressed mood, and dementia with behavioral disturbance but does not include any other dementia unless the dementia occurs in conjunction with another diagnosable serious mental illness. The following disorders also are included only if they occur in conjunction with another diagnosable serious mental illness: (a) A substance use disorder. (b) A developmental disorder. (c) A "V" code in the Diagnostic and Statistical Manual of Mental Disorders.

Serious physical harm	Physical damage suffered by a recipient that a physician or registered nurse determines caused or could have caused the death of a recipient, caused the impairment of his or her bodily functions, or caused the permanent disfigurement of a recipient.
Support Plan	A written plan that specifies the personal support services or any other supports that are to be developed with and provided for a recipient.
Therapeutic de-escalation	An intervention, the implementation of which is incorporated in the individualized written plan of service, wherein the recipient is placed in an area or room, accompanied by staff who shall therapeutically engage the recipient in behavioral de-escalation techniques and debriefing as to the cause and future prevention of the target behavior.
Time out	A voluntary response to the therapeutic suggestion to a recipient to remove himself or herself from a stressful situation in order to prevent a potentially hazardous outcome.
Unreasonable force	Physical management or force that is applied by an employee, volunteer, or agent of a provider to a recipient in one or more of the following circumstances: 1. There is no imminent risk of serious or non-serious physical harm to the recipient, staff or others. 2. The physical management used is not in compliance with techniques approved by the provider and the responsible mental health agency. 3. The physical management used is not in compliance with the emergency interventions authorized in the recipient's individual plan of service. 4. The physical management or force is used when other less restrictive measures were possible but not attempted immediately before the use of physical management or force.

V. LEGAL REFERENCES

1973 PA 116, MCL 722.111 to 722.128.
1997 federal Balanced Budget Act at 42 CFR 438.100
MCL 330.1700, Michigan Mental Health Code
MCL 330.1704, Michigan Mental Health Code
MCL 330.1712, Michigan Mental Health Code
MCL 330.1740, Michigan Mental Health Code
MCL 330.1742, Michigan Mental Health Code
MCL 330.1744, Michigan Mental Health Code
MDHHS Administrative Rule 7001(l)
MDHHS Administrative Rule 7001(r)
MDHHS Administrative Rule 7199(2)(g)

DETROIT WAYNE INTEGRATED HEALTH NETWORK

Quality Improvement Dept.
PI 10 - Recidivism - Adults

QOTAW Meeting
10.30.24

Adult Hospital Recidivism

What is Hospital Recidivism?

Data

Barriers and Gaps Identified

Interventions

Recidivism

- Performance Indicator (PI) #10 correlates to patient recidivism and is the percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge. This data was pulled from DWIHN's MHWIN system.

- Goal = for CRSP's to remain below a 15% recidivism rate

Data

Follow Up After Hospitalization (FUH): Member has a visit with a Therapist, Psychiatrist, or Nurse Practitioner within 30 days of the hospitalization.

- **6.74 percentage point increase in adults 18-64 and a 11.06 percentage point increase in adults 65+**

July 2023

- MDHHS set a goal of 58%

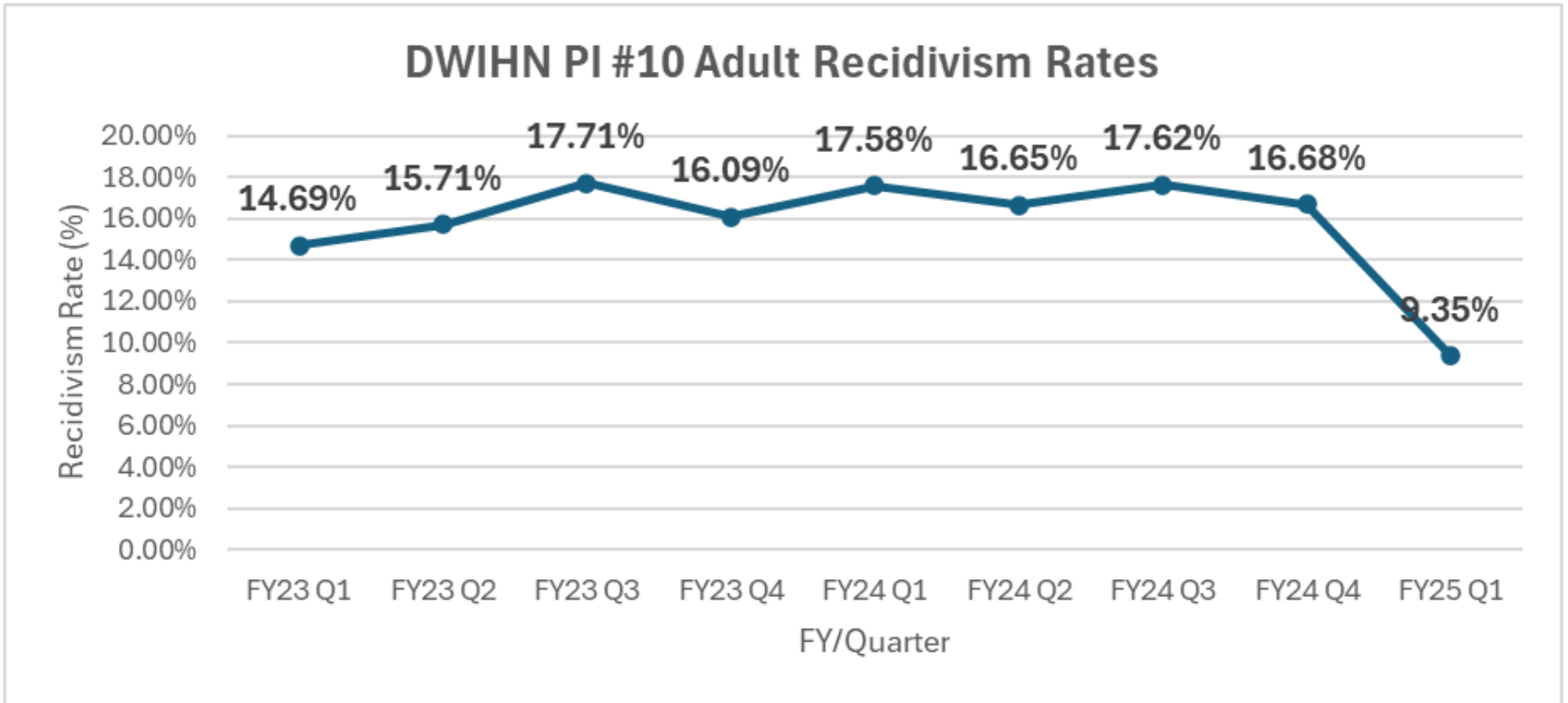
Age Group	Adults That Completed a Post Hospital Visit	Adults Hospitalized	(%)
18-64 years old	2214	4739	**46.72%**
65+	60	196	**30.61%**

July 2024

- MDHHS set a goal of 58%

Age Group	Adults That Completed a Post Hospital Visit	Adults Hospitalized	(%)
18-64 years old	2357	4409	**53.46%**
65+	70	168	**41.67%**

Data


DWIHN PI #10 Adult Recidivism Rates
Recidivism Rate (%)
20.00%
18.00%
16.00%
14.00%
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
14.69%
15.71%
17.71%
16.09%
17.58%
16.65%
17.62%
16.68%
9.35%
FY23 Q1
FY23 Q2
FY23 Q3
FY23 Q4
FY24 Q1
FY24 Q2
FY24 Q3
FY24 Q4
FY25 Q1
FY/Quarter

Data

Inpatient Admissions: There was a decrease (144) of inpatient hospital admissions for adults from Q2 to Q3

Adult Population			
Timeframe	**# of Discharges Readmitted to Inpatient Care within 30 Days of Discharge**	**# of Discharges from Psychiatric Inpatient Care during the Reporting Period**	**Recidivism Rate**
FY24 Q1	314	1786	**17.58%**
FY24 Q2	299	1796	**16.65%**
FY24 Q3	291	1652	**17.62%**
FY24 Q4	280	1679	**16.68%**
FY25 Q1	36	385	**9.35%**

Goal = <15%

Barriers / Gaps

- Crisis Screening Trends
- Crisis Plans
- Hospital Discharge Planning with Providers and Hospitals
- Members are overwhelmed with information at discharge. They have several people telling them appointment dates. There are many reminder calls coming from various people.
- Incorrect Contact Information
- Members are not made aware of their 30-day follow-up appt
- Transportation
- Stigma/Bias towards receiving mental health services

Interventions

- ACT Providers have increased their after 5pm services by more than **20%** from FY24 Q3 to Q4. This identified a **15.9% decrease** in the number of members hospitalized, and a **6.78% decrease** in the number of days spent in the hospital. These totals equate to quarterly savings of **$9,396** Medicaid dollars.

- Updating the CRSP Re Engagement Policy for Adult Providers to complete the CRSP Discharge Records when “administratively closing” case when member does not attend intake appointment post hospital discharge appointment and following 5 engagement attempts.

- Updated MHWIN for Crisis Screeners to select common risk factors when completing screeners to identify trends and needs for services (Ex: Suicidal / Homicidal behaviors, Medication, Substance Use, Elopement, etc.).

Interventions

- Facilitate 60-day Provider meetings to review Hospital Recidivism Performance Indicator #10 and Hospital Discharge Follow Up Indicator 4a
- Case consultation meetings (Outcomes Improvement Committee)
- Adding discussion of Performance Improvement Plans (PIP's) for Performance Indicators (PI's) at the CRSP 30-45 day follow up meetings to ensure CRSP's are following their actions plans and deadlines
- Clinical Specialists assigned to the CRSP will start attending the 30–45-day follow-up meeting to provide feedback and help close the loop

Questions?