



Detroit Wayne Integrated Health Network

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PROGRAM COMPLIANCE COMMITTEE MEETING

Administration Bldg.
8726 Woodward, 1st Floor Board Room
Wednesday, February 12, 2025
1:00 p.m. – 3:00 p.m.

AGENDA

- I. Call to Order
- II. Moment of Silence
- III. Roll Call
- IV. Approval of the Agenda
- V. Follow-Up Items from Previous Meeting
 - A. **Corporate Compliance Report** – Provide a list (breakdown) of where individuals were placed from Pontiac General Hospital; Provide information on the tiered corrective action plan being implemented for repeat offenders in accordance with the organization’s compliance framework.
 - B. **Crisis Care Services’ Quarterly Report** – Provide update on the Procurement of panic buttons.
- VI. Approval of the Minutes – January 8, 2025
- VII. Report(s)
 - A. Chief Medical Officer
 - B. Corporate Compliance
- VIII. Quarterly Reports
 - A. Access Call Center
 - B. Innovation and Community Engagement
 - C. Residential Services
 - D. Substance Use Disorder

Board of Directors

Dr. Cynthia Taueg, Chairperson
Karima Bentounsi
Jonathan C. Kinloch

Kevin McNamara, Vice Chairperson
Angela Bullock
Bernard Parker

Dora Brown, Treasurer
Lynne F. Carter, MD
William Phillips

Eva Garza Dewaelsche, Secretary
Angelo Glenn
Kenya Ruth

James E. White, President and CEO



IX. Strategic Plan

- A. Customer Pillar

X. Quality Review(s)

- A. Quality Assurance Performance Improvement Program (QAPIP) Executive Summary
- B. Updated QAPIP Plan Description FY 2023-25
- C. QAPIP Evaluation and Work Plan FY 2024
- D. QAPIP Work Plan FY 2025

XI. Utilization Management (UM) Program Evaluation FY 2024

XII. VP of Clinical Operations' Executive Summary

XIII. Unfinished Business

- A. **BA #21-64 (Revised 3)** – COVID Supplemental Carryover
- B. **BA #23-15 (Revised 2)** – DWC Training Platform Contract Extension 2
- C. **BA #23-57 (Revised 4)** – Claims Audit and Utilization Review Systems (CAURS) and Information Technology Consulting – Bizanalytix Technologies, LLC
- D. **BA #25-24 (Revised)** – Autism Spectrum Disorder Service Provider Network FY 25

XIV. New Business (Staff Recommendations)

- A. **BA #25-08** – COVID Comprehensive Behavioral Health (CCBH) FY 25
- B. **BA #25-55** – Michigan Child Collaborative Care (MC3) Program and Behavioral Health Consultant
- C. **BA #25-53** – AI Models; Development and Implementation Discussion (**Finance Committee**)

XV. Good and Welfare/Public Comment

Members of the public are welcome to address the Board during this time up to two (2) minutes (***The Board Liaison will notify the Chair when the time limit has been met.***). Individuals are encouraged to identify themselves and fill out a comment card to leave with the Board Liaison; however, those individuals that do not want to identify themselves may still address the Board. Issues raised during Good and Welfare/Public Comment that are of concern to the and may initiate an inquiry and follow-up will be responded to and may be posted to the website. Feedback will be posted within a reasonable timeframe (information that is HIPAA related or of a confidential nature will not be posted but rather responded to on an individual basis).

XVI. Adjournment

PROGRAM COMPLIANCE COMMITTEE

MINUTES

JANUARY 8, 2025

1:00 P.M.

IN-PERSON MEETING

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| MEETING CALLED BY | I. Commissioner Jonathan Kinloch, Program Compliance Chair at 1:17 p.m. |
| TYPE OF MEETING | Program Compliance Committee |
| FACILITATOR | Commissioner Jonathan Kinloch, Chair |
| NOTE TAKER | Sonya Davis |
| TIMEKEEPER | |
| ATTENDEES | <p>Committee Members: Angela Bullock; Commissioner Kinloch; Bernard Parker; William Phillips; and Dr. Cynthia Taueg</p> <p>Committee Member(s) Excused: Dr. Lynne Carter</p> <p>Staff: Brooke Blackwell; Judy Davis; Stacie Durant (Virtual); Dr. Shama Faheem; Monifa Gray; Marlena Hampton; Sheree Jackson; Marianne Lyons; Melissa Moody; Sherri Ruza (Virtual); Manny Singla (Virtual); Andrea Smith; Yolanda Turner; Ortheia Ward; Daniel West; James White; Rai Williams; and Grace Wolf</p> |

AGENDA TOPICS

II. Moment of Silence

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| DISCUSSION | Commissioner Kinloch called for a moment of silence. |
| CONCLUSIONS | A moment of silence was taken. |

III. Roll Call

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| DISCUSSION | Commissioner Kinloch called for a roll call. |
| CONCLUSIONS | Roll call was taken by Lillian Blackshire, Board Liaison and there was a quorum. |

IV. Approval of the Agenda

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| DISCUSSION/ CONCLUSIONS | Commissioner Kinloch called for a motion to approve the agenda. The committee was informed that BA #25-49 (MDHHS/FEMA Wayne County Strong) would be moved to the Executive Committee meeting for review and approval. Motion: It was moved by Mr. Parker and supported by Mr. Phillips to approve the agenda as amended. Commissioner Kinloch asked if there were any more changes/modifications to the agenda. There were no further changes/modifications to the agenda. Motion carried as amended. |
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V. Follow-Up Items from Previous Meetings

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| DISCUSSION/ CONCLUSIONS | <i>There were no Follow-Up Items from Previous Meeting to review this month.</i> |
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VI. Approval of the Minutes

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| DISCUSSION/ CONCLUSIONS | Commissioner Kinloch called for a motion to approve November 13, 2024, meeting minutes. Motion: It was moved by Mr. Parker and supported by Mr. Phillips to approve the November 13, 2024 meeting minutes. Commissioner Kinloch asked if there were any changes/modifications to the November 13, 2024, meeting minutes. There were no changes/modifications to the meeting minutes. Motion carried. |
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VII. Reports

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| DISCUSSION/ CONCLUSIONS | <p>A. Chief Medical Officer – <i>The Chief Medical Officer's report was deferred to the Program Compliance Committee meeting in February 2025.</i></p> <p>B. Corporate Compliance – Sheree Jackson, VP of Compliance submitted and gave an update on the Corporate Compliance report. The following items were reported:</p> <ol style="list-style-type: none"> 1. Activity 1: Compliance Investigation – FY 24 (Q4), the Compliance Department managed an average of 33 investigations, 11 of which originated from the OIG’s office. Three full-time staff members manually completed 78 Medicaid Claims Verification audits, resulting in recoupments totaling \$2,377.61 associated with 21 beneficiaries. There were eight (8) additional referrals received during the fourth quarter are pending assignment. A manual repayment plan has been established through the DWIHN’s Finance department for Novus Living I, a former provider site no longer contracted with DWIHN. There is an anticipated overpayment of \$44,073.67 resulting from using the wrong billing code. 2. Activity 2: Contract Action – A contract termination notification was issued to Pontiac General Hospital, effective December 11, 2024 due to actions taken by CMS that impact the services provided to DWIHN members. Pursuant to the termination and with the assistance of the DWIHN’s Utilization Management (UM) team, all affected members have been appropriately removed from the facility prior to the termination date. 3. Activity 3: Compliance Risk – The Compliance department has been alerted to an increase in compliance risks related to conflicts of interest, fraudulent billing and insufficient documentation for claims submitted from Q1 through Q4. Investigations are being carried out in coordination with the Office of the Inspector General. A tiered corrective action plan has been implemented for repeat offenders in accordance with the organization’s compliance framework. Additional information will be provided to the committee on the layers of tiers of compliance risks and where the individuals were placed from Pontiac General Hospital. 4. Activity 4: Unauthorized Access – A follow-up was provided on the August 20, 2024 Unauthorized Access from a staff member’s DWIHN-issued laptop while performing personal tasks that occurred in which a Threat Actor gained remote access. Investigations revealed that the Threat Actor accessed files that were open at the time of the incident. All members and reporting agencies have been notified and credit monitoring has been |
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| | <p>offered to the members. As of December 30, 2024, nine (9) members have registered for credit monitoring.</p> <p>The Chair opened the floor for discussion. Discussion ensued. The committee requesting the following: (Action)</p> <ol style="list-style-type: none"> 1. Provide a list (breakdown) of where individuals were placed from Pontiac General Hospital. 2. Provide information on the tiered corrective action plan being implemented for repeat offenders in accordance with the organization’s compliance framework. 3. Provide a FOIA report to the Executive Committee monthly. <p>The Chair noted that the Corporate Compliance’s report has been received and placed on file.</p> |
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VIII. Quarterly Reports

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| <p>DISCUSSION/ CONCLUSIONS</p> | <p>A. Adult Initiatives – Marianne Lyons, Director of Adult Initiatives submitted and gave highlights of the Adult Initiatives’ quarterly report. It was reported that:</p> <ol style="list-style-type: none"> 1. Activity 1: Clubhouse – Adult Initiatives will be taking over the task of completing and maintaining the grant funds for clubhouse, effective January 2025. It was determined that the Clubhouse will begin to receive more grant funding in the new year, allowing them to provide more services to members on spenddown, while alleviating that difficulty resulting from losing the general fund money. Clubhouse has been removed from the general fund with DWIHN. Adult Initiatives has encouraged Clubhouse’s to reach out and engage with ACT and AOT platforms to have these members explore Clubhouse if deemed appropriate. 2. Activity 2: Med Drop – FY 25 (Q1), the Med Drop program had 64 members participating. This quarter, 13 new referrals were received and three (3) new cases enrolled in the Med Drop program. Of the 64 members participating, only three (3) of those members were hospitalized during this quarter. The Med Drop video, a key tool for promoting the program was filmed and will be released on DWIHN’s social media sites in January 2025. Adult Initiatives will continue to meet with the Med Drop coordinator and program providers to discuss ways to increase admission and barriers to the referral process and use various outreach platforms to promote the program to members and providers. 3. Activity 3: Evidenced Based Supported Employment (EBSE)/Individual Placement and Support (IPS) – Data reflecting recidivistic members and IPS engagement continues to be gathered; CRSPs have been continuously encouraged to meet internally with various outpatient programs to encourage IPS among all members, especially recidivistic members. Adult Initiatives met with representatives from MiSide and Hegira (separately) to discuss the area of need as it pertains to a fidelity review. These agencies have not performed one in years and must be able to meet the minimum fidelity score of 74. Supervision from both agencies ensured this department that they will be able to accommodate this requirement. Adult Initiatives will continue to assist providers with identifying recidivistic and at-risk populations (members on treatment orders) with the goal of introducing and involving those members in IPS services, as another means of engaging and reducing hospitalizations. <p>Commissioner Kinloch opened the floor for discussion. Discussion ensued. The committee requested that the department publish information on what</p> |
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works with being best in class in Med Drop program after six months and share Med Drop video with the Committee. **(Action)**

B. **Crisis Care Services** – Grace Wolf, VP of Crisis Care Services submitted and gave highlights of the Crisis Care Services’ quarterly report. It was reported:

1. **Activity 1: Adult Crisis Stabilization Data** – During the month of November, there was a total of 155 presentation at the Adult Crisis Stabilization Unit with 128 admissions (African Americans made up 78% of the presentations); Individuals between the ages of 25-34 made up 35% of the presentations and males made up 55%.
2. **Activity 2: Building Empowered and Supportive Transitions Unit (BEST) Data** – The BEST Unit is a post-crisis transitional unit. The unit is run by our Peer Support Specialists and focuses on continued support and services post crisis intervention. On an average, we serve 15 individuals a month, they stay just over three (3) days, and the majority of the individuals are seeking CRSP’s appointments post-discharge. There has been a large uptick on our adult unit in the past two months of individuals needing AFC or group home care and those referrals take a lot longer than we have on the three days available to us on the adult unit. The unit has been able to assist in getting some of those placements.
3. **Activity 3: Child and Family Crisis Unit (CFCU)**- The unit sees 29 presentations a month; 19 admissions a month and 66% of the individuals on average that are presented get admitted to our unit. The demographics for children, the majority seen are African American males between the ages of 10 and 14 years old. Last quarter, more children from ages 15 to 17 years old were being seen. There is a small number of children that go to inpatient from our children’s unit. Only 10%, have been referred to inpatient for children services. For the months of October and November, there were no physical management, no emergency medications and no mechanical restraints, serving almost 300 presentations at the facility.
4. **Mobile Crisis Data (September 2024 – November 2024)** – On the average, the unit received 218 dispatches a month. The average response time is 37 minutes; average time on scene is 64 minutes; 36% of the individuals seen in the community require mobile crisis transport and 7% require law enforcement assistance which are individuals that cannot remain in the community voluntarily and need assistance with transportation. On the average, 49% can remain safely in the community; 34% end up going to a crisis stabilization unit and 17% go to an emergency department.

Commissioner Kinloch opened the floor for discussion. Discussion ensued. The committee requested an update on the Procurement of panic buttons.

(Action)

C. **PIHP Crisis Services** – Daniel West, Director of PIHP Crisis Services submitted and gave highlights of the PIHP Crisis Services’ quarterly report. It was reported that:

1. **Activity 1: Centralize Dispatch of Pre-Admission Reviews (PARs)** – Since November 1, 2024, the PAR Dispatch Department has fielded 2,536 calls; 1,343 of those calls resulted in a request for services (1,088 adult and 255 child requests); onboarded and trained nine (9) full and six (six) part-time staff to facilitate dispatch of PARs for adults and children; received positive feedback from the community thus far and has achieved an 88% service level. The team meets regularly on the ACT forum

conducted by Adult Initiatives to reiterate the importance of ACT teams completing the PAR.

2. **Activity 2: Inpatient Hospital Discharge Planning** – For FY 25 (Q1), there was 132 appointments scheduled, and 109 appointments kept (82% increase) with the individuals that we see that made their aftercare appointments. The team has shown an improvement in members receiving services within 30 days of discharge from selected hospitals in comparison to all other hospitals.
4. **Activity 3: Reduce Inpatient Hospitalizations** – Inpatient admissions for adults and children have decreased from quarter to quarter. The team has worked closely with Adult Initiatives and coordinating PAR assessments with ACT teams from the PAR Dispatch Department; worked with PCE to provide mandatory documentation of CRSP contact within the PAR. The department has worked with PCE to add CSU as a tracked level of care within the RFS (dropdown selection).
5. **Quarterly Update** – Recidivism for adults and children has decreased for FY 25 (Q1). The adult recidivism percentage is currently at 15.78% and the children is at 9.73%.

Commissioner Kinloch opened the floor for discussion. Discussion ensued.

- D. **Utilization Management** – Marlina Hampton, Director of Utilization Management submitted and gave highlights of Utilization Management’s quarterly report. It was reported:

1. **Activity 1: General Fund Exception Updates** – The General Fund Benefit Grid underwent several revisions during the previous quarter to address the need to reduce the number of requests and utilize General Fund only for identified essential services which was in response to the termination of the Pandemic Emergency Order which resulted in members losing Medicaid eligibility or failing to take the steps necessary to keep their benefits active. There was an approximate 38% decrease in General Fund Exception requests since implementation of the revised benefit grid on 11/1/24. In addition to review and revision of the General Fund Benefit Plan, staff continue to focus on overall process improvement. This includes collaboration with DWIHN’s I.T., Health Homes and Fiscal Informatics teams to review efficiencies and reduce/eliminate any authorization requests that are not traditional General Fund from the queue.
2. **Activity 2: Outpatient Authorization Updates** – The department is frequently involved with audits and system updates to ensure the department meets various MDHHS regulatory requirements. A dedicated SUD Authorizations inbox, which will be separate from PIHP Authorizations (Outpatient) and streamline communication between service areas was created; and an UM Administrator has resumed progress on SUGs for SUD, following review by the Director of SUD services and Associate VP of Clinical Operations. The department worked with I.T. to make system updates that send reminders to provider staff that an authorization was returned to them requiring further documentation/justification; continue monitoring the progress of our return to requester queue and I.T. reminders; improve timeliness and documentation of adverse benefit determination processing, in alignment with MDHHS and updated Integrated Care Organization (ICO) guidelines.
3. **Activity 3: UM Program Description and Evaluation** – The Program Description and Program Evaluation, along with its’ corresponding policies and procedures are currently being updated. The UM Director is meeting with staff and various departments to ensure that updated documents align

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| | <p>with feedback from HSAG review, new guidelines from NCQA, MI Health Link ICO requirements and PIHP/CMHSP contractual requirements. The UM Director with support of the VP of Clinical Operations, Strategic Operations' Director and available consultants will review the UM Work Plan which will promote timeliness and influence the next steps in presenting Utilization Management in its best light.</p> <p>Commissioner Kinloch opened the floor for discussion. Discussion ensued. The Chair noted that the Adult Initiatives, Crisis Care Services, PIHP Crisis Services and the Utilization Management's quarterly reports have been received and placed on file.</p> |
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IX. Strategic Plan Pillar

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| DISCUSSION/ CONCLUSIONS | <i>There was no Strategic Plan Pillar to review this month.</i> |
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X. Quality Review(s)

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| DISCUSSION/ CONCLUSIONS | <i>There were no Quality Review(s) to report this month.</i> |
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XI. VP of Clinical Operations' Executive Summary

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| DISCUSSION/ CONCLUSIONS | <p>Melissa Moody, VP of Clinical Operations submitted and gave an executive summary of the VP of Clinical Operations' report. It was reported:</p> <ol style="list-style-type: none"> 1. Health Home Initiatives – The Health Home team will be presenting at the CMHAM Conference in Kalamazoo, Michigan on February 4, 2025. The CCBHC currently has 15,637 members enrolled as of December 19, 2024 (over 26% increase since November 2024). DWIHN continues to work with CCBHC providers on implementation of CCBHC Handbook changes that impact policies and procedures. Individual meetings were held with providers to gain feedback on DWIHN's State CCBHC Implementation Plan. The Plan was submitted to MDHHS for review and approval in December 2024. DWIHN Care Clinic was given CCBHC full-certification status and will be joining the CCBHC State Demonstration as our region's 8th CCBHC site on January 1, 2025. The Behavioral Health Home (BHH) currently has 828 members enrolled as of December 19, 2024. The Substance Use Disorder Health (SUDHH) currently has 726 members enrolled as of December 19, 2024 (over 9% increase since November 2024). 2. Children's Initiatives – The department hosted the Annual Report to the Community "Shine Brighter Together" as a deliverable for the System of Care Block Grant. This showcased highlights and accomplishments for meeting the needs of children, youth and families in Wayne County. Attendees also received a copy of the System of Care Report to the Community which provides a summary of utilization and outcome data for FY 24. 3. Autism Services – There was a total of 2,757 members assigned to DWIHN's ABA provider network for December 2024. This was a moderate increase of 54 members added from November to December. In addition, among the three (3) Individual Diagnostic Evaluation Providers, there were a total of 155 referrals, 132 kept appointments and 19 no-show appointments (it is noted the data for this month is preliminary and subject to change during next month's report). As of December 2024, there are 12 ABA Providers who passed the RFQ process. |
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| | <p>There are currently 22 ABA Providers contracted with DWIHN (Note: Successfully passing the RFQ does not automatically guarantee a contract).</p> <p>4. Substance Use Disorder Services – DWIHN will be involved with a Recovery Incentive (RI) Pilot Initiative which focuses on stimulant use and the use of contingency management (evidence-based treatment for stimulant use disorder). We have 14 providers that are ready to kick-off the initiative this month. This initiative aims to explore innovative solutions and gather valuable insights over a comprehensive two-year period. Participants will engage in a series of activities and assessments designed to track progress and measure outcomes.</p> <p>5. Clinical Initiatives - DWIHN is currently working with the Wayne County Health Department and the City of Detroit on a potential partnership regarding rapid access to low barrier treatment; specifically, Medications for Opioid Use Disorder (MOUD) and services for justice impacted youth, adults and families. This is currently in the data collection and planning phase. DWIHN is working with Waye RESA on a potential plan to expand school-based prevention and treatment services to Pre-K children in stand-alone Pre-K facilities. A meeting was held to discuss the need to provide behavioral health consultation support for children Pre-K and Kindergarten classrooms. DWIHN provided an overview of the School Success Initiative Program and explained the Infant and Early Childhood Consultation Grant as well as an additional resource. The State of Michigan was awarded through CMS an Innovation and Behavioral Health Model, which the goal is to improve quality of care and behavioral health and physical health outcomes for adults enrolled in both Medicaid and Medicare with moderate to severe mental health conditions. The Care team is there to address patient care and health related social needs, including housing, food and transportation. We do not know if our region will be a part of that initiative, yet the State will need to decide what PIHP regions will be involved.</p> <p>Commissioner Kinloch opened the floor for discussion. Discussion ensued. The committee requested a copy of the System of Care Report. (Action) The Chair noted that the VP of Clinical Operations’ Executive Summary has been noted and placed on file.</p> |
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XII. Unfinished Business

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| <p>DISCUSSION/ CONCLUSIONS</p> | <p>A. BA #25-01 (Revised 1) – Multicultural Integration – Staff requesting board approval to amend the original board action for Comprehensive Services for Behavioral Health FY 2025 with the Department of Health and Human Services (MDHHS). The DWIHN Veteran Navigator received additional funding for FY 25 in the amount of \$35,207.00 which brings the total amount for the Veteran Navigator, Peer Navigator and the Navigator Assistant to \$195,207.00. The additional funding does not include the other participants who are apart of the Multi-Cultural Integration Grant (American Indian Health and Family Services (AIHFS), Community Health and Social Services (CHASS) Center, Southwest Counseling Solutions (Hispanic and Veterans) and Association of Chinese Americans (ACA). Revenue for these services is supported by E-Grants and Management Systems (EGrAMS) categorical funds for Ethnic Services. The amount proposed term of this Memorandum of Understanding is October 1, 2025 through September 30, 2025 and will not exceed \$765,837.00. A budget adjustment to certify the additional funds will be forthcoming. The Chair called for a motion on BA #25-01 (Revised 1). Motion: It was moved by Dr. Tauog and supported by Mr. Phillips to move BA #25-01 (Revised 1) to Full Board for</p> |
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| | <p>approval. Commissioner Kinloch opened the floor for discussion. There was no discussion. Motion carried.</p> <p>B. BA #25-02 (Revised 1) - Substance Use Disorder (SUD) Treatment Provider Network FY 25 – Staff requesting board approval to provide additional SUD treatment services in an amount not to exceed \$1,406,939.00 (Grant Funds \$1,056,939.00 and PA2 Funds \$350,000.00). With the additional allocations noted above, SUD treatment services are funded with Grant dollars (\$4,178,721.00) and PA2 Funds (\$1,771,100.00) totaling \$5,949,821.00. The Chair called for a motion on BA #25-02 (Revised 1). Motion: It was moved by Dr. Tauog and supported by Mrs. Bullock to move BA #25-02 (Revised 1) to Full Board for approval. Commissioner Kinloch opened the floor for discussion. Discussion ensued. Motion carried with Mr. Phillips abstaining.</p> <p>C. BA #25-03 (Revised) – Substance Use Disorder (SUD) Prevention Provider Network FY 25 – Staff requesting board approval to provide additional prevention services funded through two key sources (PA2 Funds \$320,000.00 and Healing and Recovery Opioid Settlement Funds received from MDHHS for \$497,826.00). With the addition of the aforementioned amounts, total SUD prevention services are funded with grant funds totaling \$3,940,434.00 and PA2 Funds totaling \$3,025,075.00. The revised not to exceed amounts totals \$6,467,683.00. The proposed funding increase will allow for the continuation and expansion of vital prevention services that have shown effectiveness in addressing substance use challenges in our communities. The Chair called for a motion on BA #25-03 (Revised). Motion: It was moved by Mrs. Bullock and supported by Mr. Parker to move BA #25-03 (Revised) to Full Board for approval. Commissioner Kinloch opened the floor for discussion. There was no discussion. Motion carried with Mr. Phillips abstaining.</p> |
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XIII. New Business: Staff Recommendation(s)

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| DISCUSSION/ CONCLUSIONS | <p>A. BA #25-48 – ARCs Renewal – Staff requesting board approval of three (3) one-year contract renewals with ARC Detroit (not to exceed \$117,369.00), ARC of Northwest Wayne County (not to exceed \$296,101.00) and ARC of Western Wayne County (not to exceed \$185,927.00). Each contract period will begin October 1, 2024 through September 30, 2025. The proposed contracts will provide advocacy, supportive services and educational information by addressing issues facing persons with intellectual/developmental disabilities. The Chair called for a motion on BA #25-48. Motion: It was moved by Mr. Parker and supported by Mrs. Bullock to move BA #25-48 to Full Board for approval. Commissioner Kinloch opened the floor for discussion. Discussion ensued. Motion carried.</p> <p>B. BA #25-51 – DWIHN Provider Network System – Staff requesting board approval to add five (5) additional residential providers (CNS Hearts of Love Home Care, LLC, New Dawn AFC Home, LLC, No Places Like Home AFC, Pauline’s Place LLC and Special Care Services 2 Inc.) to the DWIHN provider network without change to the total provider network amount. The Chair called for a motion on BA #25-51. Motion: It was moved by Mr. Phillips and supported by Mrs. Bullock to move BA #25-51 to Full Board for approval.</p> |
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| | Commissioner Kinloch opened the floor for discussion. There was no discussion. Motion carried. |
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XIV. Good and Welfare/Public Comment

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| DISCUSSION/ CONCLUSIONS | <i>There was no Good and Welfare/Public Comment this month.</i> |
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| ACTION ITEMS | Responsible Person | Due Date |
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| 1. Corporate Compliance – A. Provide a list (breakdown) of where individuals were placed from Pontiac General Hospital; Provide information on the tiered corrective action plan being implemented for repeat offenders in accordance with the organization’s compliance framework. B. Provide a FOIA report to the Executive Committee monthly. | Sheree Jackson | February 12,2025 COMPLETED |
| 2. Crisis Care Services – Provide update on the Procurement of panic buttons | Grace Wolf | February 12, 2025 |
| 3. Adult Initiatives – Public information on what works with being best in class in Med Drop program after six months. 4. Share Med Drop video with the Committee. | Marianne Lyons | TBA COMPLETED |
| 5. VP of Clinical Operations Executive Summary – Provide System of Care report to the Committee | Melissa Moody | COMPLETED |

The Chair called for a motion to adjourn the meeting. **Motion:** It was moved by Dr. Taueg and supported by Mrs. Bullock to adjourn the meeting. **Motion carried.**

ADJOURNED: 2:41 p.m.

NEXT MEETING: Wednesday, February 12, 2025 at 1:00 p.m.

**Program Compliance Committee
Chief Medical Officer's Report
February 2025**

BEHAVIORAL HEALTH EDUCATION, OUTREACH AND UPDATES:

- The PA and NP Psychiatry Rotations at Crisis Centers have been going well.
- Two PA student completed their Psychiatry rotation, and another one is starting in February. Informal feedback by students was positive. Me and Dr. Mammo met with the Program Director for Physician Assistant Program for more formal feedback, and she shared that her student evaluations and feedback has been positive about the rotation at our Crisis Center. She discussion option of some PAs to come back for an elective month, esp. the ones who wish to pursue a career in Psychiatry and we were open to that.
- Wayne State University is interested in doing a study at our Child and Family Crisis Unit regarding children who are send from schools for clearance after making any statements that prevent them from returning until they get a clearance letter from psychiatrist. This has been an observed pattern in certain schools resulting in loss of school days. We have requested them to submit a formal request for proposal review for Research Advisory Committee.

MDHHS UPDATES:

- **PIHP/CMHSP MEDICAL DIRECTOR MEETING:**
 - Dr. Pinals updated that the MDHHS leadership has asked to expedite Youth Crisis Service rules. A Child and Adolescent Psychiatrist (CAP) from U of M is helping Dr. Pinals with those rules.
 - There was detailed discussion around Mobile Crisis response. Several PIHP/CMHSP Medical Directors shared their opinion and some shared significant reservations about community mobile crisis response in terms of safety for their clinicians. State on the other hand is motivated to expand mobile criis and has issued an RFP for that purpose. I shared Wayne County's one year mobile crisis data indicating:
 - 1400 members served between Dec 2023-Nov2024, with 23% of them requiring mobile crisis transport and only 6% of them requiring law enforcement assistance. Among those requiring law enforcement assistance, most of them were for transport of involuntary individuals. Our average dispositions were: Follow-up with CRSP- 29% ; New CRSP- 3% Intensive Crisis Stabilization Team- 15% Crisis Stabilization Unit- 27% Emergency Department- 13% Refused Follow-up- 13%.
 - Several Medical Directors were assured to hear the law enforcement involvement data. Dr. Pinals supported that the thought and intent of mobile crisis is that properly trained clinicians would help de-escalate the individuals and hence decrease the need for law enforcement response.
 - Dr. Pinals updated on the new requirements that are being developed on incident reporting structure for Crisis Stabilization Units that would require PIHPs to collect incident reportson restraints and emergency medications from certified CSUs.
 - Michigan has been selected by CMS as one of the four states to participate in Innovative behavioral health model. There was a lot of interest and questions by Medical Directors, so Dr. Pinals has asked the leads of the program to do a presentation for Medical Directors in March/April
- **STATE MEDICAL DIRECTOR AOT ADVISORY SUB-COMMITTEE:**
 - Dr. Pinals went through the Psychiatrist Responsibilities during the AOT process and took feedback on the AOT Toolkit developed by the Center for Behavioral health and Justice.
 - Judge Mack updated on the progress of AOT Bills that are still going through final phases of Health Policy review.

Program Compliance Committee Chief Medical Officer's Report

- NGRI State leads were invited to the State AOT Medical Director Sub-Committee to discuss the overlap of AOT with NGRI population. They discussed that NGRI committee was created as part of a settlement and is responsible for oversight only if a person is maintained on an AOT order, hence it is prudent for the members released from the forensic system to be maintained on their NGRI status and hence on their AOT orders.
- Internally, we have been working on creation of AOT dashboard as part of AOT grant received through the State Diversion Council. Demo scheduled in two weeks.

INTEGRATED HEALTH DEPARTMENT

POPULATION ASSESSMENT:

| Top 5 Behavioral Health Dx Children 2024 | Top 5 Behavioral Health Dx Children 2023 |
|---|---|
| 1. Autism Spectrum Disorder | 1. Attention-Deficit/Hyperactivity Disorder |
| 2. Attention-Deficit/Hyperactivity Disorder | 2. Oppositional Defiant Disorder |
| 3. Adjustment Disorder | 3. Autistic Disorder |
| 4. Oppositional Defiant Disorder | 4. Major Depressive Disorder |
| 5. Major Depressive Disorder | 5. Adjustment Disorder |

| Top 5 Physical Health Dx Children 2024 | Top 5 Physical Health Dx Children 2023 |
|--|--|
| 1. Asthma | 1. Asthma |
| 2. Allergic Rhinitis | 2. Obesity |
| 3. Obesity | 3. Cerebral Palsy |
| 4. Cerebral Palsy | 4. Allergy/Epilepsy |
| 5. Epilepsy | 5. Diabetes |

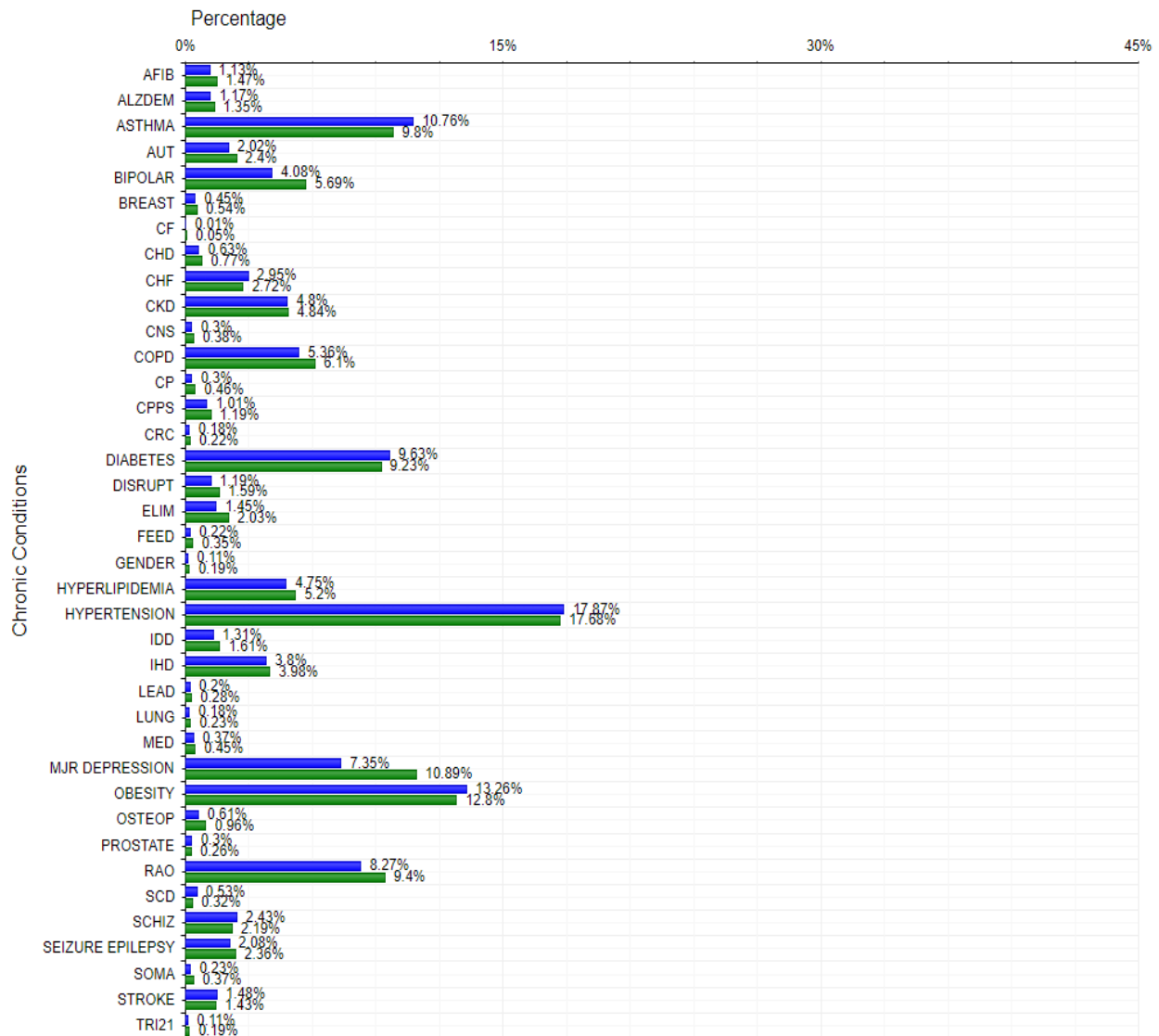
| Top 5 Behavioral Health Dx Adults 2024 | Top 5 Behavioral Health Dx Adults 2023 |
|--|--|
| 1. Major Depressive Disorder | 1. Major Depressive Disorder |
| 2. Anxiety | 2. Anxiety Disorder |
| 3. Alcohol Use Disorder | 3. Schizoaffective |
| 4. Bipolar Disorder | 4. Bipolar I |
| 5. Cannabis Use Disorder | 5. Opioid Dependence |

| Top 5 Physical Health Dx Adults 2024 | Top 5 Physical Health Dx Adults 2023 |
|--------------------------------------|--------------------------------------|
| 1. Hypertension | 1. Hypertension |
| 2. Diabetes Mellitus | 2. Diabetes Mellitus |
| 3. Asthma | 3. Asthma |
| 4. Chronic Pain | 4. Chronic Pain |
| 5. Obesity | 5. Hypercholestrtolema |

Program Compliance Committee Chief Medical Officer's Report

Detroit Wayne Integrated Health Network

— Current Plan Percentage — Statewide Percentage



Complex Case management has expanded their program to include children with asthma and will be creating a report to look for active enrollment and outreach rather than provider referral. Several provider educational and training sessions on asthma and these medical and behavioral conditions were conducted by IHC Department.

CRISIS CENTER MEDICAL DIRECTOR UPDATES:

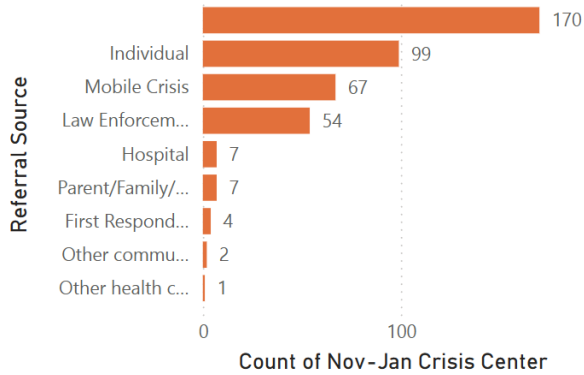
Crisis Center has now been open for 7 months. Dr. Mammo has worked in this capacity for more than a year. We have 23 psychiatric providers including 12 psychiatrist (1 FT, 11 PT) and 11 Advance Practice Providers (6 FT NP, 2 FT PA, 3 PT NPs).

Overall psychiatrist and APPs continue to provide positive feedback about the flows and process improvements.

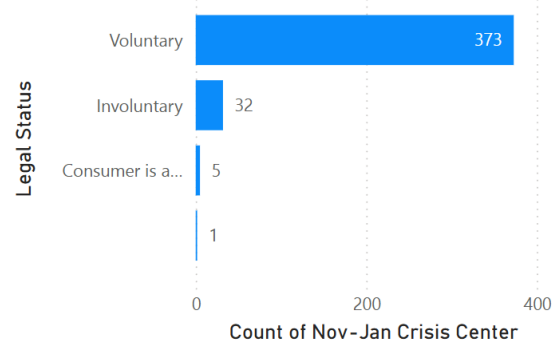
Adult CSU- 411 admissions during Nov-Jan

Program Compliance Committee Chief Medical Officer's Report

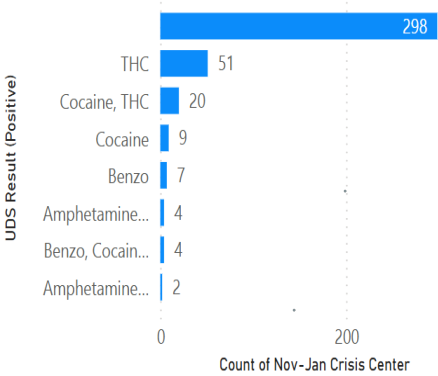
Count of Nov-Jan Crisis Center by Referral Source



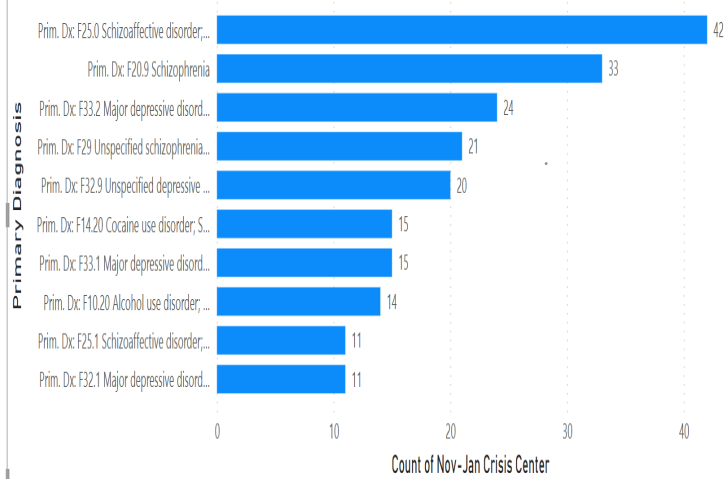
Count of Nov-Jan Crisis Center by Legal Status



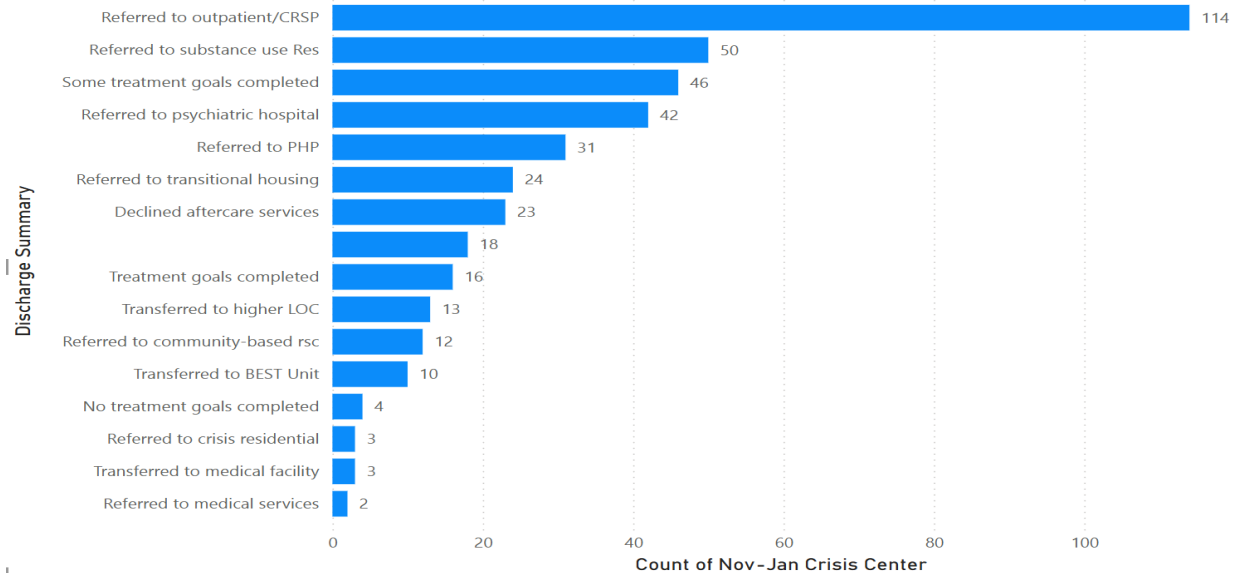
Count of Nov-Jan Crisis Center by UDS Result (Positive)



Count of Nov-Jan Crisis Center by Primary Diagnosis

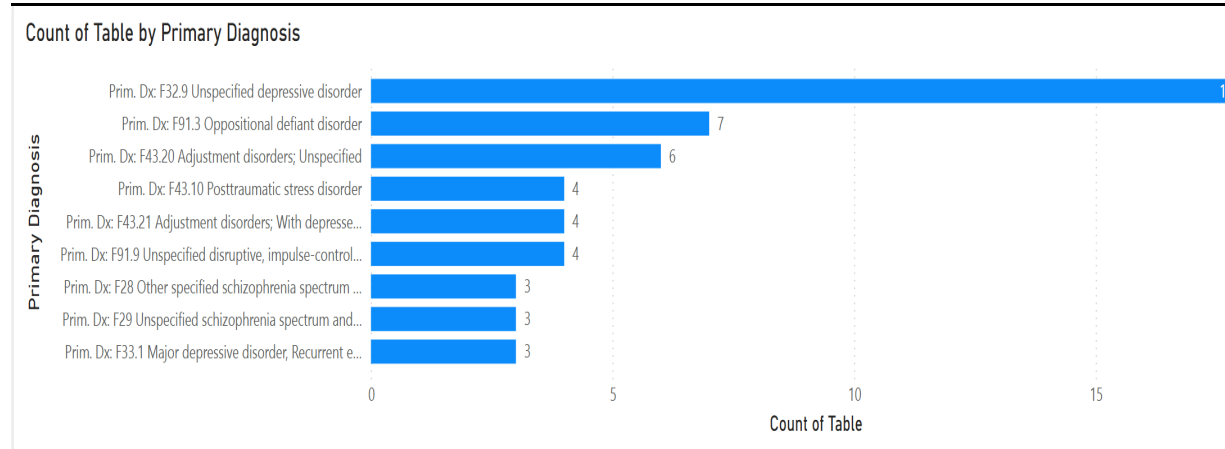
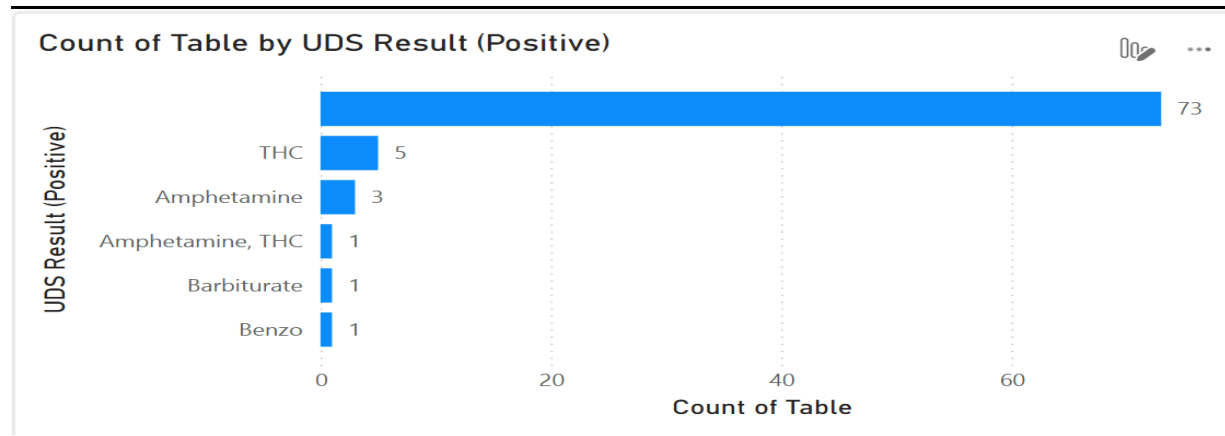
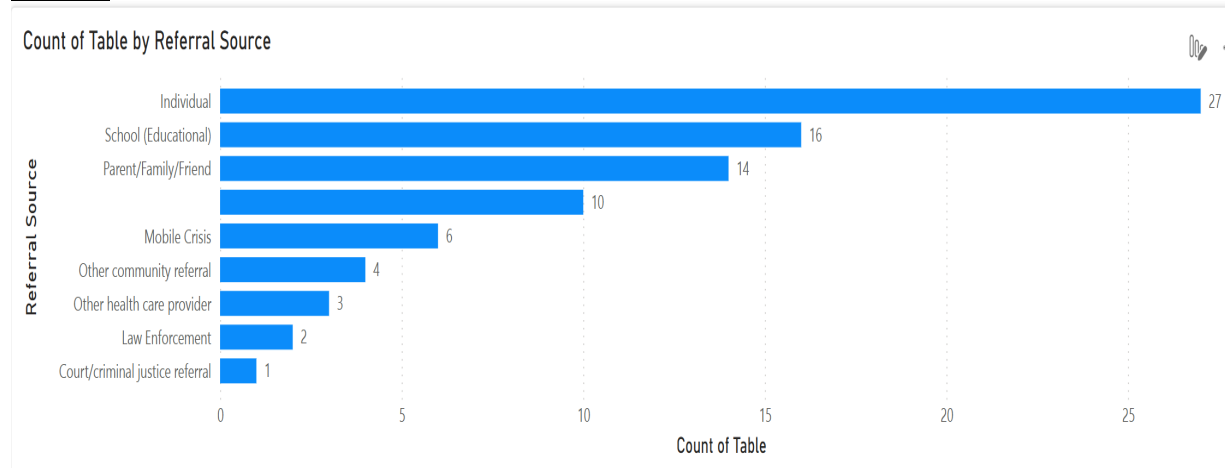


Count of Nov-Jan Crisis Center by Discharge Summary



Program Compliance Committee Chief Medical Officer's Report

CFCU- 84 admissions



Medication & Diagnostic Trends:

Agitation Medication: B52 ordered 10 times in 3 months

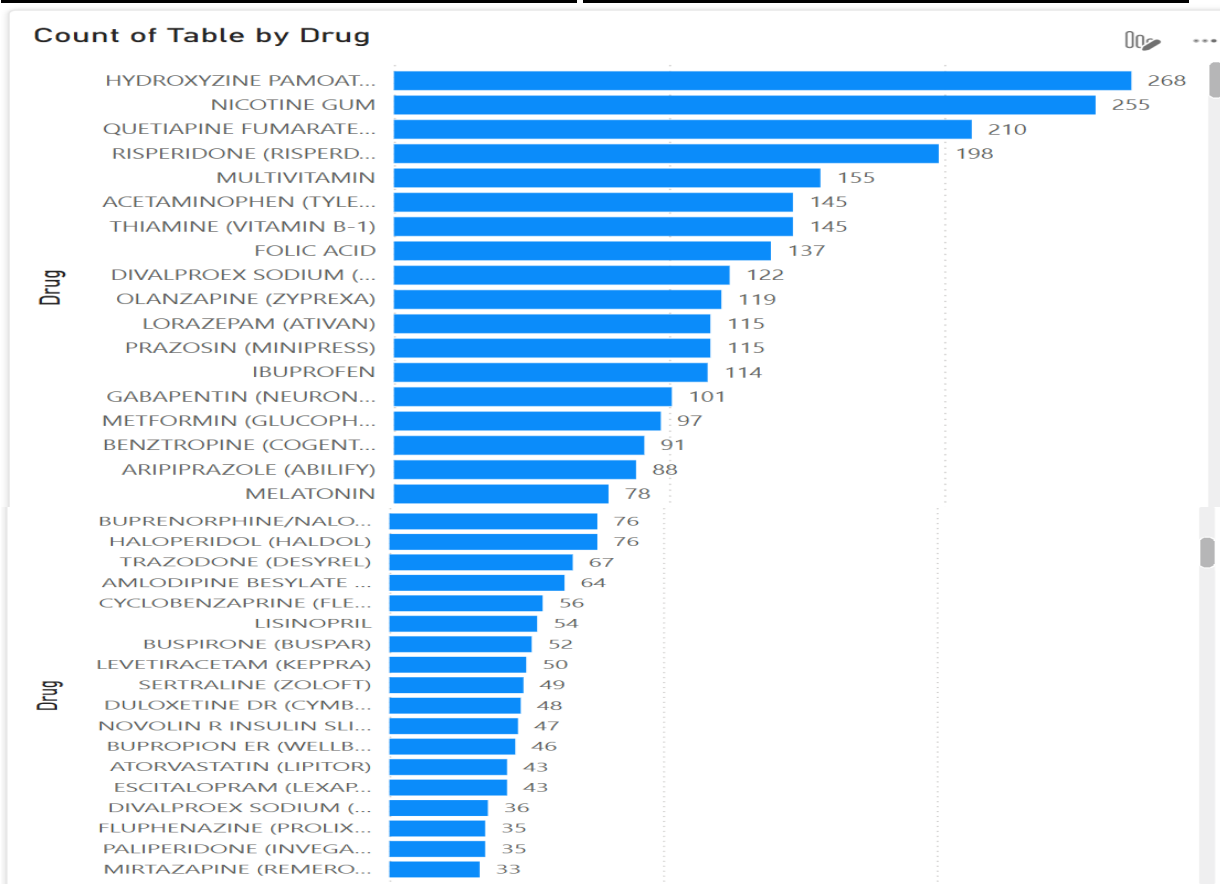
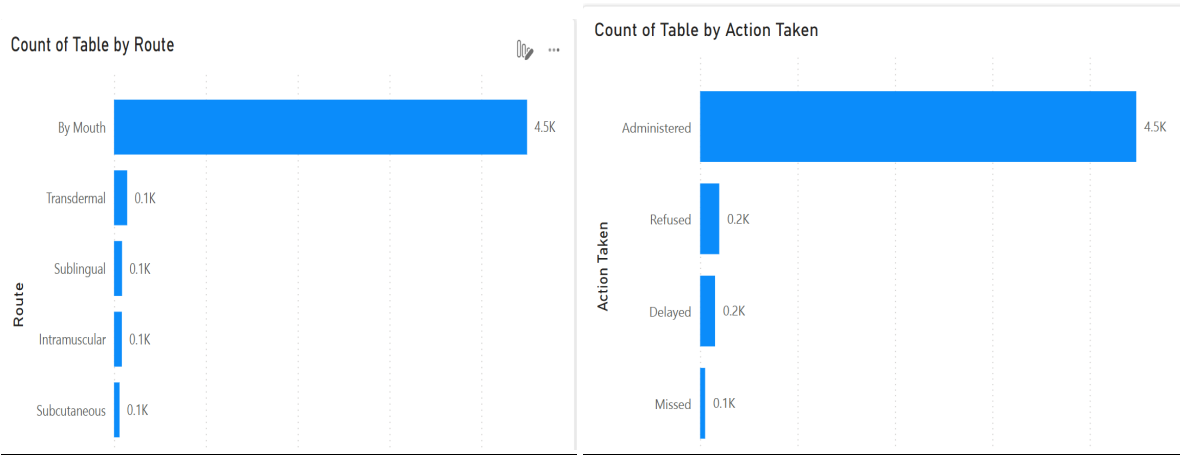
Primary Diagnosis of Opioid Use- 7 individuals times in 3 months. We had 76 doses of buprenorphine/naloxone given, and 7 doses of buprenorphine given during this time period.

Interestingly, Cocaine use disorder was the highest primary Substance Use disorder seen at Crisis Center during this time period.

Nicotine gum is frequently used which was the goal to make it part of admission orders.

Program Compliance Committee Chief Medical Officer's Report

Other Medication Observations:



OUTPATIENT CLINIC/CCBHC MEDICAL DIRECTOR UPDATE

DWIHN has started outpatient services and has been serving both adult and children. Dr. Severe started in July and is the Medical Director and Adult Psychiatrist for the outpatient Clinic. We also hired a part time child psychiatrist for Dr. Brinkiji. These doctors along with the rest of the team hired under Ms. Ebony Reynolds have started serving both adults and children population. Goal is to have a hub location with multiple satellite location that provide fully integrated care under CCBHC

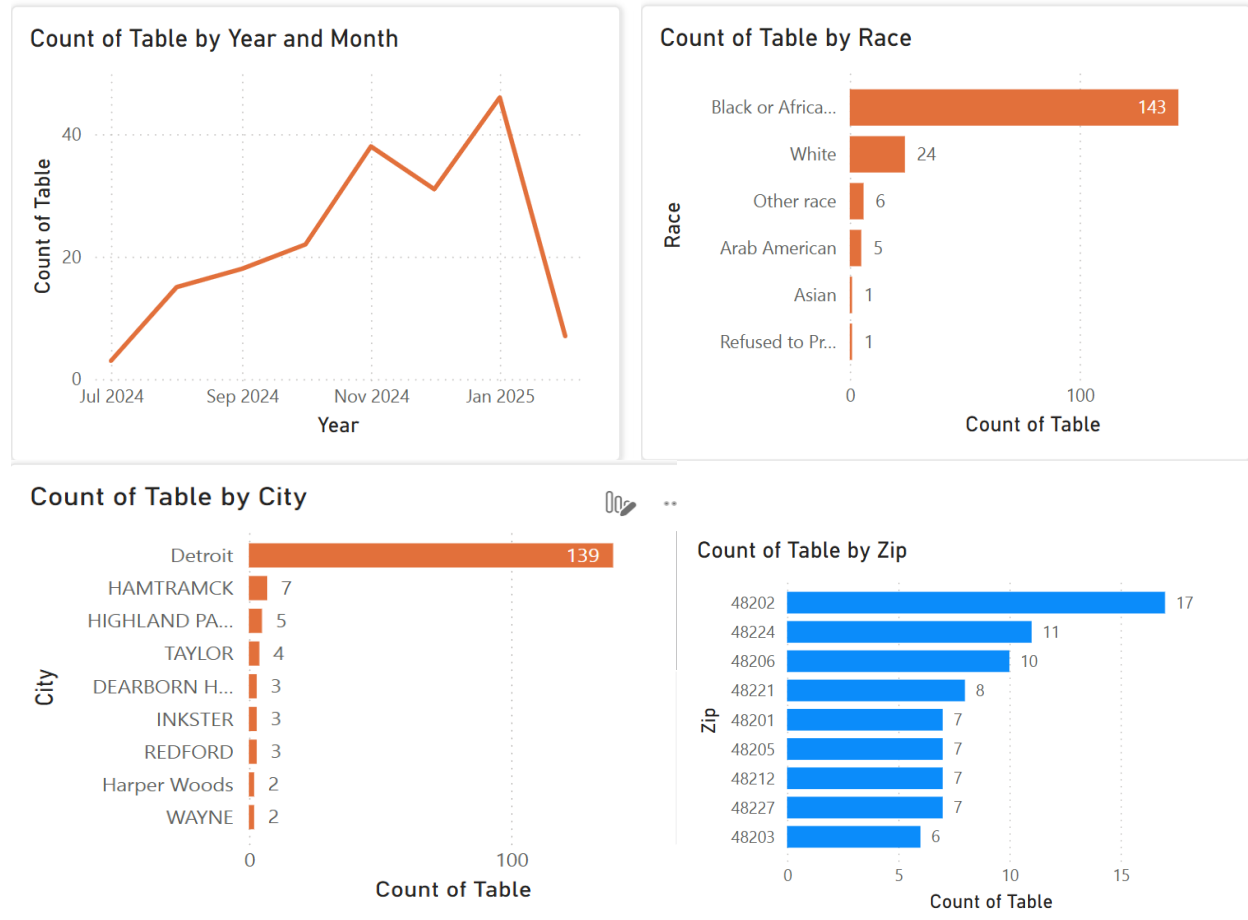
Program Compliance Committee Chief Medical Officer's Report

certification, in collaboration with primary care providers such as FQHCs, that address physical and behavioral health needs of individuals.

Created 2 contingent positions for coverage needs for PTO and hired 2 CT psychiatrists.

Clinic has:

181 Scheduled patients, 144 seen



Program Compliance Committee Meeting
Yvonne Bostic, MA, LPC (Director) – DWIHN Access Call Center
First Quarter (FY 24/25)



Main Activities during 1st Quarter FY 24-25:

- **Call Center Performance – Call detail report.**
- **Appointment Availability**
- **Accomplishments and Updates**

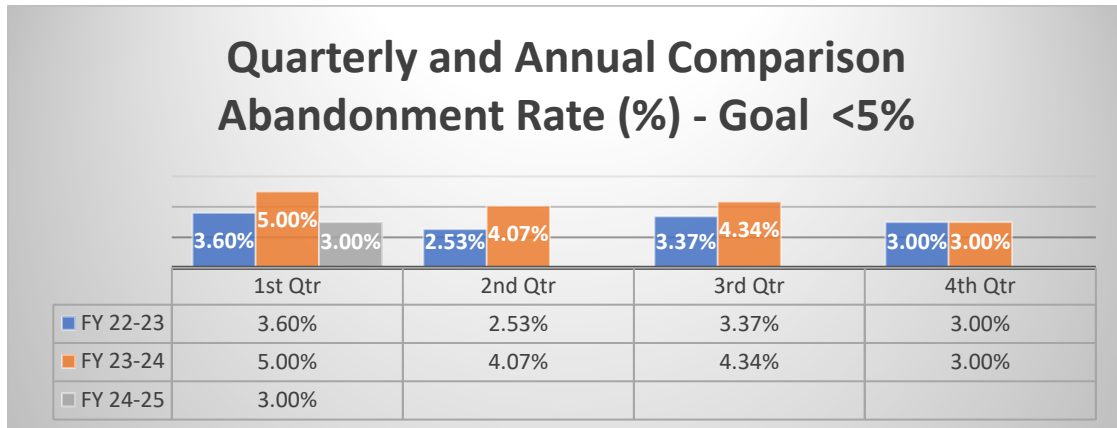
Activity 1: Call Center Performance – Call Detail Report

- **Description:** Majority of the calls that come into the call center are from members in the community seeking mental health and SUD services, information, and referrals. The rest of the incoming calls are from in-network providers and other community agencies like local hospitals, foster care workers, etc. Incoming calls are monitored from the first point of contact with the DWIHN Access Call Center Representatives and then after they are transferred to a screener (MH/SUD or other resource).
- MDHHS Standards and Call Center Performance for 1st Quarter FY 24-25 (October - December 2024):
 - % Abandoned Goal is < 5% (3.0%)
 - Avg. speed to answer Goal <30 sec. (:20 sec)
 - % of calls answered Goal > 80% (95.0%)
 - Service Level Goal >80% (84.0%)

| | Incoming Calls | Calls Handled | Calls Aband. | % Aband . | Average Speed Answer | Avg Call Length | % of Calls Answered | Avg Service Level |
|---------------------|----------------|---------------|--------------|-----------|----------------------|-----------------|---------------------|-------------------|
| FY 24-25 1st QTR | 47,674 | 42,327 | 1,379 | 3.0% | :20 sec | 5:33 mins | 95.0% | 84.0% |
| FY 23-24 1st QTR | 52,564 | 49,850 | 2,714 | 5.0% | :34 sec | 5:30 mins | 95.0% | 76.0% |

- **Current Status:** For the 1st Quarter of FY 24-25 there were 42,327 calls handled by the access call center.
 - **Breakdown**
 - 12,006 (28.3%) calls handled related to SUD services with an average handle time of 16:15 minutes.
 - 4,859 (11.5%) calls handled, related to MH services, with an average handle time of 18:40 minutes.
 - 25,462 (60.2%) calls handled, related to other requests: provider inquiries, information and referrals for community programs and services, screening follow up calls, Hospital Discharge appointments, enrollments (Infant Mental Health (IMH), Foster Care, TCW/ PCW, Hospital Inpatient, Etc.), Transfer calls (Crisis, ORR, Customer Service, Grievance, etc.)

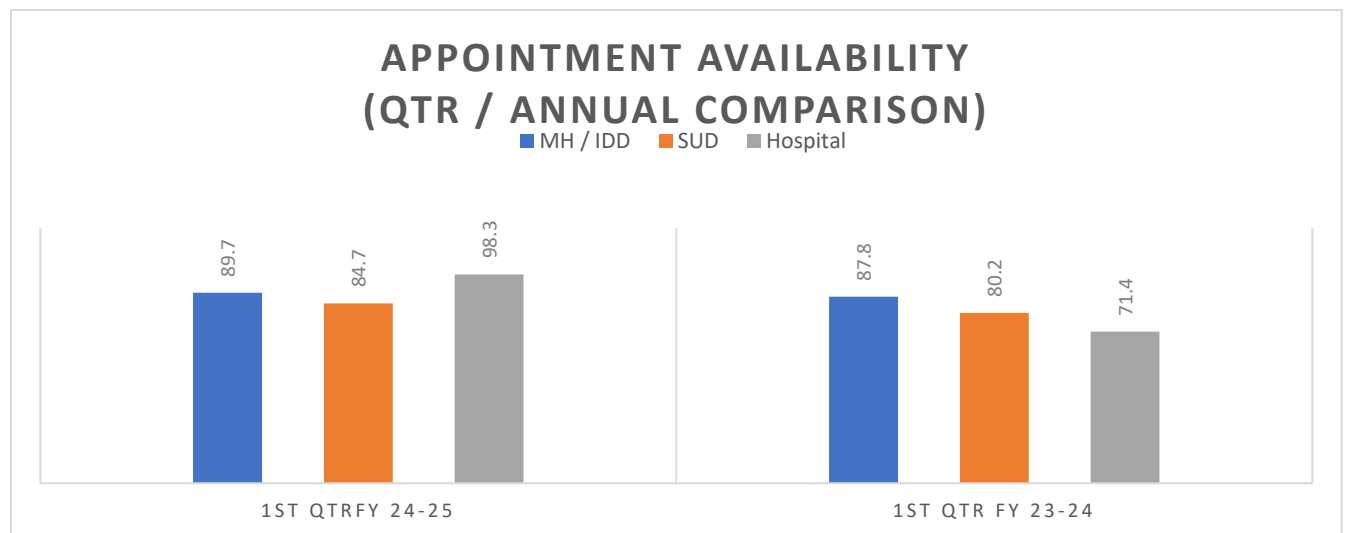
In an annual comparison of 1st Quarter FY 23-24 (5.0%) to 1st Quarter FY 24-25 (3.0%) abandonment rate, there was a 2% improvement. There has also been an improvement in the service level and speed to answer. The Access Call Center management team continues to monitor call volume, trends, staff customer service skills and techniques and phone system functioning; making adjustments to schedules as needed and offering more opportunities for training and skill enhancement.



Activity 2: Appointment Availability

Description: The Access Call Center schedules routine MH intake appointments within 14 days, SUD routine, urgent and emergent intake appointment and hospital discharge / follow up appointments (within 7-day requirement) for individuals being discharged from short stay inpatient psychiatric treatment.

The Access Call Center schedules these types of appointments based on the Clinical Responsible Service Providers (CRSP) availability and ability to provide services, timely.



Summary:

In comparison to FY 23/24 to FY 24/25 there was an increase in all areas of focus for appointment availability with the greatest increase for Hospital Discharge Follow-up appointments by almost 27%. There has been a collaborative effort between the Access Call Center, DWIHN UM department, DWIHN Hospital Liaisons / Clinicians of DWIHN PIHP Crisis department, CRSP Liaisons and the Discharge Departments at various hospitals, when it comes to coordinating the 7-day follow up appointment post hospital discharge. For MH and I/DD intake appointments there was very little change in appointment availability. Representatives from the Quality department, Children / Adult Initiatives, Integrated Care and Access Call Center have 30-45 day meetings with the CRSP providers to identify barriers and discuss interventions. There are 3 new additions to the provider network – Community Care Clinic, Vital Health and Gesher during the last few months, which have provided access to more intake appointments for child, adult, MH/IDD and SUD populations.

Activity 3: Accomplishments and Updates:

- **October 2024 – December 2024 Department Overviews and Trainings** – PIHP Crisis Services (Dan West); MI HEALTH LINK and Integrated Care Services (Nakia Young); DWIHN Access Call Center Program Description and Scope of services (Policy Stat); How to help callers access DWIHN Mobile Crisis Services (Jakeya Kellum); DWIHN Enrollment and Screening Procedures (Policy Stat); DWIHN Customer Service Department Overview (Michele Vasconcellos); How to help callers access DWIHN Community Care Clinic services - CCBHC (Ebony Reynolds); Gesher Human Services-company / services overview (Laura Hearshen, Director of Supports Coordination)
- **Staffing 1st Qtr FY 24/25** - The Access Call Center has almost reached their goal of being fully staffed and have begun to implement the use of contingent staff to cover UPTO/PTO and unexpected high call volume times.
 - 25 Access Call Center Reps (21 FT, 1 PT, 3 Contingent)
 - 19 Call Center Clinicians (10 FT, 6 PT, 3 Contingent)
 - 18 SUD Technicians (15 FT, 2 PT, 3 Contingent)

There continues to be a regular review of applications, interviewing, hiring and training so that vacancies can be filled. Vacancies during 1st Qtr - 1 x Access Call Center Rep. (contingent), 1 x Access Call Center Manager – Clinical (**Filled 2/3/25**)

- **Progress on Previous Improvement Plans:**
 - CRSP Change- update request form and improve data collection and reporting process
 - Mailing Enrollment Packets and related notifications – develop an electronic option using email and My DWIHN App; make changes to data collection and reporting to meet HSAG requirements
 - Appointment Timeliness Report – add more detailed reporting to capture breakdown of populations including specialty population breakdown (Pregnant Users, Parent’s at risk of losing their children, MDOC referred, etc.) to meet HSAG requirements.

Executive Summary: ICE Quarter 1 FY25 Board Report

Introduction

The Innovation & Community Engagement (ICE) Department of the Detroit Wayne Integrated Health Network (DWIHN) remains committed to advancing innovative service models, workforce development, and community engagement to support recovery and resilience. This report highlights key initiatives and accomplishments for Quarter 1 (October–December 2024).

Key Activities & Accomplishments

Justice-Involved Initiatives

- **Jail Releases & Mental Health Court:** Despite challenges due to a new jail facility transition and a cyberattack on the Jail Management System, 247 individuals were released, with 85 assigned a Community Reentry Support Program (CRSP) worker.
- **Returning Citizens Program:** Smooth operations continued, with three individuals returning on an Assisted Outpatient Treatment (AOT) order. A new system was implemented to improve post-release monitoring.
- **Jail Mental Health:** Adjustments to the new jail layout and hiring delays impacted services. Cross-training efforts were launched to improve documentation.
- **Jail Diversion Efforts:** Co-response mental health teams, a 911-embedded Behavioral Health Specialist, and the Detroit Homeless Outreach Team provided vital support:
 - 949 co-response encounters, with 267 individuals connected to services.
 - 57 individuals assisted by the Communications Behavioral Health Specialist.
 - 718 individuals engaged by the Detroit Homeless Outreach Team, with 38 linked to resources.
- **Challenges:** Persistent housing shortages hinder reentry and diversion efforts.

Community Awareness & Relationship-Building

- **Training & Public Engagement:**
 - Planned the Annual Trauma Conference.
 - Continued supporting student internships and professional training.
 - Provided trauma-informed training to Detroit Public Schools Culture Deans.
- **Suicide Prevention Efforts:**
 - Hosted the Suicide Survivors Day of Loss event.
 - Expanded crisis response coordination with Wayne, Oakland, and Macomb counties.
 - Reach Us Detroit Virtual Therapy Collaborative handled 521 calls in Q1.

Workforce Development

- **Detroit Wayne Connect Training:**
 - Hosted 11 training events for 438 participants, an increase from last year despite fewer events.
 - Conducted Mental Health First Aid (MHFA) and Question, Persuade, Refer (QPR) suicide prevention training for 126 individuals.
 - High demand continues, but attendance no-shows remain a concern.

Future Plans & Recommendations

- **Expand Justice-Involved Partnerships:** Strengthen collaborations between behavioral health providers and law enforcement.
- **Enhance Training Initiatives:** Increase training capacity and content depth, while addressing no-show issues.
- **Improve Housing Access:** Explore alternative housing solutions and improve shelter conditions.
- **Continue Suicide Prevention & Crisis Intervention:** Scale public awareness campaigns and expand co-response efforts.

Conclusion

This quarter demonstrated progress in mental health crisis response, training expansion, and public awareness. However, persistent housing challenges, workforce shortages, and justice-system gaps remain key issues. Moving forward, ICE will continue leveraging innovation, community partnerships, and strategic initiatives to advance mental health services in Wayne County.

Innovation & Community Engagement October-December 2024: Quarter 1

Presented February 12, 2025

Andrea L. Smith, Director

Department Mission: To lead the organization in innovation by providing effective and efficient workforce development needs to the provider network. We strive to provide continuous support to the community through educational outreach and engagement while emphasizing and supporting recovery and resilience.

Main Activities during 1st Quarter Reporting Period:

- Justice Involved Initiatives
- Workforce Development

Justice Involved Initiatives

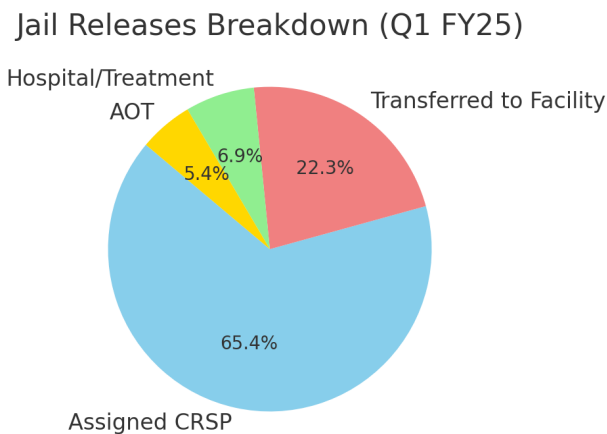
Progress On Major Activities:

Activity 1: Jail Releases; and Mental Health Court

Description: This section highlights jail diversion programming.

Current Status: During this quarter, the jail moved into the new criminal complex. There were initial problems with the space that needed to be corrected. In addition to physical space issues, there was a cyber-attack on the JMS system, so all data may not have been captured. Mental Health was not accepting new referral due to the absence of a case manager.

Significant Tasks During Period: In the third quarter there were **247** jail releases. Of those releases, 85 had an assigned CRSP; 29 were sent directly to another correctional facility (i.e. prison or another jail); 9 were sent to a hospital or treatment facility; and 7 were on an AOT order. Monthly meetings continue to occur with Naphcare which is beneficial to solve issues or collaborate on jail mental health.



Returning Citizens

Description: The Returning Citizens meeting is attended by Professional Counseling Services (PCS); MDOC; DWIHN; and the three participating providers Team; CCIH; and Hegira.

Current Status: The process continues to run smoothly without any current reported issues. There is constant communication between PCS; the providers; MDOC; and DWIHN and the Access Center.

Significant Tasks During Period: There were 3 returning citizens for the quarter and all returned on an AOT order.

Major Accomplishments During Period: The group worked on a solution for PCS and the parole agents so they may receive updated information on the member, specifically if post release appointments are being kept with the CRSP. There will be an assigned contact person for each CRSP to communicate with PCS and MDOC on post-release information.

Jail Mental Health

Description: The Jail Mental Health first quarter statistics are shown below.

Current Status: The first quarter focused on adjusting to the new jail which includes a new layout. It took at least two months to address and fix the physical issues and deal with the JMS system.

Major Accomplishments During Period: Cross training is beginning to occur in addition to a strong effort on improved documentation.

Needs or Current Issues: Naphcare is still hiring Mental Health Professionals. In the interim, contingent workers continue to be utilized.

| Demographic Data | | |
|--------------------------------|----------------|---------------------|
| | Quarter | Year To Date |
| # Persons Screened/Eligibility | 2673 | 2673 |
| # New Admissions | 241 | 241 |
| # Males | 196 | 196 |
| # Females | 45 | 45 |
| # Residential Division | 15 | 15 |
| # Outpatient, Division I & II | 374 | 374 |
| #Bio-psychosocial Assessments | 1069 | 1069 |
| # Individual Therapy | 2098 | 2098 |
| # Case Management | 2032 | 2032 |
| #Discharge Planning | 111 | 111 |
| #Residential Placements | 41 | 41 |
| # Crisis Interventions | 310 | 310 |
| #Co-Occurring | 791 | 791 |
| # Psychiatric Evaluations | 616 | 616 |
| # Pharmacological Management | 969 | 969 |
| # Probate Referrals | 9 | 9 |
| MAT admissions | 147 | 147 |

A Behavioral Health Specialist (BHS) continues to be embedded at DPD's Communication Center to assist with any calls that need mental health support and resources. There were **57** individuals referred for follow-up, individuals received various mental health resources and support.

Jail Diversion: Co-response mental health teams, 911 Embedded Behavioral Health, Mental Health Jail Navigator and the Detroit Homeless Outreach Team continue to function.

Description: The Justice-Involved Initiatives are implemented to offer support to our law enforcement and jail partners. This collaboration has enhanced community mental health awareness and linkage to DWIHN's provider network. Since our collaboration has expanded communities throughout Wayne County are more knowledgeable about DWIHN services.

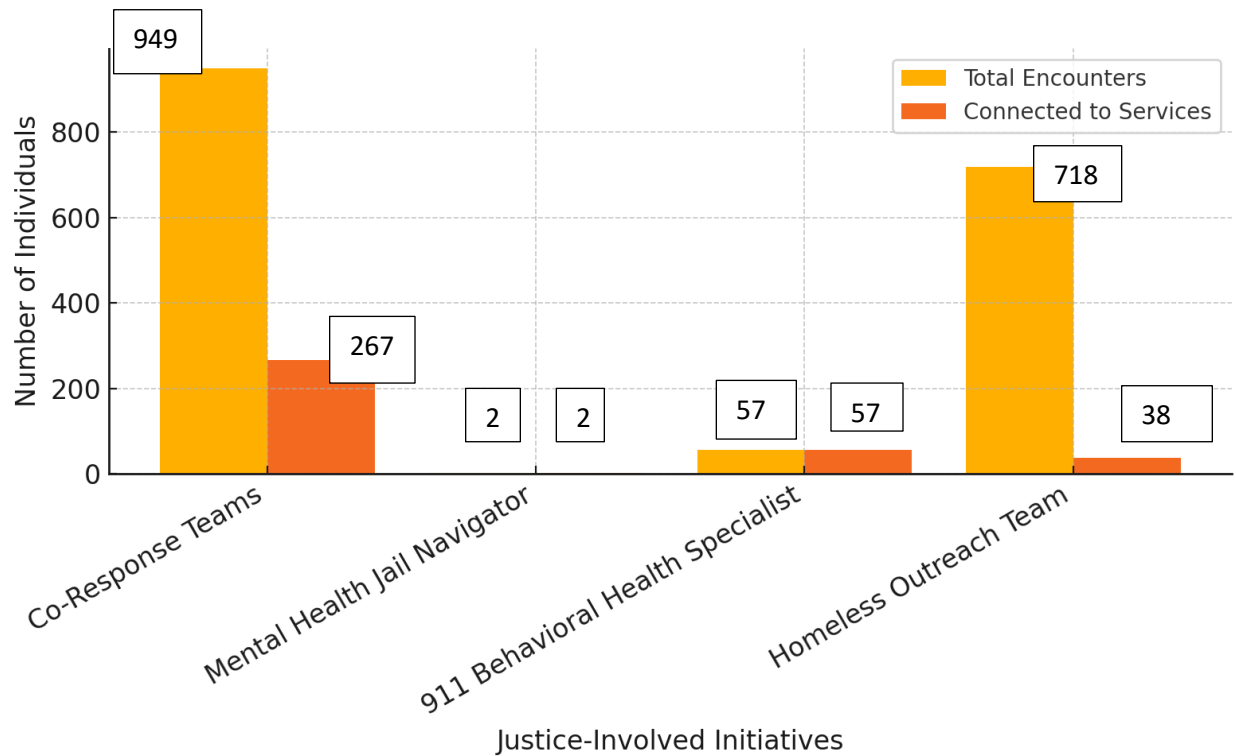
During this quarter, there was participation in weekly Detroit Homeless "DHOT" Outreach Meetings. Identified complex cases and assisted with coordination of care to address individual needs.

The DHOT Teams – DWIHN-DPD and Central City Integrated Health encountered **718** individuals, **38** were connected to various housing and mental health resources. DWIHN-DPD's team continues to introduce the Homeless Outreach van to various Detroit neighborhood community organizations, maintain communication and collaboration with community organizations, such as Salvation Army and Wayne Metro for clothing and housing resources. Partnerships were established to ensure unhoused individuals receive adequate resources to address their needs.

Organized, and coordinated bi-weekly DWIHN Co-Response check-in w/ TWC and CNS. Identified complex cases and assisted with coordination of care to address individual needs. During the quarter, DPD co-responders, which includes data from the City of Detroit had an approximate total of **949** encounters **267** individuals were connected to a service. Various resources were provided for mental health, substance use and unhousing needs.

During the months of October - November, there were no jail navigator referrals. The Wayne County Jail has undergone staff shortages, and there is no designated staff to assist with the referral process. As of December, two (2) individuals were referred and interviewed, met criteria and were referred to various treatment providers, Genesis House III, Team Wellness Center and/or Christian Guidance Center. Currently, all individuals are being monitored and receiving jail navigation services.

Major Accomplishments During Period: Major accomplishments included 1726 encounters from all justice-involved teams, and 364 individuals were connected to a DWIHN resource.



Needs or Current Issues:

The challenges are the lack of housing resources for individuals within Detroit and Wayne County. The point of entry/access is through CAMS, individuals are placed on a list, regardless of housing needs. In addition, follow-up is minimal, individuals report being placed on the list for 2 years. Housing shelters aren't adequately staffed, and living conditions are deplorable, because of this, individuals decline shelter resources.

Plan:

DWIHN continues to build justice-involved partnerships throughout Wayne County. The collaboration has increased mental health awareness and reach within our community. Narrow gaps as it relates to access to treatment through a strategic marketing campaign throughout Wayne County.

Significant Tasks During Period: DWIHN offered mental health first aid and crisis intervention team training throughout the reporting month.

Mental Health First Aid and Crisis Intervention Team Training

Description:

Co-facilitated mental health first aid and Crisis Response Team training to law enforcement, call-takers and dispatchers working with the City of Detroit. The objective is to increase mental health knowledge and awareness amongst first responders. During the reporting period, there were approximately 208 participants who attended MHFA and 188 for QPR.

Current Status:

Monitoring justice-involved activities that encounter individuals with mental health concerns, providing linkage and coordination to DWIHN provider network.

Significant Tasks During Period:

Monitoring justice-involved activities that encounter individuals with mental health, providing linkage and coordination to DWIHN provider network.

Major Accomplishments During Period:

Co-facilitated mental health first aid and Crisis Intervention Team training to law enforcement, call-takers and dispatchers working with the City of Detroit.

Needs or Current Issues:

There are no current issues or challenges.

Plan:

DWIHN continues to build justice-involved partnerships throughout Wayne County.

Things Doing Especially Well:

Innovation and Community Engagement are reaching the goals and objectives of the Justice-Involved Initiative. Each Team is making a difference in how individuals are connected to the DWIHN provider network. The community is knowledgeable and aware of the collaborative efforts between the City of Detroit, Detroit Police and DWIHN.

Activity 2: Workforce Development: Community Awareness & Relationship-Building

Significant Tasks – Began planning the Annual Trauma Conference and continued with supporting student learners with their educational internship requirements and placement needs. Training also continued for the network, offering both live and remote learning opportunities. We also maintained the Reach Us Detroit Virtual Therapy Collaborative hope line.

Expanding community relationships remained a focus, particularly in increasing awareness of DWIHN services. Trauma-informed training sessions were delivered to Detroit Public Schools Culture Deans, with one middle school successfully integrating trauma-informed care principles into its framework. However, frequent staffing changes at partner organizations created challenges in maintaining consistency. To address this, introductory training modules will be developed to ensure continuity in community education efforts.

DWIHN played an active role in suicide prevention efforts, hosting a Suicide Survivors Day of Loss event attended by 11 participants. Additionally, engagement in Metro Regional Meetings facilitated coordination among crisis response teams across Wayne, Oakland, and Macomb counties. Future plans include expanding collaboration with crisis intervention teams and increasing public awareness of suicide prevention resources.

Reach Us Detroit

Significant Tasks:

- Supported **148 calls in October, 214 calls in November, and 159 calls in December**, for a total of **521 calls this quarter**.

Major Accomplishments:

- Increased call volume attributed to heightened media awareness.
- Delivered direct services and resource connections.
- Strengthened collaborations with crisis centers and mobile crisis teams.

Workforce Development

Detroit Wayne Connect (DWC) - In Q1 of 2024-25 the DWC training calendar posted 11 events both in-person and virtual/hybrid. These events were attended by 438 participants. During the same quarter of 2023-24, DWC Training hosted 15 events, attended by 378 participants. Four fewer events in 2024, but an increase of 60 participants from 2023. Both, Adult Mental Health First Aid and QPR are required for all new hires and offered to members of the DWIHN network. During this quarter, three In-person AMHFA classes and two virtual Adult QPR classes were conducted, each respectively training **63** new Mental Health First Aiders and **63** new QPR Gatekeepers. The demand for these trainings remains high, as registration often exceeds capacity. Unfortunately, the no-show rate hovers around 25% for MHFA and 15% for QPR.

Major Accomplishments:

- Hosted **438** individuals through training and events
- Delivered Mental Health First Aid (MHFA) and Question, Persuade, Refer (QPR) suicide prevention training to **63** individuals at DWIHN or in the Network

Challenges: High demand for these programs persists, though no-show rates remain an ongoing issue.

Future Plans

Looking ahead, DWIHN will continue to expand justice-involved partnerships to improve service accessibility for individuals in crisis. Training initiatives will be strengthened, with an emphasis on increasing capacity and enhancing training content. Addressing the housing crisis remains a key priority, with plans to explore alternative housing solutions and improve access to shelter resources.

Successes & Opportunities for Improvement

The past quarter demonstrated considerable progress in strengthening mental health crisis response, expanding training initiatives, and increasing public awareness of available resources. The successful coordination of co-response teams, the expansion of mental health training programs, and the growth of community partnerships all contributed to enhanced service delivery. However, challenges remain, particularly in securing stable housing resources, addressing workforce shortages, and improving coordination between mental health providers and justice-involved programs.

**Program Compliance Committee Meeting
Ryan Morgan Director of Residential Services**

Date: February 12, 2025



Main Activities During Reporting Period: Quarter 1

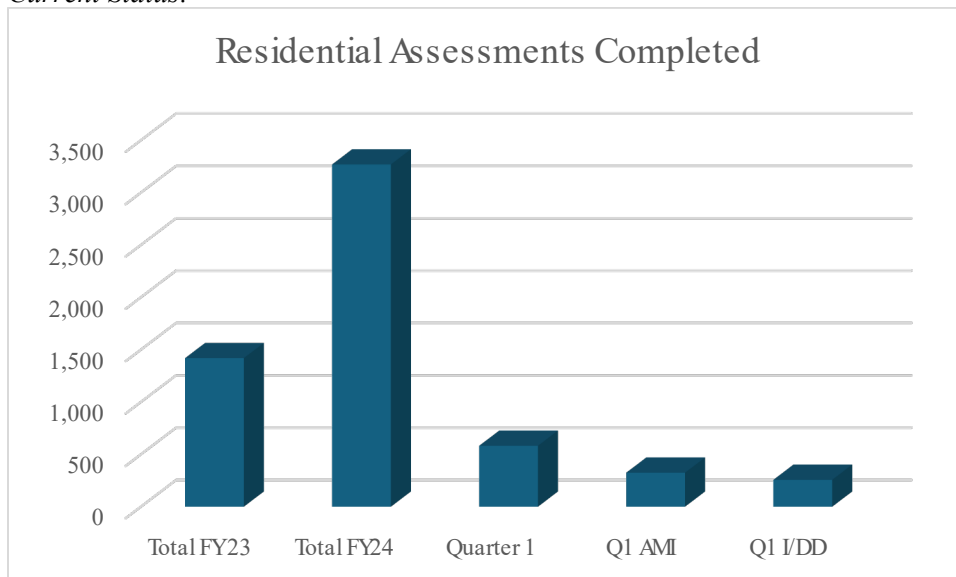
- **Residential Assessment Updates**
- **Hospital Referral Efficiency**
- **Examining Newly Referred Members**

During FY 24-25 Quarter 1, the Residential Services Department served 2,863 members in Licensed and Unlicensed residential settings.

Progress On Major Activities:

Activity 1: Residential Assessment Updates

- *Description:* Throughout the first quarter, the Residential Services Department continued the process of ensuring that members have up to date assessments. The Residential Assessment ensures that members are receiving medically necessary services that meet their needs. It is important that all members are consistently assessed in order to reflect changes that may occur in a member's condition and account for the services they are receiving.
- *Current Status:*



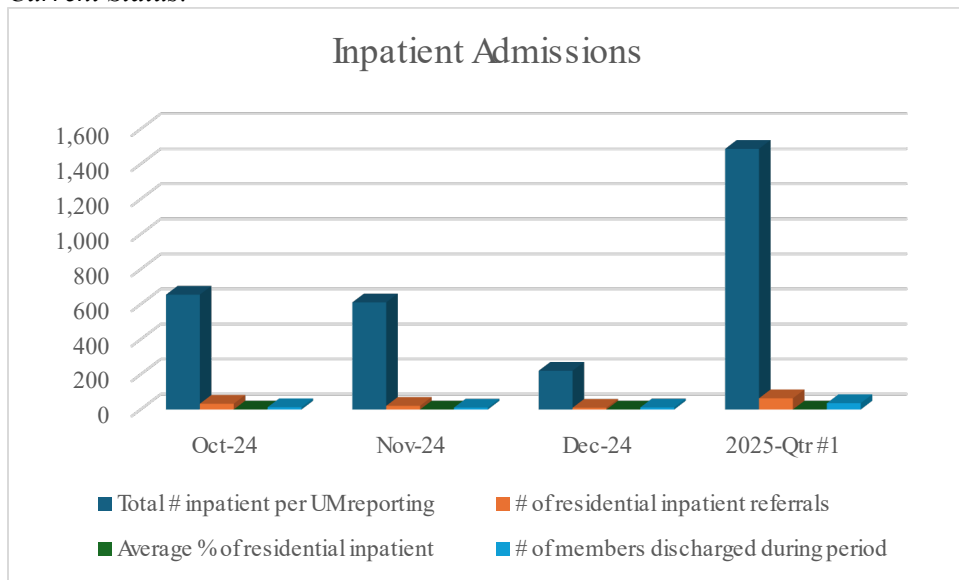
| Total FY23 | Total FY24 | Quarter 1 | Q1 AMI | Q1 I/DD |
|------------|------------|-----------|--------|---------|
| 1,419 | 3,269 | 582 | 325 | 257 |

- *Significant Tasks During Period:* During the first quarter of FY 25 the department completed (582) Residential Assessments with (325) of those being completed with Adults with Mental Illness (AMI) and (257) with members who have an Intellectual/Developmental Disability. This is on track to ensure all assessments are completed timely this fiscal year.

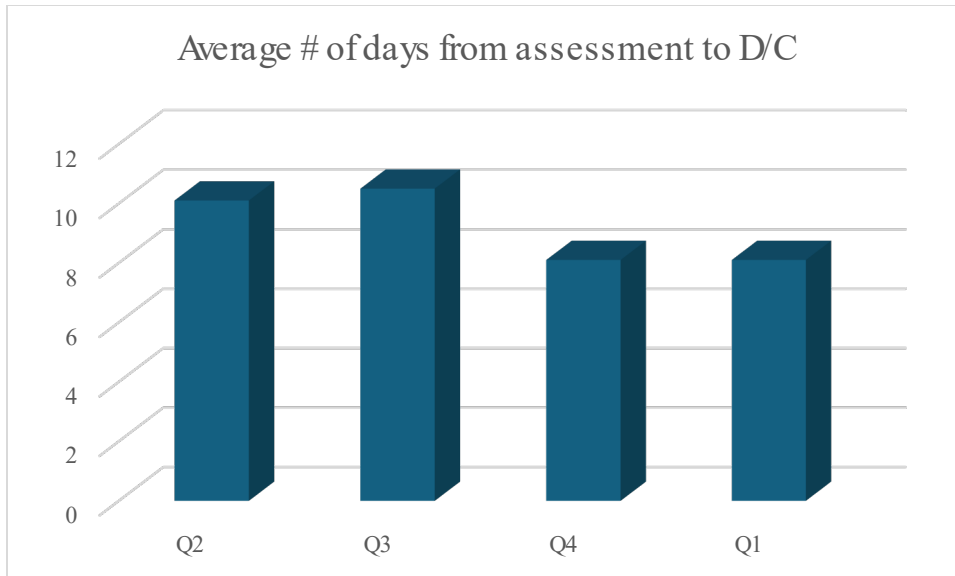
- *Major Accomplishments During Period:* The residential authorization’s unit Manager continues to provide monthly reports to both the I/DD and AMI unit managers indicating treatment plans that are coming due. This allows managers to schedule residential assessments in advance to ensure compliance is maintained.
- *Needs or Current Issues:* The Residential Services Department has worked to ensure that residential assessments are completed annually and on a timely basis. Although the timely completion of these assessments is critical, ensuring that each assessment is accurate and clinically thorough is needed to make sure all quality standards are met.
- *Plan:* In January the Residential Services Department implemented a clinical monitoring system specifically designed to analyze the quality of Residential Care Specialist’s assessments. The AMI and I/DD unit managers will be auditing and reviewing residential assessments ongoing during monthly supervision sessions with staff.

Activity 2: Hospital Referral Efficiency

- *Description:* The Residential Services Department continues to monitor and track the hospitalization data of residential members in acute care settings. It is important to track this information in order to ensure that members spend the least amount of time in inpatient settings as possible. Monitoring the frequency and duration of a member’s inpatient stay will allow the department to improve the overall efficiency of the placement process.
- *Current Status:*



| | Oct-24 | Nov-24 | Dec-24 | 2025-Qtr #1 |
|---------------------------------------|--------|--------|--------|-------------|
| Total # inpatient per UM reporting | 655 | 611 | 221 | 1,487 |
| # of residential inpatient referrals | 33 | 21 | 10 | 64 |
| Average % of residential inpatient | 5.04% | 3.44% | 4.52% | 4.30% |
| # of members discharged during period | 13 | 11 | 12 | 36 |

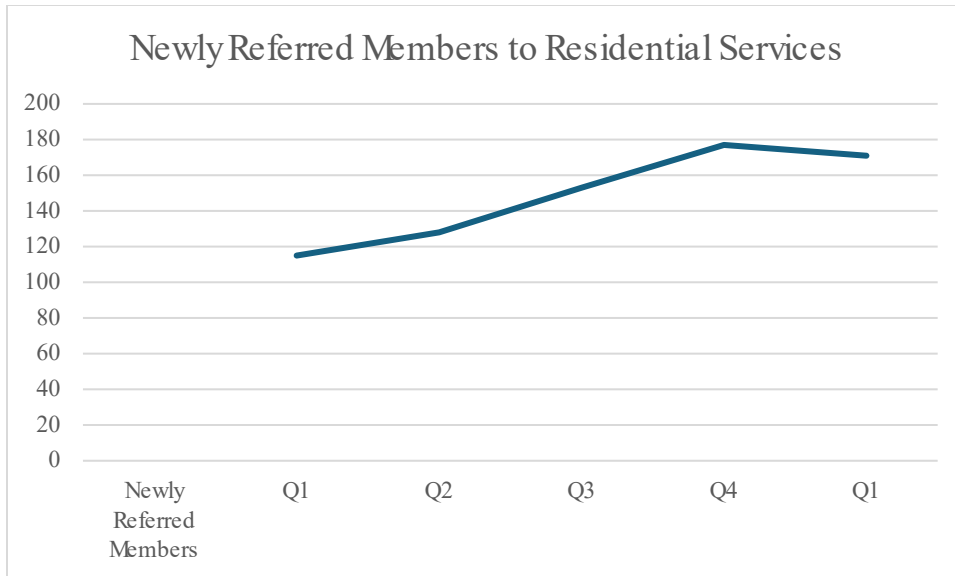


| | Q2 | Q3 | Q4 | Q1 |
|--|------|------|-----|-----|
| Average # of days from assessment to D/C | 10.1 | 10.5 | 8.1 | 8.1 |

- *Significant Tasks During Period:* During Quarter 1 the Residential Services Department was able to discharge thirty-six (36) members out of acute inpatient psychiatric facilities and place them into the community. The average time to discharge a member has remained constant at (8.1) days.
- *Major Accomplishments During Period:* During Quarter 1 the Residential Services Department was able to onboard four (4) new providers. These new providers produced eighteen (18) new placement opportunities for individuals to live in the community.
- *Needs or Current Issues:* The network continues to need barrier-free homes that can manage individuals with comorbid complex medical conditions. Additionally, some providers continue to struggle with staff turnover that prevents them from offering enhanced staffing placement opportunities.
- *Plan:* The Residential Services Department continues to work closely with Managed Care Operations (MCO) and the Quality Department to identify and onboard barrier free providers that are committed to joining the network as quickly as possible.

Activity 3: Examining Newly Referred Members

- *Description:* The Residential Services Department monitors the number of new referrals coming into the department to gauge capacity of our network and population trends. It is important to track new referrals coming into the department so that we can monitor and reallocate resources as needed.
- *Current Status:*



| Newly Referred Members | Q1 | Q2 | Q3 | Q4 | Q1 |
|------------------------|-----|-----|-----|-----|-----|
| | 115 | 128 | 153 | 177 | 171 |

- *Significant Tasks During Period:* During the first quarter of the fiscal year the department saw (171) new members referred for residential services who have not received residential services previously.
- *Major Accomplishments During Period:* Management has started to meet weekly with all Residential Care Coordinators to brainstorm and consult on cases that are difficult to place. This allows management to ensure that staff are making all efforts to place incoming cases.
- *Needs or Current Issues:* The Residential Services Department currently has one open Residential Care Specialist position that needs to be filled by a licensed clinician who will be able to complete residential assessments and assist with placements.
- *Plan:* The department will continue to monitor newly referred members and assess available resources to ensure that there are enough residential placements within the network to meet the needs of the members. We have begun to track where individual members are placed (licensed, unlicensed, barrier free, SUD, etc) to help determine resource allocation.

Quarterly Update:

- **Things the Department is Doing Especially Well:**
 - The Residential Services Department processed three thousand, two hundred and thirty (3,230) residential authorizations during Quarter 1 and 93% of those authorizations were processed within fourteen (14) days.
 - The Residential Services Department was able to help discharge eight (8) members out of long-term state psychiatric facilities and into the community.
 - The department began updating residential policies. Three (3) policies have been completed with seven (7) in draft.

- **Identified Opportunities for Improvement:**

- The department continues to work on establishing a process for completing Adverse Benefit Determination (ABD) letters. The ABD letter is designed to notify a member when there is a reduction in services. The target date for this roll-out is February 1, 2025.

- **Progress on Previous Improvement Plans:**

- The Residential Services Department continues to send out monthly reports to Clinically Responsible Service Providers (CRSP) for Individual Plans of Service (IPOS) that are coming due within the next three months. This is designed to assist CRSP case holders with maintaining up to date treatment plans for their members. This process has helped improve IPOS completion and overall communication. It is essential that members have updated plans to ensure that medically necessary services continue to be authorized without interruption.



Detroit Wayne Integrated Health Network
 Substance Use Disorder (SUD) Quarterly Program Compliance Report
 Judy Davis, SUD Director
 Date: February 12, 2025

Main Activities:

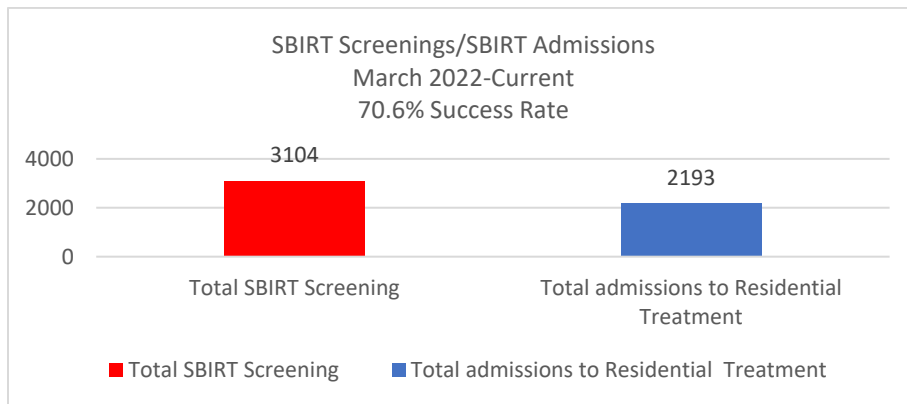
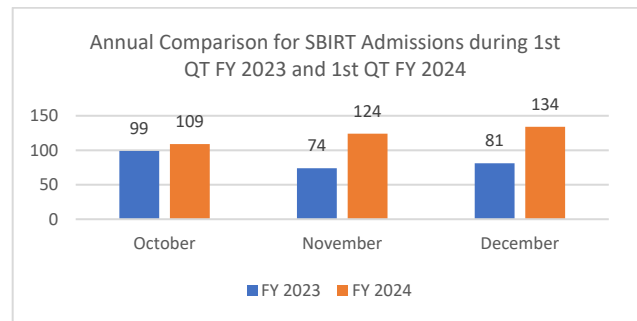
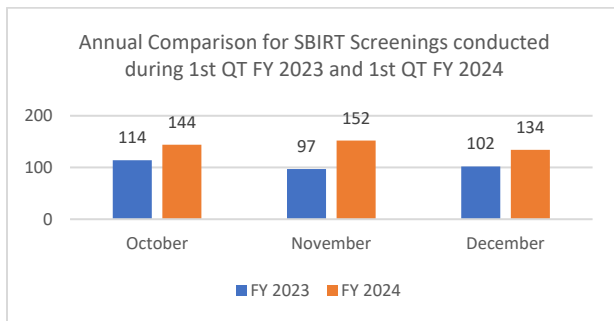
- DMC Screening Brief Intervention Referral to Treatment (SBIRT) Initiative
- CHES Health Initiative
- Follow Up After Emergency (FUA)

PROGRESS ON MAJOR ACTIVITIES

Activity I: DMC SBIRT Initiative

Description: SBIRT is an evidence-based method for identifying and addressing substance use issues. It starts with screening for risky substance use using tools like the AUDIT and DAST. If a concern is identified, a brief intervention provides feedback and motivation to change, and individuals may be referred to appropriate treatment services if needed.

Current Status: In collaboration with Sobriety House, this activity outlines the Peer Recovery Coach services available at Detroit DMC Hospitals. It details the SBIRT screenings, support services, and outcomes associated with substance use disorder treatment for the period from October 2023 to September 2024. The aim is to enhance understanding and accessibility of these essential services to improve recovery outcomes for individuals struggling with substance use disorders.



The baseline provided in the document indicates that from March 8, 2022, to the current date there have been a total of 3,104 SBIRT screenings conducted. Out of these 2,193 individuals were referred to and/or admitted into residential or outpatient treatment, which represents 70.6% of those who receive SBIRT screenings.

Provided 70.6% of individuals who received SBIRT screenings were admitted into residential or outpatient, this percentage can serve as a performance benchmark for future comparisons

Significant Tasks During Period: Peer Recovery Coaches play a crucial role in supporting individuals with substance use disorders through various tasks. They conduct weekly team huddles with physicians to ensure collaborative patient care, while regular reporting of SBIRT encounters keeps everyone informed. Additionally, they offer peer support services to DMC staff family members, advocate for expecting and postpartum mothers with substance use issues and provide transportation assistance. Their efforts also extend to homeless individuals by distributing gender specific care packages, connecting them to shelters, and assisting with personal hygiene needs. Collectively, these tasks are vital for delivering comprehensive care to homeless individuals, linking people to shelters, and assisting those in need of hygiene and self-care

Major Accomplishments: Accomplishments include conducting SBIRT screenings using AUDIT/DAST tools, providing educational lectures quarterly to residents and crisis teams, and holding weekly huddles with physicians. The team will also submit weekly summaries and provide monthly reports on SBIRT encounters and outcomes.

Needs or Current Issues: There is a pressing need for better integration of SBIRT within general healthcare practices to ensure comprehensive care. Raising public awareness about substance use risks and the availability of screening services is essential to support the environment for those in need. Addressing these challenges is crucial for optimizing the effectiveness of SBIRT and improving public health outcomes related to substance use.

Plan: The goal for the Peer Recovery Coach services is to increase the percentage of individuals receiving SBIRT screenings who are referred to and/or admitted into residential or outpatient treatment from 70.6% to 80% by the end of the service period on 9/30/2025.

This goal aims to enhance the effectiveness of the SBIRT program and ensure more individuals receive the necessary treatment and support.

Activity II: CHESS Health Initiative

Description: The CHESS Health Analytics tool offers a groundbreaking approach for SUD to access and manage member data comprehensively. This platform streamlines the viewing and extraction of essential information, enabling a deeper insight into member progress and outcomes.

Current Status: The baseline for the CHESS Health initiative is the initial enrollments by the two providers. Quality Behavioral Health enrolled its first member on July 17, 2024, and Personalized Nursing Light House enrolled its first member July 31, 2024. These initial enrollments mark the starting point for measuring progress and outcomes of the initiative.

Benchmarks: *Show initial enrollment and enrollment growth*

- By the end of November, the total number of members enrolled was 107
- By the end of December, the number of enrolled members increased to 109, marking a 15% increase in enrollment

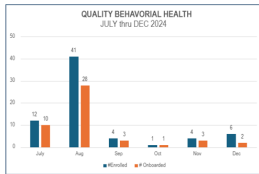
DEMOGRAPHICS

107 Individuals Enrolled To Date

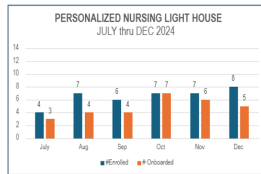
July 17, 2024 – December 31, 2024

15% Increase in enrollment over last month!

68 Individuals Enrolled to-date



39 Individuals Enrolled to-date



Gender

July 17, 2024 – December 31, 2024

| Gender | QBH | PNLH |
|-----------------------|-----------|-----------|
| Male | 49 | 25 |
| Female | 13 | 13 |
| Non-Binary | 1 | 0 |
| Prefer not to respond | 5 | 1 |
| Total | 68 | 39 |

December Escalations

| Type | QBH | PNLH |
|---------------|----------|----------|
| Not Confident | 0 | 3 |
| Return to Use | 0 | 0 |
| Reported Use | 0 | 0 |
| Safety | 0 | 0 |
| Risk of Use | 0 | 0 |
| Other | 0 | 0 |
| TOTAL | 0 | 3 |

- On 12/13, 12/15 and 12/16/24, patient in PNLH entity reported "Not Confident" on Daily Confidence Check-in's.
 - Patient requested Peer Contact following the 12/16 escalation.
- CHES Peer reached out via in-app messaging.
 - Two subsequent Daily Confidence Check-in's noted this same patient as "Confident".

Age

July 17, 2024 – December 30, 2024

| Age | QBH | PNLH |
|--------------------|-----------|-----------|
| 0 to 20 years old | 0 | 0 |
| 21 to 30 years old | 2 | 3 |
| 31 to 40 years old | 16 | 5 |
| 41 to 50 years old | 15 | 10 |
| 51 to 60 years old | 16 | 15 |
| 61+ years old | 19 | 6 |
| Total | 68 | 39 |

Individuals are Engaging within Connections App

adinas
I'm just proud of myself for making it this far and looking forward to the future 🙌🏻
Posted: 12/31/24, 2:49 AM
Onboarding Date: 8/23/2024
Region/Entity: CHES1/Quality Behavioral Health (QBH)

Slim56
Through the GRACE of God, and some caring, loving people, I'm 219 days ill And I'm NOT looking back...
Posted: 10/5/24, 9:22 AM
Onboarding Date: 8/23/2024
Region/Entity: CHES1/Quality Behavioral Health (QBH)

Individuals are Engaging within Connections App

babygienn
I'm very grateful for my peer support for giving the app. I've just finished setting it up, now to enjoy the benefits we all use to stay Drug-Free! ❤️
Posted: 1/3/25, 9:22 AM
Onboarding Date: 12/18/2024
Region/Entity: CHES1/Quality Behavioral Health (QBH)

My Recovery Data
Weekly Points Goal: 110/1000
Level 31
Weekly Status Completed: 0
Earned Badges: 5 (Distractions, Liberty Goal, Super Responder, Responder, 30-day Daily Check-in Milestone)

Significant Tasks During Period: We are currently convening with our providers every Wednesday to actively engage members in the enhancement of this initiative.

Major Accomplishments During Period: At the close of November, the total number of members enrolled stood at 107. By the end of December, this number had impressively risen to 109, marking a substantial 15% increase in enrollment.

Needs or Current Issues: Enrolling members in programs faces challenges such as lack of awareness, accessibility issues, and privacy concerns. A strategy is needed to simplify enrollment, improve outreach, ensure accessibility, and tailor programs to diverse needs

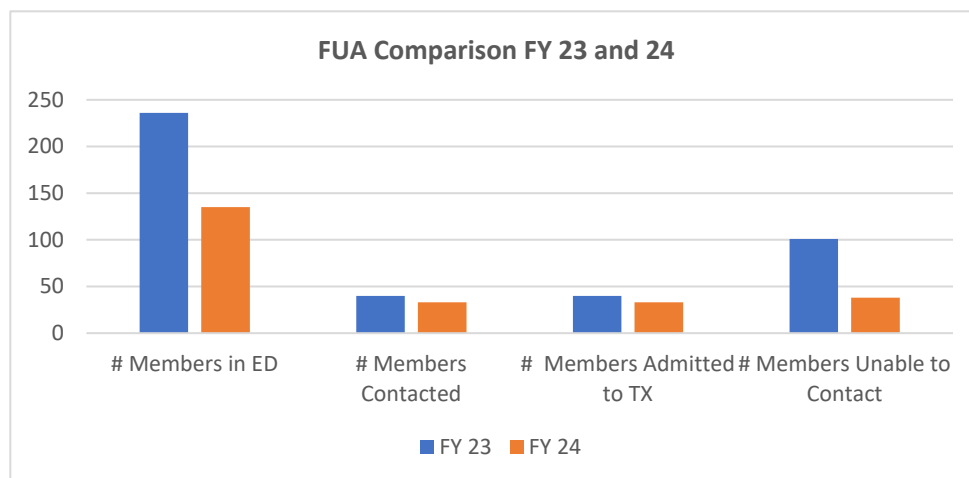
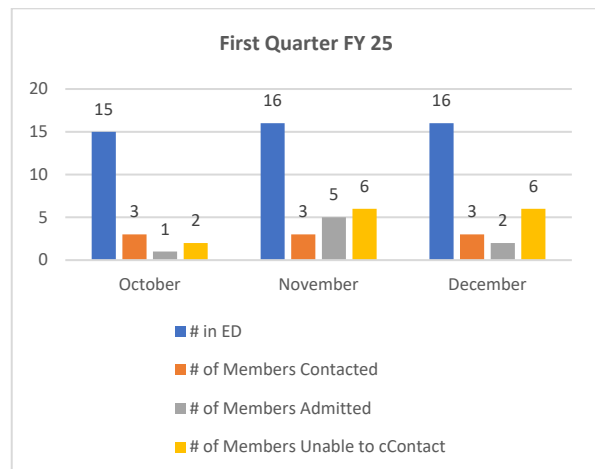
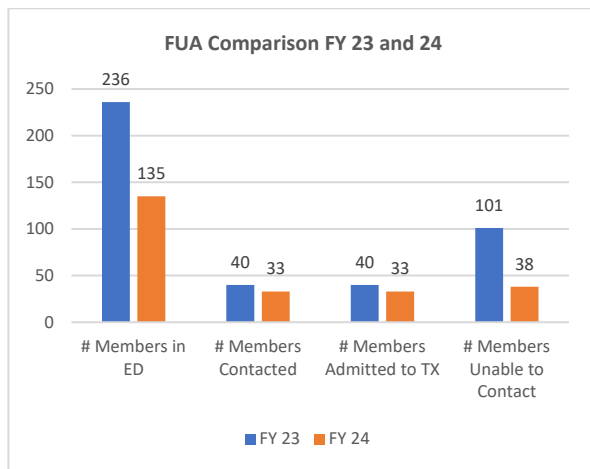
Plan: The goal of the CHES Health Initiative is to enhance the enrollment and engagement of members in substance use disorders by using the CHES Health Analytics tool. This tool aims to provide comprehensive access and management of member data, streamline the viewing of essential information and offer deeper insights into member progress and outcomes

Activity III: FUA Follow Up After Emergency

Description: This activity outlines follow-up actions and strategies for improving care and engagement for members with SUD admitted to the emergency department.

Current Status: FY 25, first quarter 16 members designated as having a SUD were admitted into the ED in December. The numbers are consistent in the first quarter, with each month averaging 16 members admitted. The number of members with no phone or contact information is 6. There are 3 follow-ups per month.

Baseline data for FY 25: From October to December, the Emergency Department (ED) data reveals important trends. In October, there were 15 members, with 1 admission to substance use disorder treatment and 2 failed to contact. November saw an increase to 16 members, resulting in 5 admissions and 6 failing to contact, the highest of the three months. However, by December, the member count remained at 16, but admissions to SUD treatment dropped to 2, while no contact stayed steady at 6. Additionally, the number of members without contact information varied, peaking at 2 in October, increasing to 6 in November, and rising again to 6 in December. These fluctuations indicate ongoing challenges in effectively reaching members



Significant Tasks During Period: The benchmarks from the data reveal key insights into Emergency Department (ED) performance over the three months. The number of members consistently remained at 16 in November and December, following a slight dip to 15 in October. Follow-ups were stable at 3 each month. Admissions to Substance Use Disorder treatment varied: 1 on October 5 in November, and 2 in December. Treatment referrals increased from 2 in October to 6 in both November and December. Meanwhile, the number of members without phone or contact information fluctuated, starting at 2 in October, increasing to in November, and December. These benchmarks highlight progress and areas for improved outreach.

Major Accomplishments: There has been a 57% reduction in the number of members in the ED from FY 23 to FY 24. Also notable is that there is an increase in members being admitted to SUD services in FY 24 48% compared to 40% admitted to SUD treatment service in FY 23. The number of members contacted after following up also increased from 17% in FY 23 to 24% in FY 24. 1/3 of the treatment referrals were utilized and the members were admitted into treatment programs

Needs or Current Issues: More responses from providers and more reengagement efforts from therapists. Members should be contacted by the therapist, case manager, or recovery coach if there is no communication from the member in a 30–45-day period. The lack of phones and inability to contact transient members refuse our ability to follow up.

Plan: The goal is to improve member support and engagement. First, there is a push to increase engagement efforts among therapists to better connect with members. The SUD department is also tasked with enhancing follow-up communication through dedicated call efforts to reach members more effectively. Additionally, providers are encouraged to actively refer transient members to housing opportunities and assist them in obtaining telephones. To facilitate reengagement, therapists, case managers, or recovery coaches will reach out to members who have not communicated within a 30–45-day period. Lastly, addressing contact issues, particularly the lack of phone calls among transient members, is crucial for improving overall follow-up capabilities. These goals collectively aim to bolster member outreach and support.

Updates

Opioid Settlement Funds Key Components:

- Children Program: This program supports children who have lost a parent or guardian to opioid overdose or experienced related trauma, aiming to foster resilience and emotional well-being in a safe environment.
- Comprehensive Analytics Program: This initiative analyzes opioid overdose trends in African American and Caucasian populations in Wayne County to improve health outcomes through targeted interventions.
- Syringe Services: Harm Reduction Services Initiative: Enhances access to services through mobile units in Detroit and Wayne County.

MCBAP Discussion:

- The Michigan Certification Board of Addiction Professionals (MCBAP) certifies addiction professionals in Michigan, ensuring high standards in education, training, and ethics. To provide services, staff members at SUD providers are required to hold relevant certifications, such as Certified Alcohol and Drug Counselor (CADC).
- We participated in a discussion about introducing alternative certifications within the network. This initiative is designed to enhance professional development opportunities and support diverse learning paths for our members. By offering various options, we can better meet the needs of our community and encourage greater participation.
- There is a need for more staff to become certified, as existing members of the workforce age out and leave the field. Additionally, new entrants often struggle to pass the certification exam, highlighting the necessity for enhanced support and training programs. Implementing mentorship initiatives and targeted preparatory courses could help bridge this gap and ensure a steady flow of qualified professionals in the addiction treatment field.

**Program Compliance Committee
Vice President of Clinical Operations' Report
February 12, 2025**



CLINICAL PROGRAM UPDATES

UTILIZATION MANAGEMENT

Outpatient Authorization Update- DWIHN Utilization Management reviews standard and expedited authorization requests for several lines of business, including Outpatient and Substance Use Disorder services. Based on underutilization data and clinical best practices, Utilization Management develops Service Utilization Guidelines (SUGs) for behavioral health requests – a group of pre-approved services for members with similar needs. The remaining authorization requests are manually approved by UM staff. In addition to SUGs, the department reviews internal procedures to improve efficiency of utilization review and decrease/eliminate delays in service delivery or authorization.

In January 2025, the Utilization Management department initiated a non-clinical Quality Impact Assessment (QIA) for timeliness of non-urgent, preservice authorization decisions, with the goal of decreasing decision time from fourteen (14) to seven (7) calendar days by 2026. Currently 38.27% of requested authorizations are approved within 7 days of submission. Plans to achieve this goal include development of Certified Clinical Behavioral Health Clinic SUGs, reviewing current SUGs compared to most frequently requested services and adjust as indicated, increasing staff efficiency through additional training and monitoring of staff performance, implementing system controls to send provider reminders when additional documentation is being requested, and daily monitoring of the authorization return queue.

UM Highlights:

- Self-Directed Services (SD) Team was invited to participate in Partners Advancing Self-Determination (PAS), a collaboration with MDHHS to offer free state-level technical assistance, training, and support to advance self-directed services in our community.
- Habilitation Supports Waiver (HSW) continues to exceed MDHHS requirement of 95% program slot utilization.
- Collaboration with the Health Homes Department on the implementation of CCBHC SUG requirements into the UM program.

CHILDREN'S INITIATIVES

Integrated Pediatric Health- Is a new pilot program with Starfish Family Services that provides coordination between OBGYN clinics and behavioral health services. This program implements Perinatal Programming within Wayne County for pregnant and new mothers by addressing mental health, substance use, and social determinants of health. The main two (2) goals of the program are: 1). Increase access to services for identified patients in OBGYN clinics, 2). Increase the likelihood of desired health outcomes for pregnant and new mothers.

According to FY25/Q1 data there were 47 patients seen in which 24 presented with perinatal health (pregnant and or postpartum symptoms). Nineteen (19) of the 24 patients seen were enrolled in eligible services (79%).

DWIHN coordinated with Southeast Michigan Perinatal Quality Improvement Coalition (SEMPQIC) regarding new training opportunity for 10 clinicians to be trained in Postpartum Depression Screenings for Wayne County, Oakland County, and Macomb County.

Evidenced Based Practices- Provider network clinicians successfully completed the Trauma Focused Cognitive Behavioral Therapy (TFCBT) evidenced based practices cohort (5 clinicians from Hegira Health and 2 clinicians from Starfish). Current evidenced based practice cohorts include the following:

- *TFCBT Cohort 38:* DWIHN Community of Care, Starfish
- *Motivational Interviewing Cohort 11:* Black Family Development
- *TFCBT Cohort 34:* Starfish
- *Caregiver Education Cohort 30:* Assured Family Services

ADULT INITIATIVES

Assisted Outpatient Treatment (AOT)- Assisted outpatient treatment (AOT) is the practice of placing individuals with severe mental illness and a history of struggling with voluntary treatment adherence under a court order to follow a prescribed treatment plan while living in the community. Wayne County Probate Court (WCPC) has created a Behavioral Health Unit (BHU) to provide oversight and ensure AOT compliance.

There are currently 810 active AOT orders, including 45 new orders that became effective in the month of January. There were 826 active orders in December. In December 2024, to better identify AOT outcomes and circumstances around expired court orders, the Adult Initiatives team developed monthly data collection methods to obtain information on expired orders and evaluate the effectiveness of the treatment orders. From 11/1/2024 through 12/1/2024 there were 104 orders that had expired; 38 of those members engaged in services and were able to be taken off the order. The remaining 66 members were not compliant with both services and the order for treatment.

DWIHN met with the Detroit Veterans Affairs inpatient and outpatient programs to discuss AOT collaboration. VA reported receiving infrequent notifications of veterans with AOTs from non-VA hospitals, in addition to generally low numbers of AOTs. The VA is open to improving communication on these members and is the first step in coordinating to monitoring AOTs for non-DWIHN members.

Current AOT/NGRI Orders

| Orders | NGRI | New Orders | Transport Orders | Non-Compliance | New Hospitalizations | Unassigned |
|--------|------|------------|------------------|----------------|----------------------|------------|
| 810 | 77 | 45 | 7 | 3 | 29 | 48 |
| | | | | | | |

HEALTH HOME INITIATIVES

Behavioral Health Home (BHH) - 837 members enrolled as of January 31, 2025

Substance Use Disorder Health Home (SUDHH) – 640 members enrolled as of January 31, 2025

Certified Community Behavioral Health Clinic (CCBHC) – 18,541 members enrolled as of January 31, 2025 (over 18.57% increase since Dec. 2024)

It is DWIHN's goal to expand access to members in both the Behavioral Health Home and SUD Health Home programs to reach 1,000 respectively in FY2025. Health Homes focus on integrating care, generate cost-efficiencies, and increase a member's health status. These models create a mechanism to pay for historically difficult to reimburse integration activities that affect the social determinants of health. Health Homes provide:

- Comprehensive Care Management
- Care Coordination
- Comprehensive Transitional Care
- Health Promotion
- Individual and Family Support
- Referral to Community Social Support Services

The Health Home Team, led by Emily Patterson, facilitated a CMHA Winter Conference session titled "Behavioral and SUD Health Homes: Keys to Success and Context in the CCBHC Demonstration" was very well received and had very positive audience feedback.

Behavioral Health Home and SUD Health Home success stories

- 1) Member arrived at initial appointment with impaired vision, hypertension, and several other conditions: Just released from incarceration with little support following release:
 - Person was initially guarded to receiving assistance
 - BHH Community Health Worker (CHW) with lived experience built a relationship with the member, sharing stories that were relevant to the person
 - CHW assisted them with addressing physical health needs: vitals, hypertension, and diet
 - This person is now proactive: Calls ahead to confirm appointments and is continuously working on their disposition towards others
- 2) Member arrived at initial appointment in a wheelchair very disheveled, with an infected amputated leg:
 - BHH team worked with this person to address biopsychosocial needs
 - Helped them receive a prosthetic leg and walker
 - Assisted with obtaining relief of chronic back pain from prolonged wheelchair use.
 - Person reports feeling more independent and self-sufficient thanks to BHH staff
- 3) Member utilizing the Emergency Room (ER) regularly to address an infected toe:
 - ER would refer to a podiatrist, person would never follow up
 - SUDHH Team located a podiatrist to see the person and coordinated transportation to appts.

- Podiatrist identified other foot-related concerns and now meets with individual monthly
 - Team follows up to ensure transportation is provided and concerns coordinated and addressed
- 4) Mother of two (2) receiving medications for opioid use disorder (MOUD) during both pregnancy:
- SUDHH services were critical - many external needs being a mother with an opioid use disorder
 - Lots of provider coordination needed and provided by SUDHH team
 - Despite the challenges of addiction and being a single mother, she has completed treatment, and her children are healthy and happy
- 5) Member with untreated Hepatitis C for nearly a decade:
- Enrolled in the SUDHH program at the treatment facility
 - Treatment team coordinated appts, evaluated, and now is receiving proper treatment

CLINICAL UPDATES

Conflict Free Access and Planning (CFAP): Centers for Medicare and Medicaid Services (CMS) require States to implement CFAP policies that will directly impact the provision of behavioral health services across the State and in our region. CFAP states that CMHSPs, in their role as a provider, may not offer both service planning and direct services to the same member. DWIHN is awaiting receipt of MDHHS implementation plan and timeline to provide guidance on specific requirements and technical details.

Medicaid Update: DWIHN has seen a significant increase in the request for use of general funds to cover clinical services since the end of the Federal Emergency in May of 2023. Starting in June of 2023, MDHHS required members re-apply for Medicaid and Medicaid deductibles were reinstated. Many members were put on Plan First which does not cover behavioral health services. MDHHS has recognized this issue and is ending this automatic plan assignment process and are tackling the highest risk members to process their Medicaid applications. DWIHN has also implemented internal measures to manage and decrease the use of general funds.



VP of CLINICAL OPERATIONS' REPORT
Program Compliance Committee Meeting
Wednesday, February 12, 2025

ACCESS CALL CENTER – Director, Yvonne Bostic
No Monthly Report

ADULTS INITIATIVES (CLINICAL PRACTICE IMPROVEMENT) – Director, Marianne Lyons
Please See Attached Report

Autism Spectrum Disorder (ASD) – Director, Cassandra Phipps
Please See Attached Report

CHILDREN'S INITIATIVES – Director, Cassandra Phipps
Please See Attached Report

PIHP CRISIS SERVICES – Director, Daniel West
Please See Attached Report

CUSTOMER SERVICE – Director, Michele Vasconcellos
Please See Attached Report

INNOVATION AND COMMUNITY ENGAGEMENT (ICE) – Director, Andrea Smith
No Monthly Report

INTEGRATED HEALTH CARE (IHC) – Director, Vicky Politowski
Please See Attached Report

MANAGED CARE OPERATIONS – Director, Rai Williams

RESIDENTIAL SERVICES – Director, Ryan Morgan
No Monthly Report

SUBSTANCE USE DISORDER (SUD) – Director, Judy Davis
No Monthly Report

UTILIZATION MANAGEMENT – Interim Director
Please See Attached Report

Monthly Report-January 2025
Marianne Lyons, LMSW, CAADC
2/12/2025



Adult Initiatives Monthly Report January 2025

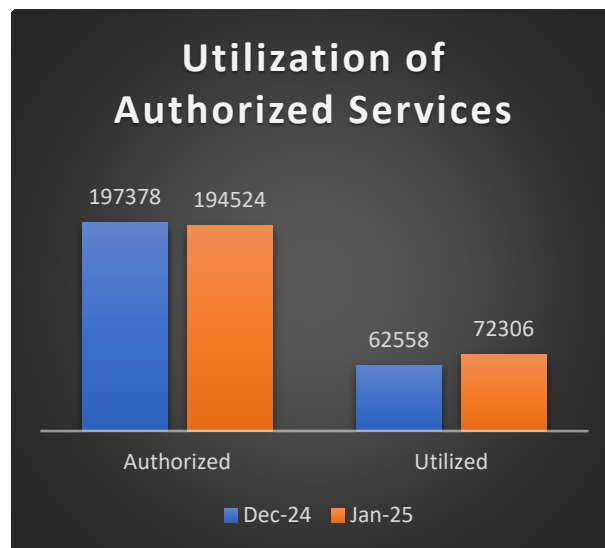
Main Activities during monthly reporting period:

- Assertive Community Treatment (ACT)
- Clubhouse
- Assisted Outpatient Treatment (AOT)

Progress on Major Activities:

Activity 1: Assertive Community Treatment (ACT) Utilization of Services and Engagement

- *Description:* Assertive Community Treatment (ACT) is an intensive, community-based, mobile team of clinical professionals who provide treatment to members who are diagnosed with severe and persistent mental illness. The staff to member ratio is 1:10, interventions and services are delivered in vivo and are comprehensive. There are currently **504 DWIHN members receiving ACT services throughout the 9 ACT teams** within the DWIHN provider network.
- *Current Status:* The billing code H0039 is used to bill for 15 minutes of face-to-face services for ACT members. The Service Utilization Guideline for ACT members is 480 units per member per year; this guideline is used to authorize services as identified in the member's Individualized Plan of Service (IPOS). The Michigan Medicaid Provider Manual states that 120 minutes per week is the requirement for provision of ACT services and fidelity to model. Adult Initiatives monitors the utilization of authorized services by ACT teams monthly to assist in following the model.



- *Significant Tasks During Period:* As represented by the chart above, there is a significant under-utilization of authorizations requested. Adult Initiatives is working with each ACT

team to review members appropriateness for this level of care.

- *Major Accomplishments During Period:* Adult Initiatives has identified opportunities with providers to increase use of authorized services and face to face contact with ACT team members such as increased visits if a member is hospitalized and increasing the number of encounters that occur after 5:00pm.
- *Needs or current issues:* Continue to identify members who no longer meet criteria to participate in the ACT program by reviewing LOCUS scores, PHQ-9 scores and members IPOS. Work with ACT teams to identify ways to continue to increase engagement attempts with those who still require ACT services and to graduate or step-down members into traditional outpatient for those who qualify.
- *Plan:* Adult Initiatives continues to collaborate with the ACT providers to improve hospital discharge planning and appropriateness to participate in the ACT program. Adult Initiatives will continue to monitor the number of underutilized services monthly and will continue to monitor the number of monthly encounters per member.

Activity 2: Clubhouse Utilization of Services and Engagement

- *Description:* Clubhouse is an accredited service, reviewed every 3 years by Clubhouse International, and provides daily activities to members with persistent mental illness. Clubhouse is voluntary and without membership term lengths. Members choose how to utilize their Clubhouse, including participation in varying activities, roles, and responsibilities within the Clubhouse. Clubhouse offers varying opportunities, applicable to individuals with varying cognitive capabilities, including working within administration, enrollment, hiring, training, public relations, and advocacy. The goal is to help members regain self-worth, purpose, and confidence.
- *Current Status:* All the Clubhouses within DWIHN's provider network are accredited. The total number of Clubhouses within DWIHN is five (5). To assist tracking utilization and ensure that authorizations are utilized, it is important to recognize inactive members. It should be noted that Clubhouse directors are responsible for reaching out to case holders of inactive members (members who have not attended Clubhouse in the last 6 months), to ensure that either the member will return to Clubhouse or to identify reasons why the member has been inactive. The following is the data reflecting inactive member numbers:

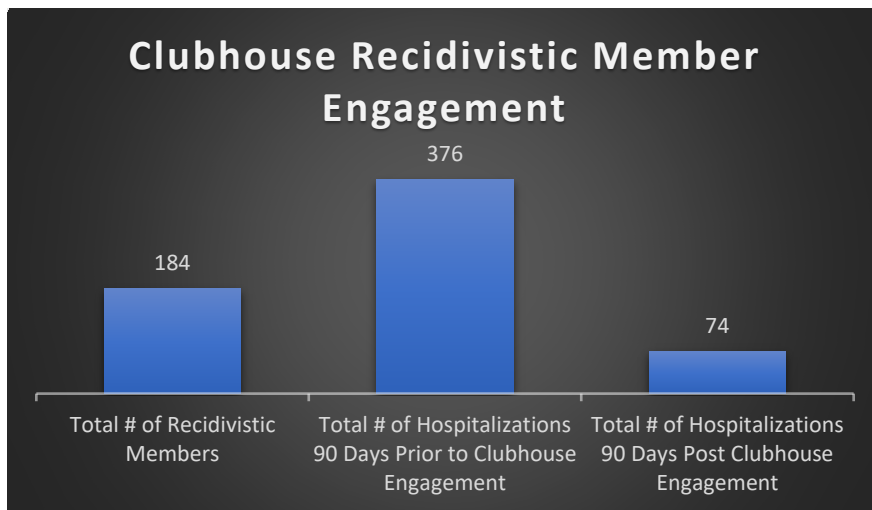
- ACCESS (Hope House): 10
- DCI (New Directions): 8
- Hegira (Turning Point): 31
- Lincoln Behavioral (The Gathering Place): 5
- Goodwill (A Place of Our Own): 2

Clubhouse fidelity suggests that members receiving transitional employment, supported employment, and independent employment should account for 25% of the Average Daily

Attendance (ADA). The following data reflects the total number of members receiving each type of employment service at each clubhouse as well as the percentage as it relates to each clubhouse ADA:

| | Average Daily Attendance (ADA) | Transitional Employment (TE) | Supported Employment (SE) | Independent Employment (IE) |
|-------------------------------|--------------------------------|------------------------------|---------------------------|-----------------------------|
| ACCESS (Hope House) | 35 | 6 (17%) | 2 (6%) | 13 (37%) |
| DCI (New Directions) | 20 | 0 | 0 | 2 (10%) |
| Hegira (Turning Point) | 42 | 2 (5%) | 1 (2%) | 1 (2%) |
| LBS (The Gathering Place) | 40 | 17 (43%) | 12 (30%) | 6 (15%) |
| Goodwill (A Place of Our Own) | 47 | 8 (17%) | 11 (23%) | 6 (13%) |

- Significant Tasks During Period:* Adult Initiatives has created and utilized data reports to collect and measure data to compare member recidivism to Clubhouse engagement. Reports have been reflected, according to previous monthly and quarterly reports, to show a significant decrease in hospitalization following clubhouse engagement. Please see the charts below to see the results.



Major Accomplishments During Period: CNS has reported a desire to reopen Motor City Clubhouse. Adult Initiatives has been in contact with MDHHS, Clubhouse Michigan, and CNS to discuss the plan. CNS is planning to have a grand opening on April 14, 2025.

- Needs or Current Issues:* Adult Initiatives would like to assist with improved marketing of the Clubhouse’s within our network. Clubhouse is an evidence-based program that has demonstrated positive outcomes for our members and with improved understanding of the program and benefits, we hope to increase membership.

- *Plans:* Clubhouse Directors and members will attend Adult Initiatives’ adult outpatient provider meetings to best advocate for increased membership. They will also be invited to ACT and AOT meetings, hosted by Adult Initiatives, to encourage recidivistic members to consider Clubhouse attendance, following the results of the data request which reflects a reduction in hospitalization with Clubhouse attendance.

Activity 3: Assisted Outpatient Treatment (AOT) Utilization of Services and Engagement

- *Description:* Assisted outpatient treatment (AOT) – sometimes known as “court-ordered outpatient treatment” or “outpatient commitment” – is the practice of placing individuals with severe mental illness and a history of struggling with voluntary treatment adherence under court order to follow a prescribed treatment plan while living in the community. Wayne County Probate Court (WCPC) has created a Behavioral Health Unit (BHU) to provide oversight and ensure AOT compliance.
- *Current Status:* There are currently 810 active AOT orders, including 45 new orders that became effective in the month of January. There were 826 active orders in December. Although active and new orders have been tracked previously, it was brought to the attention of the AOT team that expired orders had not been tracked or followed up on as to the reason for the expiration of the order; non-compliance, successfully engaged in treatment, so the order was no longer necessary, etc. The team has developed a data collection sheet with the providers to gather more information for expired orders and the effectiveness of the treatment orders and implemented this in December of 2024, utilizing data from November through December. A comparison from 11/1/2024 through 12/1/2024 demonstrated there were 104 orders that had expired; 38 of those members engaged in services and were able to be taken off the order. The other 66 members were not compliant with both services and the order for treatment.
- *Significant Tasks During Period:* The initial data sheet shared with providers was expanded to include additional categories such as change in provider, inability to locate or relocation to another county/jurisdiction. The list of expired orders will be provided to the CRSP on the first day of the month with the expectation of it to be completed and returned by the 20th of the month to gather a more complete picture of utilization and engagement in services and effectiveness of the treatment order.
- *Major Accomplishments During Period:* Coordinated a meeting with Detroit Veterans Affairs inpatient and outpatient programs to discuss AOT collaboration. VA reported receiving infrequent notifications of veterans with AOTs from non-VA hospitals in addition to generally low numbers of AOTs. The VA is open to utilizing the Smartsheet created by Adult Initiatives, however, it may be simpler to communicate updates through email due to infrequency of orders. This coordination is the first step to monitoring AOTs for non-DWIHN members.
- *Needs or Current Issues:* Adult Initiatives needs non-DWIHN members to be added to MHWIN to better track these orders and their inclusion in the overall AOT data set. With the volume of members on treatment orders, Adult Initiatives and leadership met with PCE

on several occasions during the past two months to enhance our EMR, for improved collaboration with the CRSPs and BHU and to track informative data.

- *Plans:* We have a launch date set for April 2025 for the needed and recommended PCE enhancements.

Current AOT/NGRI Orders:

| Orders | NGRI | New Orders | Transport Orders | Non-Compliance | New Hospitalizations | Unassigned |
|--------|------|------------|------------------|----------------|----------------------|------------|
| 810 | 77 | 45 | 7 | 3 | 29 | 48 |
| | | | | | | |

Things the Department is Doing Especially Well: The Adult Initiatives team has gained an increased understanding and knowledge in the area of AOT/NGRI procedures and policies in working with Wayne State Center for Behavioral Health and Justice, which ultimately has resulted in less expired orders and improved collaboration with our CRSPs.

The Adult Initiatives team has also requested several new data collection reports through IT, which has been beneficial in determining outcomes and improvements within several of the programs we provide oversight and monitoring.

Program Compliance Committee Meeting Autism Services Department January 2025 Monthly Report



Main Activities during Reporting Period:

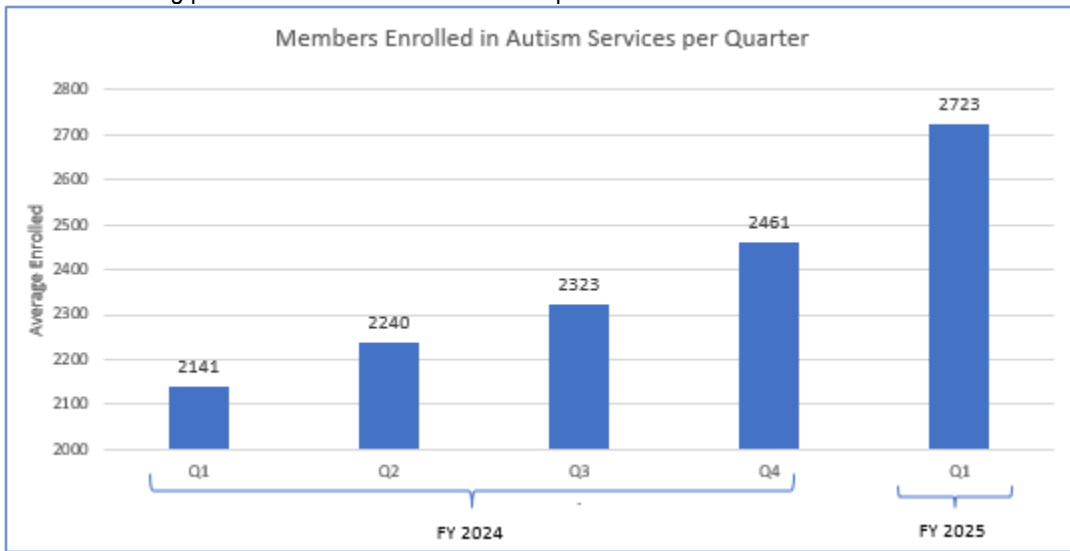
- Activity 1: Autism Benefit Enrollment / Expansion
- Activity 2: Monthly ABA Provider Meeting
- Activity 3: Wrap Around Training on ABA

Progress On Major Activities:

Monitoring Autism Benefit Enrollment / Expansion

Description: DWIHN Autism Services Department oversees autism services for youth and young adults up to 21st birthday. Applied Behavior Analysis (ABA) is an intensive, behaviorally based treatment that uses empirically supported techniques to bring about meaningful and positive changes in communication, social interaction, and repetitive/restrictive behaviors that are typical of ASD.

Current Status: The first set of data highlighted below outlines the consistent increase of individuals enrolling in ABA therapy. The second image lists the status of ABA Providers since the RFQ 20023-005 REBID began in March of 2023. A total of 15 providers were within network prior to the RFQ being posted. A total of 7 providers have been added to the network with 9 more providers pending while completing the credentialing process which leaves 3 additional providers added to the network on the Qualified List.



| | | | |
|---|--|--|--|
| Acorn Health of Michigan Attendant Care Behavior Frontiers Centria Healthcare Chitter Chatter Gateway Pediatric Therapy HealthCall of Detroit Merakey MetroEHS Open Door Living Association Patterns Behavioral Services Positive Behavior Supports Strident Healthcare Total Spectrum Zelexa 15 Original ABA Providers | Advance ABA Care Downriver Therapy Associates Emagine Health Services Illuminate ABA Services IOA Lumen Pediatric Therapy Peak Autism Center 7 New Providers | Golden Steps Integrative Pediatric Therapy Autism of America Euro-Therapies Akoya Behavioral Health Apex Therapy Services BlueMind Kdcare Community ABA Services Brightview Care 9 Pending Providers | Bright Behavior Therapy Gorbald Behavioral Karing Kids Residential Options, Inc. 4 Qualified List |
|---|--|--|--|

Significant Tasks During Period: To support the expansion of autism services and ABA Providers, the Request for Qualifications (RFQ) 2023-005 REBID continues until 5/1/2028. Currently the RFQ Evaluation Committee finalized the 3rd evaluation for 2023-005 REBID which added 1 new provider to the qualified list.

Major Accomplishments During Period: As of January 2025, there are 3 ABA Providers approved by Credentialing Committee and are included in the February 2025 board action. The addition of these providers will bring the total ABA Providers in network to 23 Providers.

Needs or Current Issues: The Qualified List of ABA Providers pending credentialing are as follows: Autism of America, Mansch Enterprises LLC (dba Euro-Therapies), Apex Therapy Services, Mohamdali Maxloum (dba BlueMind), Golden Steps ABA, and Integrative Pediatric Therapy.

Plan: Continue to coordinate with Contracts and Credentialing departments regarding onboarding new ABA Providers and facilitate ABA orientation for the new ABA Providers.

Activity 2: Monthly ABA Provider Meeting

Description: DWIHN Autism Department facilitates a monthly meeting with ABA Providers to ensure ABA Providers receive current updates regarding ABA policies and requirements.

Current Status: The ABA Provider meeting was held 1/27/2025 with all the independent diagnostic evaluators, ABA Providers and (Clinically Response Service Provider) CRSP that oversee members enrolled in the autism benefit.

Significant Tasks During Period: Monthly ABA Provider meeting was held this month. During this meeting various topics were discussed with ABA Providers including the following:

Autism Services: The network has expanded to include new providers and locations that was shared during the meeting. The DWIHN Quality Team discussed that staff must complete the IPOS Training Form whenever an IPOS is updated in MHWIN and should be linked to the supports coordinator case holder as well. Updates to clinical tools include extending the upload timeframe for behavioral assessment reports from 10 to 14 business days. The Physical Environmental Review Tool has changed from a summary in clinical reports to a scorable tool. Additionally, required posters and forms for grievances, recipient rights, and abuse and neglect must be displayed in English, Spanish, and Arab languages.

Training: There are a multitude of trainings and workgroups that were covered at this month's meeting.

- **Compliance Department:** The Detroit Wayne Integrated Health Network (DWIHN) Compliance department covered a training on frequent noncompliance issues in operations. These issues include billing for unrendered services, inaccurate time records, insufficient clinical documentation, failure to provide records upon request, outdated staff records in MHWIN, workforce background check issues, inadequate training, and incorrect billing codes. To prevent citations, organizations should conduct regular audits, stay updated on healthcare regulations, and review DWIHN policies. Clear policies and procedures must be implemented, along with ongoing staff training on compliance, fraud prevention, HIPAA, and billing. Maintaining accurate documentation of patient care, billing, and HR records is essential for transparency and accountability.
- **Customer Service Department:** Provided a training on Due Process for the ASD Provider network. The State of Michigan has updated documentation requirements for Adverse Benefit Determination (ABD) notifications, ensuring they meet a 6.9 reading grade level.
- **Utilization Management Department:** The DWIHN UM department team also completed a brief training on the process for early terminating authorizations and ways to avoid authorizations being returned. Authorizations must be early terminated when service changes overlap with a previous authorization, and the new start date cannot overlap with the prior end date.

Major Accomplishments During Period: DWIHN has developed an Autism Risk Matrix to enhance data-driven decision-making and optimize service delivery. This comprehensive tool systematically tracks the number of eligible members, those assigned or unassigned to ABA services, provider distribution, and the ratio of open to closed cases, facilitating more efficient resource allocation and service planning. Additionally, DWIHN has established FY25 Autism Service Goals to uphold the highest standards of care. These objectives emphasize continuous quality improvement, the integration of medical necessity with evidence-based treatment approaches, and the promotion of best practices through ongoing education and performance monitoring. These initiatives are designed to enhance service efficacy, ensure patient safety, and foster a system of care that is both responsive and sustainable.

Needs or Current Issues: DWIHN has identified critical needs and challenges in organizational compliance, care coordination, and clinical outcome improvements. A key priority is establishing standardized guidelines for independent evaluators, including the development of best practice reporting frameworks, defined timelines, and refined medical necessity criteria to ensure consistency and accuracy in assessments. Additionally, enhancements in care coordination are needed, particularly in refining CRSP processes such as the care coordination form, ABA referral note, and ABA CRSP Care Coordination procedures to strengthen service integration. Among ABA providers, there is a growing need for structured risk mitigation strategies, advanced safety care training, and standardized clinical outcome procedures to improve quality of care, patient safety, and treatment efficacy.

Plan: To address these challenges, DWIHN has developed a strategic plan aimed at improving compliance, service coordination, and clinical effectiveness. Key initiatives include updating the Autism Services Utilization Guidelines, refining the ASD General Funds procedure, and developing an ABA provider capacity report to assess service availability and demand. Additionally, the launch of a care coordination pilot will facilitate improved collaboration among providers, enhance service delivery models, and ensure adherence to evidence-based practices. These efforts are designed to strengthen system-wide efficiency, uphold best practices, and promote sustainable improvements in autism service outcomes.

Activity 3: Wrap Around Training for ABA Services

Description: DWIHN Autism Department hosted a Wrap Around Training for ABA Providers, offering updates on eligibility, referrals, documentation, and supporting children's access to ABA services.

Current Status: The presentation received generally positive feedback, with 86.6% of participants agreeing that the presenters demonstrated a strong understanding of the subject matter.

Significant Tasks During Period: The Wrap Around Training for ABA Services provides key updates on eligibility, referral processes, and documentation for ABA services. Topics include how to initiate referrals, open a child's chart, access ABA goals and CPT codes, and document in-service training. The training also covered how to support a child's access to ABA and the process for transferring or discharging a child from services.

Needs or Current Issues: Enhancing ABA Wraparound services starts with making the referral process more efficient, so families can connect with care without unnecessary delays. Expanding provider networks and keeping referral forms accessible and up to date will help improve service availability. Equipping professionals with ongoing training and resources ensures children receive the best possible support. Clearer guidelines and better coordination in the authorization process can prevent frustrating service delays. Staying informed on the latest autism research allows providers to deliver the most effective care. Additionally, addressing co-occurring conditions like ADHD, anxiety, and sensory challenges is essential for truly comprehensive support.

Plan: To improve the process developing a more streamlined referral form to simplify and improve the transition into ABA services. This new form will ensure all necessary information is captured efficiently.

Monthly Update

Things the Department is Doing Especially Well:

- Successfully tracked and followed up on six-month assessments, ensuring cases stay on schedule and decreasing outdated assessments.
- Officially launched the ABA Availability Log, enhancing service coordination by tracking provider openings and ensuring timely access to services.
- Worked closely with CRSPs and Providers, sharing the ABA Provider Availability Form to ensure members can quickly access the services they need, fostering smoother transitions into care.
- Created the ABA Program Assignment Referral & Closing Form draft, streamlining the referral process and improving communication between teams and providers.
- Developed and distributed the 2024 Combined Frequently Asked Q&A, addressing common questions and providing valuable clarity for ABA providers.
- Beginning stages of the Autism Risk Matrix, ensuring that data remains accurate and trustworthy before it's shared with ABA providers, maintaining the integrity of our service delivery.
- Engaged with providers like to discuss member intake processes, progress, and six-month assessments, ensuring alignment with DWIHN expectations and clarifying the correct upload process to improve data accuracy and workflow
- Continued collaborations with organizations like The Arc to ensure alignment with community needs.
- Conducted multiple rounds of Request for Quotation (RFQ) analysis to support ongoing network expansion initiatives.
- Developed a comprehensive report to assess and quantify the number of individuals awaiting Applied Behavior Analysis (ABA) services. Subsequently, provided detailed data reports to the Michigan Department of Health and Human Services (MDHHS).
- Ensured timely access to ABA services for members, ensuring adherence to service delivery timelines.
- Maintained the accuracy and completeness of the Autism Spectrum Disorder (ASD) Department's annual training log, ensuring all records were current and precise.
- Successfully completed over 262 case assignments, effectively connecting members to appropriate ABA services.
- Developed and submitted the requested report on waiting members to MDHHS, contributing to enhanced tracking and accountability for service provision.

- Collaborated with the ASD Department team to onboard new providers from the RFQ-qualified list, further expanding the network's capacity to deliver services.
- Collaborating with contracted network providers and school-based contacts to enhance the integration of ABA services within educational settings, facilitating broader access to services for members.
- Ensuring the accuracy and integrity of data within the Autism Risk Matrix prior to disseminating information to ABA providers.
- Continuously monitoring and reporting changes in the data concerning members awaiting services, ensuring transparency and accountability in the service delivery process.

Identified Opportunities for Improvement:

- Follow up with ABA providers who have pending or overdue six-month assessments to ensure timely completion.
- Continue tracking the implementation of the ABA Availability Log to ensure smooth service coordination.
- Finalize and distribute the ABA Program Assignment Referral & Closing Form to improve the referral process.
- Address any gaps in the clarity of the Frequently Asked Q&A to provide clearer guidance for ABA providers.
- Ensure better communication with providers regarding data upload processes to avoid discrepancies and improve accuracy.
- Increase engagement with schools and educational partners to better support members.
- Addressing the need for comprehensive training and support for newly contracted providers as they integrate into the service delivery model.
- Update the Detroit Wayne Integrated Health Network (DWIHN) with new ABA provider contact information as additional providers are contracted, ensuring seamless communication and coordination within the network.

Progress on Previous Improvement Plans:

ABA Service Delivery Performance Improvement Plan (PIP): In January, reviewed six-month assessments to ensure cases were on track and took follow-up actions for overdue assessments. In addition, streamlined the ABA Program Assignment Referral & Closing Form with a Smartsheet draft to improve communication when members start, transfer, or close services. The ABA Availability Log was successfully implemented to track provider openings, ensuring quicker access to services. Furthermore, the Wrap Around Training for ABA Services was held this month, providing valuable updates and guidance on eligibility, referral processes, and documentation, which supports the overall improvement of ABA service delivery.

Program Compliance Committee Meeting



Children's Initiative Department January 2025

Main Activities during the Reporting Period:

- Activity 1: Juvenile Justice System of Care
- Activity 2: Pediatric Integrated Health
- Activity 3: Department of Health and Humans Services (DHHS) MichiCANS Screener

Progress On Major Activities:

Activity 1: Juvenile Justice System of Care

Description: Within the System of Care Block Grant DWIHN Children Initiative Department partners with the Juvenile Justice system of care to address barriers of youth and young adults connected to the juvenile justice system.

Why is this Important?: The goal of community mental health services is to offer treatment options for children, youth, and family to remain in the home and community setting. Youth entering the juvenile justice system is a barrier that prevents family stability and is a risk factor that is a focus to support in Wayne County.

Current Status: According to Fiscal Year 2025, Quarter 1 there were 149 youth who were adjudicated within the court system:

- Probation Level 2 (Placed in residential setting) = 27 youth (18%)
- Probation Level 1.5 (Home setting with higher supervision) = 26 youth (18%)
- Probation Level 1 (Home setting) = 96 youth (64%)

Overall, the majority of the youth received Probation Level 1. In addition, 189 youth were referred to the Right TRAC Department for Prevention Services for additional diversion programs.

Significant Tasks During Period: Juvenile Justice and Community Mental Health Partnership Meeting was held this month. Areas of focus was to review FY25/Q1 juvenile justice data as well as discuss the new juvenile justice screening initiative per Michigan Department of Health and Human Services (MDHHS). Wayne State University hosted the JJ Critical Mapping Session to discuss the summary of the 2-day planning session from October 2024. The following goals were identified:

- 1). Funding and Resource Allocation – Develop grassroots advisory committee to enhance use of local mentorship agencies within the community.
- 2). Youth & Family Engagement – Deploy youth and family navigators across various systems of care to advocate and educate on services.
- 3). Equitable Access and Capacity Building for Grassroots Organizations – Provide assistance to community-based organizations and share resource information across organizations.
- 4). Training and Development for Cultural Competency – Develop and implement cultural competency training opportunities on implicit bias and restorative justice practices.
- 5). Enhanced Data Collection – Implement standardized assessments to measure family engagement, youth recidivism, and utilization of services.

Major Accomplishments During Period: Team Wellness hosted a Care Management Organization (CMO) Appreciation Luncheon this month to celebrate the partnership with the Juvenile Restorative Program. Recruited additional members to participate in the JJ/CMH Stakeholder Partnership meetings.

Needs or Current Issues: As a result of the JJ/CMH Stakeholder Partnership meeting it was identified to review screening tool bias, connect youth without Medicaid to CCBHC Providers for mental health services, and increase referrals to the Juvenile Restorative Program.

Plans: Wayne County is hosting a Juvenile Justice Resource Fair Feb 2025. MDHHS is hosting Cross System Juvenile Justice Conference April 2025. Coordinate with Care Management Organizations

Activity 2: Integrated Pediatric Health

Description: Launched a new pilot Integrated Pediatric Health program with Starfish for Fiscal Year 2025.

Why is this Important?: The goal of the pilot program is to provide coordination between OBGYN clinics and implement Perinatal Programming within Wayne County for pregnant and new mothers by addressing mental health, substance use, and social determinants of health. The main 2 goals of the program are: 1). Increase access to services for identified patients in OBGYN clinics, 2). Increase the likelihood of desired health outcomes for pregnant and new mothers.

Current Status: According to FY25/Q1 data there were 47 patients seen in which 24 presented with perinatal health (pregnant and or postpartum symptoms). 19 of the 24 patients seen were enrolled in eligible services (79%).

Significant Tasks During Period: Coordinated with Southeast Michigan Perinatal Quality Improvement Coalition (SEMPQIC) regarding new training opportunity for 10 clinicians to be trained in Postpartum Depression Screenings for Wayne County, Oakland County, and Macomb County. In addition, discussed Starfish incorporating the High Touch High Tech mobile app to the screening process at the OBGYN clinics.

Major Accomplishments During Period: Starfish hired additional staff to assist with the program. Currently have 4 clinicians within 6 clinics.

Needs or Current Issues: Starfish coordinate with the clinics to obtain permission to utilize the new screening mobile app. Implement additional data features to measure how many parents screened met criteria for additional support for anxiety, social determinants of health, depression, etc.

Plans: 1). Issue Request for Information to identify the clinicians to train in postpartum depression screenings. 2). Starfish update data parameters within electronic health record system

Activity 3: DHHS MichiCANS Screener

Description: MDHHS developed the MichiCANS screener and comprehensive assessment for children and youth ages 0 to 21st birthday. This tool is used to support Family Driven, Youth Guided care planning and level of care decisions, facilitate quality improvement initiatives, and monitor outcomes of services.

Why is this Important?: DHHS Health Liaison Officers (HLO) was also trained to administer MichiCANS Screener for youth in the foster care system among the three foster care offices (North Central, South Central, Western Wayne).

Current Status: During FY25/Q1 there were 121 MichiCANS screenings submitted from DHHS that met criteria for community mental health services.

Significant Tasks During Period: Meeting held with DHHS and Providers to discuss the referral process.

Major Accomplishments During Period: Finalized the new DHHS referral flowchart and the Infant and Early Childhood brochure. These documents have been added to DWIHN website as well. Improved DWIHN Access Screeners completing screenings for youth in foster care system and communicating with foster care workers.

Needs or Current Issues: Continue to educate the network of the foster care referral process.

Plans: Send memorandum to the Children Provider network of the finalized flowchart

Monthly Update

Things the Department is Doing Especially Well:

Mi Kids Now Dashboard Initiative: Children Initiative Director participated in the initial Mi Kids Now Dashboard Workgroup hosted by Michigan Department of Health and Human Services (MDHHS) to review the launch of the new dashboard system. Reviewed data pertaining to children completing intake assessments and connecting to mental health treatment. Also, crisis services and referral source for crisis events.

Michigan Department of Health and Human Services (MDHHS): Participated in the SED Waiver Workflow Workgroup this month. Discussed process for enrollment and disenrollment of members with the WSA system according to eligibility requirements for CAFAS/PECFAS and MichiCANS.

Evidenced Based Practices: Clinicians successfully completed the Trauma Focused Cognitive Behavioral Therapy (TFCBT) evidenced based practices cohort (5 clinicians from Hegira Health and 2 clinicians from Starfish). Current evidenced based practice cohorts include the following:

- **TFCBT Cohort 38:** DWIHN Community of Care, Starfish
- **Motivational Interviewing Cohort 11:** Black Family Development
- **TFCBT Cohort 34:** Starfish
- **Caregiver Education Cohort 30:** Assured Family Services

Identified Opportunities for Improvement:

Improve MDHHS Indicator 2a – The percentage of new persons completing an intake assessment within 14 calendar days of a non-emergency request for service for IDD children services. See progress below for SED children.

Progress on Previous Improvement Plans:

The goal is to improve compliance with children and youth requesting community mental health services receive an intake assessment within 14 calendar days with a Children Provider. Effective Fiscal Year (FY) 24 the goal is to achieve 57%.

- MI – Children with Serious Emotional Disturbances (ages 0 to 21st birthday)
- DD – Children with Intellectual Developmental Disabilities (ages 0 to 21st birthday)

| MDHHS Performance Indicator 2a | FY23 – Q1 | FY23 – Q2 | FY23 – Q3 | FY23 – Q4 | FY 23 Total |
|--------------------------------|---------------------------------|------------|------------|------------|-------------|
| MI / Child | 28.81% | 31.42% (+) | 26.57% (-) | 32.49% (+) | 29.82% |
| DD / Child | 28.71% | 32.08% (+) | 32.60% (+) | 46.03% (+) | 34.85% |
| MDHHS Performance Indicator 2a | FY24 – Q1 | FY24 – Q2 | FY24 – Q3 | FY24 – Q4 | FY 24 Total |
| MI / Child | 30.21% | 51.78% (+) | 59.13% (+) | 51.75% (-) | 48.21% |
| DD / Child | 21.78% | 27.92% (+) | 32.02% (+) | 56.34% (+) | 34.51% |
| MDHHS Performance Indicator 2a | FY24 – Q1 <i>Preliminary</i> | FY24 – Q2 | FY24 – Q3 | FY24 – Q4 | FY 24 Total |
| MI / Child | 48.30% | | | | |
| DD / Child | 35.04% | | | | |

Interventions:

- Discussed during various Children Provider Meetings / Trainings
Progress: Providers informed hiring additional staff mainly contributed with improvement with SED child data.
- Issued 2023-008 Request for Proposal (RFP)
Progress: Judson Center credentialed to deliver outpatient services
- Children Providers complete monthly Provider Capacity Form when experiencing challenges with providing services.
Progress: Consider requiring all Children Providers to complete the Provider Capacity Form monthly
- Children Providers begin using screening code for children screenings completed to start including in the MDHHS Performance Indicator data (School Success Initiative, Children Waiver, SED Waiver, Juvenile Justice, Ages 0 to 6, and CCBHC).
Progress: Providers were trained to utilize the new screening code on 6/28/24 and can begin using the code effective 7/1/2024. Updated the Provider Screening Bulletin to add children intellectual disability screening code as well.
- Requested for the Children Provider screenings to be added to the PI2a report.
- Effective FY25 begin collecting staffing census for Child IDD supports coordinators.

PIHP Crisis Services Department Report, January 2025

Daniel West, Director of PIHP Crisis Services

2/12/25



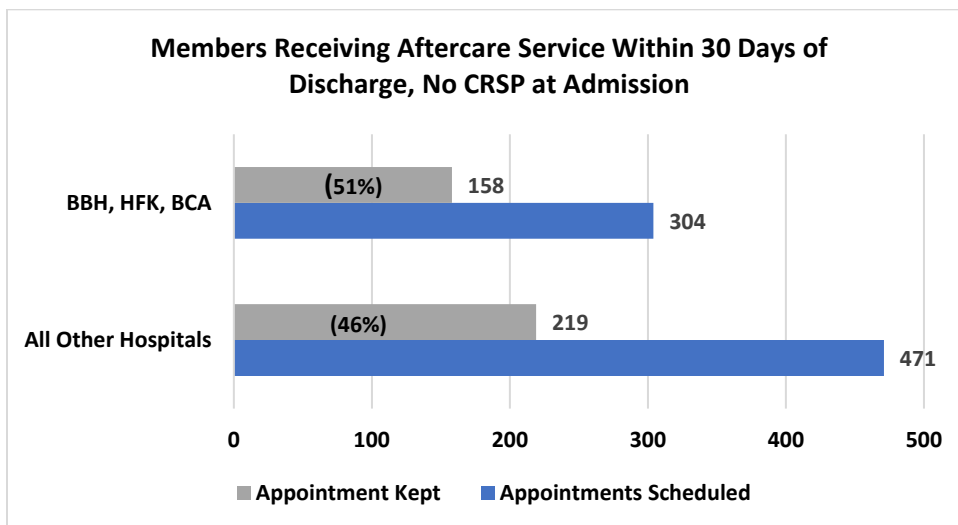
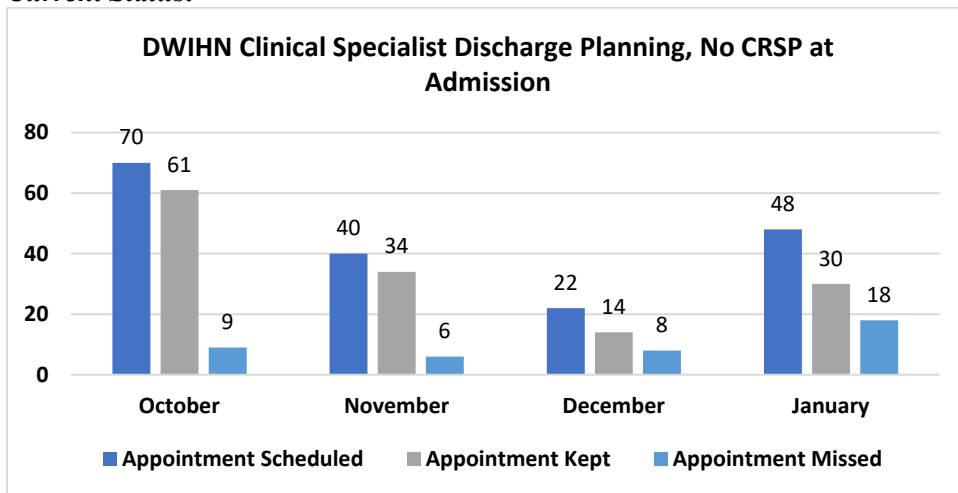
Main Activities during January 2025

- Discharge planning for members in inpatient hospitals.
- ACT team pre-admission review (PAR) completion.
- Crisis Stabilization Unit (CSU) referrals from Emergency Departments.

Progress On Major Activities:

Activity 1: Discharge planning for members in inpatient hospitals.

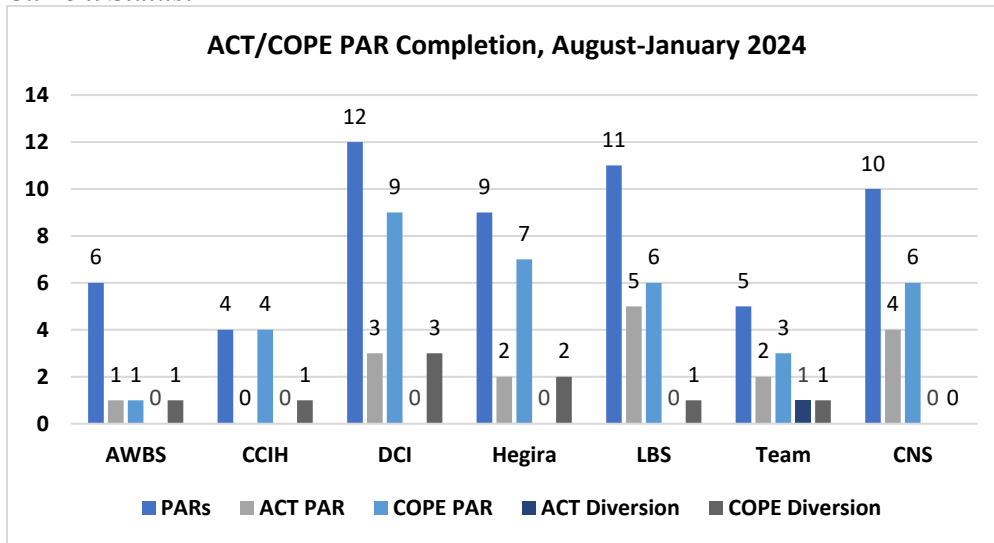
- **Description:** DWIHN Liaisons continue to meet with members at selected inpatient hospitals (BCA, Kingswood, Beaumont Behavioral (BBH)) to engage members in discharge planning when members are admitted without an assigned provider. Liaisons meet with members to discuss barriers to ongoing service connection and support selection of a preferred provider prior to discharge. Liaisons complete a discharge planning worksheet, coordinate with inpatient treatment teams, and work to ensure the member attends their hospital discharge appointment.
- **Current Status:**



- **Significant Tasks and Major Accomplishments During Period:** Clinical Specialists within the PIHP Crisis Services Department were able to connect 63% (30/48) of members to their aftercare appointments with their CRSP of choice in January. As compared to hospitals where this intervention is not present, the team has contributed to an improvement in percentage of members that kept their aftercare appointments.
- **Needs or Current Issues:** The team has found there to be a need to hire additional Clinical Specialists in order to increase the number of members seen, and to continue contribution to the value in this intervention.
- **Plan:** The PIHP Crisis Services Department is in the process of hiring 2 new Clinical Specialists, and these new team members will be trained in the current process.

Activity 2: ACT team pre-admission review (PAR) completion.

- **Description:** The PIHP Crisis Services Department established a PAR Dispatch Team in November to dispatch PAR screening clinicians to the emergency departments to complete crisis screenings. The January goal is to identify ACT team members upon call from the emergency departments for a Request for Service. The PAR Dispatch Team is to ensure and track PARs dispatched to ACT teams for completion, as ACT teams are familiar with their members and could potentially divert members from unnecessary inpatient hospitalizations for this at-risk population.
- **Current Status:**

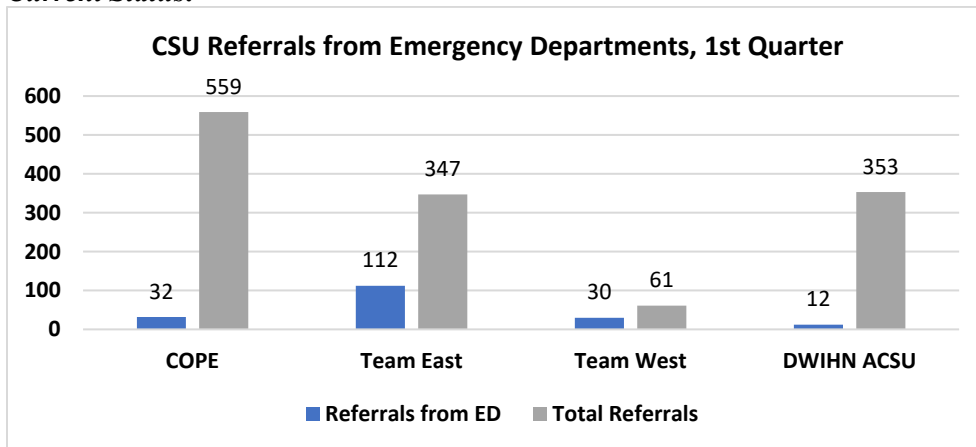


- **Significant Tasks and Major Accomplishments During Period:** In January, the PIHP Crisis Services Department collaborated with the Adult Initiatives Department to address ACT PAR completion. The PAR Dispatch team will now track and analyze data to ensure ACT teams are completing the PARs for their members. The team found LBS to be performing better than the other ACT teams regarding PAR completion.
- **Needs or Current Issues:** The team found there to be a need for ACT teams to complete PARs for the members they serve in the ACT level of care. Since August 2024, 57 PARs were dispatched to ACT teams, and 29% of those PARs were completed by ACT teams. The other 71% were completed by COPE. Overall, 15% (9/57) of ACT PAR referrals were diverted to a lower level of care since August.
- **Plan:** The PIHP Crisis Services Department will train the PAR Dispatch Coordinators to track and evaluate data on PARs completed by ACT teams and ensure collaboration with the Adult Initiatives Department. The goal is to have 50% of PARs completed by the ACT teams for their

members in the 2nd Quarter. PIHP Crisis Services will work with Adult Initiatives to identify and evaluate barriers to ACT team PAR completion.

Activity 3: Crisis Stabilization Unit (CSU) referrals from Emergency Departments.

- **Description:** The PIHP Crisis Services Department is now tracking the number of referrals made to Crisis Stabilization Units. Referrals to CSUs are more likely to be provided with an outpatient disposition post-stabilization.
- **Current Status:**



- **Significant Tasks and Major Accomplishments During Period:** The team was able to gather data on the number of referrals made to CSUs from the emergency department crisis screenings. In a sample study of 241 individual cases in July-December 2024, an average of 90% of referrals made to COPE or Team Wellness CSU resulted in an outpatient disposition.
- **Needs or Current Issues:** The team has recognized a need to increase the number of referrals made to CSUs in the 2nd quarter.
- **Plan:** The team will share data with the crisis screening agencies and reiterate the importance of CSU referrals per medical necessity and will redistribute a memo to the emergency departments highlighting the process.

Monthly Update:

- **Things the Department is Doing Especially Well:**
 - The PIHP Crisis Services Department has improved the percentage of members who receive a service within 30 days of discharge at BCA, Kingswood, and BBH. The team has leveraged solidified relationships at those hospitals to implement this intervention for members admitted without a CRSP.
- **Identified Opportunities for Improvement:**
 - The team has found there to be a need to increase the number of members referred to a CSU from an emergency department screening, as these referrals have shown to increase the likelihood of an outpatient disposition. The team has also found there to be a need to analyze and interpret barriers to ACT team PAR completion.

- **Progress on Previous Improvement Plans:**

- Clinical Specialists recognize recidivism has increased in the 1st Quarter for adults. As a result, specific CRSPs will be targeted to discuss issues with leadership. CRSPs with the highest percentage of recidivistic members per total CRSP hospitalizations will be identified and the team will meet with leadership to discuss interventions.

| Recidivism | Adults | Children |
|----------------|-----------|-----------|
| 4th Quarter | 16.09% | 11.58% |
| 2nd Quarter | 16.65%(+) | 8.82%(-) |
| 3rd Quarter | 17.62%(+) | 15.69%(+) |
| 4th Quarter | 16.52%(-) | 12.14%(-) |
| 1st Quarter ** | 16.94%(+) | 10.57%(-) |

**Data preliminary

Program Compliance Committee
Michele Vasconcellos Director, Customer Service First Quarter FY24/25 Report
February 2025

Unit Activities

- 1.) Customer Service Calls
- 2.) Grievances and Appeals
- 3.) Member Engagement

Activity 1: Customer Service Calls

The Customer Service Call Activity is inclusive of the Call Center and Reception/Switchboard. MDHHS mandated Standard is to ensure that the call abandonment rate is to be < 5%.

Reception/Switchboard Reception/Switchboard

| | Number of Offered | Number of Calls Answered | Abandonment Calls | Abandonment Rate Standard <5% | Average Speed Answered (ASA) <30sec | Service Level Standard 80% | % of Calls Answered Standard 80% |
|-----------------|-------------------|--------------------------|-------------------|-------------------------------|-------------------------------------|----------------------------|----------------------------------|
| FY-24/25 | 3,434 | 3,235 | 46 | 1% | 10 sec | 95% | 94% |
| FY-23/24 | 3,663 | 2,840 | 46 | 1.5% | 9 sec. | 99.3% | 81.3% |

Customer Service Call Center

| | Number of Offered | Number of Calls Answered | Abandonment Calls | Abandonment Rate Standard <5% | Average Speed Answered (ASA) <30sec | Service Level Standard 80% | % of Calls Answered Standard 80% |
|-----------------|-------------------|--------------------------|-------------------|-------------------------------|-------------------------------------|----------------------------|----------------------------------|
| FY-24/25 | 2,377 | 2,281 | 61 | 3% | 9 sec. | 95% | 96% |
| FY-23/24 | 1,740 | 1,263 | 106 | 8.9% | 11.8 sec. | 87.8% | 89.6% |

****DWIHN transitioned to a new phone system, Genesys Cloud in December of 2023.***

Significant Activities:

- In comparing first quarter of FY 24/25 with that of last year’s first quarter calls for our Reception Switchboard, there was a decrease in the number of calls offered and an increase in number of calls answered. Abandonment rate was slightly lower as well as the speed to answer was relatively the same. Our service level was at 95% which exceeded the 80% standard.
- In comparing the Customer Service Call Center data for FY24/25, there was a significant increase in the number of calls offered and answered. There was also a decrease in the abandoned calls and percentage rate from 8.9% to 3%. Our speed to answer also improved as well as there was an increase in percentages in the service level and calls answered standards at 95% and 96% both exceeding the 80% standard.



- Developed refresher Orientations for CS Call Center and Reception/Switchboard staff to reinforce expectations.
- Filled the CS Supervisor position which allowed for more oversight in call monitoring.

Activity 2: Grievances, Appeals State Fair Hearings

Customer Service ensures that members are provided with their means to due process. The due process is inclusive of Complaints, Grievances, Appeals, Access to Mediation and State Fair Hearings.

Complaint and Grievance Related Communications

| | FY 24/25 | FY 23/24 |
|---|------------|------------|
| Complaint/Grievance Correspondence | 708 | 941 |

Grievance Processed

| Grievances | FY 24/25 | FY 23/24 |
|----------------------------|-----------|-----------|
| Grievances Received | 24 | 29 |
| Grievances Resolved | 19 | 14 |

Grievance Issues by Category

| Category | FY 24/25 | FY 23/24 |
|---|-----------|-----------|
| Access to Staff | 6 | 2 |
| Access to Services* | 7 | 8 |
| Clinical Issues | 1 | 2 |
| Customer Service | 3 | 4 |
| Delivery of Service* | 4 | 14 |
| Enrollment/ Disenrollment | 0 | 0 |
| Environmental | 0 | 0 |
| Financial | 0 | 0 |
| Interpersonal* | 3 | 16 |
| Org Determination & Reconciliation Process | 0 | 0 |
| Program Issues | 0 | 1 |
| Quality of Care | 2 | 1 |
| Transportation | 0 | 0 |
| Other | 1 | 0 |
| Wait Time | 0 | 0 |
| Overall Total | 27 | 48 |



Note: A grievance may contain more than one issue. The trend in terms of grievances is in the areas of Access to Staff, Access to Services and Delivery of Service are the top 3 categories for Quarter 1, FY 24/25. The top 3 categories of FY '24 were Interpersonal, Delivery of Service and Access to Services.

Definitions

Interpersonal: Any personality issue between the enrollee/member and staff member (Therapist, Doctor, Program Director, etc.)

Delivery of Service: Any issue that reflects how services are being delivered to the enrollee/member (i.e. How long did the enrollee/member have to wait before he/she was seen for scheduled appointments? How long did the consumer have to wait before he/she was able to receive a specified or requested service? The consistency of case management or therapy.

Access to Services: Any service that the enrollee/member requests which is not available or any difficulty the enrollee/member experiences in trying to arrange for services at any given facility (i.e. reasonable accommodations, difficulty scheduling initial appointments or subsequent ones).

Access to Staff: Any problem the enrollee /member experiences in relation to staff's accessibility [return of phone calls, staff's availability].

MI Health Link (Demonstration Project) Grievances

| Grievance | FY 24/25 | FY 23/24 |
|---------------|----------|----------|
| Overall Total | 0 | 0 |

Appeals: Advance and Adequate Notices

| FY 24/25 | | FY 23/24 | |
|----------|---------|----------|---------|
| Adequate | Advance | Adequate | Advance |
| 1,058 | 4,948 | 926 | 5,687 |

***Appeals Communications**

| | FY 24/25 | FY 23/24 |
|---------------------------------|----------|----------|
| Appeals Communications Received | 296 | 315 |

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

Appeals Filed

| Appeals | FY 24/25 | FY 23/24 |
|------------------|----------|----------|
| Appeals Received | 3 | 5 |



DWIHN State Fair Hearings

| SFH | FY 24/25 | FY 23/24 |
|----------|----------|----------|
| Received | 1 | 1 |

MI Health Link (Demonstration Project) State Fair Hearings

| SFH | FY 24/25 | FY 23/24 |
|----------|----------|----------|
| Received | 0 | 0 |

Significant Activity:

- Worked diligently to implement new MDHHS template letters for grievances and appeals. Also had multiple conversations with ICO partners regarding updating of current CMS approved materials.
- Met with MDHHS to collaborate regarding multiple cases requesting DWIHN’s intervention.
- Defended DWIHN’s decision to deny inpatient behavioral health treatment due to lack of medical necessity criteria.

Accomplishments:

- Added a new Grievance Specialist to the unit. Posted and reviewed multiple applications for the vacant Appeals Specialist position.
- Staff participated in a successful Mediation session. We continue to encourage this due process function to resolve conflict between providers and members.
- Conducted continuous system wide trainings and technical assistance to the Provider Network regarding grievances, appeals, mediation, State Fair Hearings and disenrollment.
- Was victorious in a State Fair Hearing in collaboration with members of Utilization Management and Dr. Faheem that effectively saved DWIHN approximately \$18,000.



Activity 3: Member Engagement and Experience

Customer Service ensures that members are provided with the opportunity for DWIHN and Community inclusion through various initiatives. In addition to promoting outreach, principles of advocacy are promoted via DWIHN's Constituent Voice Committee and focus groups. Through these venues members have the opportunities to share with DWIHN's key Administration i.e. CEO, issues, concerns and recommendation for process improvements. The Unit also facilitates various survey activity. This feedback is essential to DWIHN's ability to address members, providers, and community concerns and prioritize new initiatives.

Significant Activity:

- Coordinated DWIHN's Annual participation in the State's Walk-A-Mile-In My Shoes at the capital. Over 300 DWIHN members were present. This is the second year one of our members was asked to MC the Agenda.
- Involved with the launch of the 2024 National Core Indicators Survey (NCI)- Focus on DD population. We provided 311 of the statewide family sampling of 638.
- Completed the evaluative stage of the Adult and Children's 2024 ECHO surveys.
- Assisted Peers with various opportunities to obtain necessary continuing education credits to meet the States mandated continued certification requirements.
- Published the quarterly Person Point of View member newsletter, which was member driven and provided DWIHN updates. Conducted various member venues in support of educating members on the importance of their right to vote and becoming registered.
- Conducted monthly member meetings at clubhouses and drop-in centers.

Submitted by: Michele Vasconcellos, Director, Customer Service 2/6/2025



January 2025 IHC Monthly Report
Vicky Politowski IHC Director
2/12/2025

Main Activities during January 2025 Reporting Period:

- **Complex Case Management**
- **OBRA/PASRR**
- **QIP/HEDIS**
- **MI Health Link**

Activity 1: Complex Case Management

Complex Case Management program:

Aim: To progress movement towards recovery, enhance wellness, and build resiliency through self-care and empowerment for members with medical and behavioral health concerns.

How: CCM assists members with being connected to community resources, peer advocates and other needed services/supports

Goal: Reduce hospitalizations, Connect with PCPs, reduce gaps in care and Increase participation in outpatient visits, Improve screening measurements and satisfaction scores.

CCM is Free Voluntary Provided directly by DWIHN

Current Activities:

- Developed coordination with DWIHN crisis center for CCM rounds to engage members every Wednesday.
- Engaging a new population with the focus being on children in foster care with asthma diagnosis as part of proactive engagement. (other lists include PHQ, Inpatient, Transition of Care, and Hospital Recidivism).
- Continued coordination with DWIN Internal departments for member referrals/support.

Strengths/Success: Linking members to Primary Care and CRSP apts.

ENROLLMENT

| | |
|---|--|
| Total CCM eligible members based on the criteria: | 3 out 5 referrals were eligible |
| Total CCM members enrolled: 10 | |
| New members enrolled this month: 5 | |
| Members referred through ED: 0 | |
| Members referred through Provider: 0 | |
| Members referred internally: 5 | 1 Access, 2 Crisis Center, 1 Sud, 1 OBRA |

| | | | |
|---|--|---|---|
| Total CCM Staff: 2 | | | |
| CCM Caseload per staff: 5 | | | |
| Improvement Plans: | More CCM in-service meetings with Providers, coordination with Crisis Center, foster kid focus, connecting members with PCP's, continued proactive outreach per hospital recidivism, inpatient report, PHQ list, Foster Care, and Chronic Condition list. Active enrollment list of individuals who have top 5 medical issues. | | |
| Process Measures for Plan: | Increased enrollment monitoring recording data from which lists display the most member engagement in CCM | | |
| Target Timeframe for Process Measures | 3mos, 6 mos, 9 mos | | |
| Is the Plan Successful in Improving Outcome | <input type="checkbox"/> Y <input type="checkbox"/> N <input checked="" type="checkbox"/> N Enrollment needs to increase, by new interventions above | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NA | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NA |
| Continue Plan | <input checked="" type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NA | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NA | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NA |

DISCHARGES

| | | |
|--|---|--|
| Members discharged this month: 2 | | <input type="checkbox"/> NA |
| Percentage of discharged with < 75% satisfaction rate: | | <input checked="" type="checkbox"/> NA |
| Percentage of discharged with 75%-99% satisfaction rate: | | <input checked="" type="checkbox"/> NA |
| Percentage of discharged with 100% satisfaction scores: | 2 | <input type="checkbox"/> NA |
| PHQ Score on enrollment: 7 | | <input type="checkbox"/> NA |
| PHQ Score at discharge: 2.5 | | |

| | | | |
|---|--|---|---|
| WHO-DAS scores on enrollment: 5 | | | |
| WHO-DAS Score at discharge: 2.5 | | | <input checked="" type="checkbox"/> NA |
| Improvement Plans: | | CCM did find a WHO-DAS for children and will work with IT to have that incorporated into the assessment | |
| Process Measures for Plan: | | Meet with IT to develop assessment in MHWIN | |
| Target Timeframe for Process Measures | | 2 months | |
| Is the Plan Successful in Improving Outcome | <input type="checkbox"/> Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA | <input type="checkbox"/> Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NA |
| Continue Plan | <input type="checkbox"/> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA | <input type="checkbox"/> Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NA |

ACTIVE MEMBERS

| | | | |
|---|---|---|-----------------------------|
| Percentage of enrolled members actively receiving services with CRSP | | | |
| Before CCM: 5 (50%) | | | <input type="checkbox"/> NA |
| After CCM: 7 (70%) | | | <input type="checkbox"/> NA |
| Percentage of enrolled members connected with PCP | | | |
| Before CCM 2 | | | <input type="checkbox"/> NA |
| After CCM: 2 (5 new and 3 in the process) | | | <input type="checkbox"/> NA |
| PHQ Score on enrollment: (n=7) 7 | | | <input type="checkbox"/> NA |
| PHQ Score previous month: (n=4) 4.25 | | | <input type="checkbox"/> NA |
| PHQ Score this Month: (n=3) 4.33 | | | <input type="checkbox"/> NA |
| PHQ Percentage Point change: (Initial/Current) 38% improved | | | <input type="checkbox"/> NA |
| WHO-DAS scores on enrollment: (n=7) 7 | | | <input type="checkbox"/> NA |
| WHO-DAS Score previous month: (n=4) 4 | | | <input type="checkbox"/> NA |
| WHO-DAS Score this Month: (n=3) 5 | | | <input type="checkbox"/> NA |
| WHO-DAS Percentage Point change (Initial/Current) 28% improvement | | | <input type="checkbox"/> NA |
| Improvement Plans | Members who are active continue to improve. | Increase enrollment by 20% | |
| Process Measures for Plan | Continue to carefully evaluate members to make sure they have appropriate added | Outreach to more populations who are at risk. Children in foster care, individuals with | |

| | | | |
|---|---|---|---|
| | supports to reduce level of disability if needed. Continue to educate member on symptomology, refer to Therapists and encourage use of MyStrength for symptom management. | obesity, diabetes and need primary care. Rounds at the Crisis Center have been successful in the past two months. Will continue to be there every Wednesday. | |
| Target Timeframe for Process Measures | 1-3 months | 3 months | |
| Is the Plan Successful in Improving Outcome | <input checked="" type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NA | <input checked="" type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NA | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NA |
| Continue Plan | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NA | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NA | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NA |

Care Coordination (CC) activities by CCM

GOAL: Improve HEDIS measures, Increase CCM enrollment when eligible and agreeable by member, improve care coordination during transition of care

Source of referral: Self Identification Emergency Department Providers Internal Referral: _____ Department

| | | |
|--|-----|--|
| Members Outreached: | 58 | |
| Members Successfully Contacted: | 13 | |
| Number of reminder calls/member | 100 | |
| Did Transition of Care Improve? | Yes | 10 members had confirmed FUH attendance in January vs 7 in December 2024 |
| Target HEDIS Measure | FUH | |
| Did the HEDIS Measure Improve with intervention; | yes | |

| | | |
|---------------------------------|--|--|
| Barriers to Contacting members: | Many of the members are unable to reach due to not answering the phone, numbers being disconnected, no return calls, CRSP not having updated contact information, hospitalizations | |
| Solution to the barrier: | Verifying member contact information with CRSP and hospitals to continue to | |

| | | | |
|---|--|---|---|
| | search and call alternate numbers. | | |
| Target date to achieving the solution | Ongoing | | |
| Improvement Plans | Increase number of members reached | | |
| Process Measures for Plan | Continue to coordinate with care team, search chart for updated information, and verifying contact information with members if reachable | Discuss with IT the problem of CRSP info not HIE to MHWIN | |
| Target Timeframe for Process Measures | Ongoing | | |
| Is the Plan Successful in Improving Outcome | <input checked="" type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NA | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NA | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NA |
| Continue Plan | <input checked="" type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NA | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NA | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NA |

Activity 2: OBRA/PASRR

Current Activities during January Reporting Period:

- Eliminate the back up of referrals in the INP que.
- Developing Specialized Services Training and providing training to CRSPS.
- First meeting with Residential to collaborate and improve communication via placement availability and consumer needs.
- Sent Nursing Home Agreements to all nursing homes in Wayne County via Cobblestone.

Progress On Major PASRR Activities:

1. Important Timelines:

The required turnaround times for PAS is 4 days while ARR's are 14 days.
January- PAS 100% for both MI and DD. ARR remains low at 4%.

2. Referrals:

- New screenings (Preadmission Screenings): **10**
- Annual screenings: **105**
- Partial: **54**
- Current # in Que: **594** vs **610** in December.
- Intake referrals:
January referrals: Processed **554** referrals, **276** were assigned to be completed and **278** were triaged and provided exemption letters

Prior months:

December referrals: Processed **456** referrals, **206** were assigned to be completed and **250** were triaged and provided exemption letters

| Month | Total | ARR's | 14 days | % in 14 | PAS's | 4 days | % in 4 | Partials |
|-------|-------|-------|---------|---------|-------|--------|--------|----------|
| Oct | 232 | 161 | 1 | 1% | 10 | 9 | 100% | 61 |
| Nov | 180 | 120 | 3 | 3% | 15 | 14 | 100% | 45 |
| Dec | 156 | 107 | 2 | 2% | 13 | 12 | 100% | 36 |
| Qtly | | | | | | | | |
| Jan | 169 | 105 | 4 | 4% | 10 | 10 | 100% | 54 |

3. **Previous year's Performance:**

January 2024 referrals: Processed **552** referrals, **269** were assigned to be completed and **283** were triaged and provided exemption letters

| Month | Total | Annual Resident Review | 14 days | % in 14 | Pre-Admission Screening (in hospital) | 4 days | % in 4 | Partials |
|--------|-------|------------------------|---------|---------|---------------------------------------|--------|--------|----------|
| Jan 24 | 145 | 100 | 3 | 3% | 9 | 9 | 100% | 36 |

4. **Pends:** January 6%. **3** assessments were pended for Diagnostic reasons, while **4** were pended for Incorrect/Inconsistent information. Expectation is 24%
5. **Congruence: 97%**, internal expectation is 95% or higher
6. **Internal measures:** (reasons for non-congruence)
2 determinations- MDHHS gave specialized vs DWIHN recommendation of other and on 1 determination MDHHS gave a NH determination and DWIHN recommended NO NH
7. **Staff training:** PASRR trainer has provided training to **26** Nursing homes, training **27** staff. In addition, the formal power point training regarding specialized services has been developed and approved. Laura has begun to reach out to the CRSP's to schedule training for February.
8. **Productivity Goal:** Each staff will average 5 assessments in a 5-day work week or 1 per day.
 - o 2 staff are struggling to meet productivity goals. They are both working on performance over the next 30 days.
 - o Staff productivity was noted to be slightly lower in December due to Holidays and staff vacations. January productivity will be on February report
9. **Members in NH with Specialized Services: 365**

10. Strengths:

- Experienced evaluators that are knowledgeable of the PASSR process.
- The number of assessments completed has increased and staff are working diligently to meet the needs.
- 100% completion of PAS within 4 days of referral.

11. Identified Opportunities:

- Increase turnaround times.
- Need to reduce the number in the 14-day queue.
- Improving access to nursing home records. Progress is inconsistent.
- Providing improved mental health services to individuals who have received specialized determinations via training the CRSPS.

Plans and Status on Addressing the Gaps:

- Timelines: Working with 2 staff who are not performing, HR is aware of workplans
- OBRA Trainer working with nursing homes on annual reviews and process
- Nursing Home contract are out to all nursing homes and OBRA Trainer to work with them on improving access to records
- CRSP training approved for roll out on specialized services in nursing homes.

Activity 3: HEDIS FUH, AMM, SAA and SSD

(Data for Oct-December is preliminary)

Description:

1. **FUH:** Assess the percentage of inpatient discharges for a diagnosis of mental illness or intentional self-harm among patients aged 6 years and older that resulted in follow-up care with a mental health provider within 7 and 30 days. Providing follow-up care to patients after psychiatric hospitalization can improve patient outcomes, decrease the likelihood of re-hospitalization and the overall cost of outpatient care.
2. **AMM:** Assess adults 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication and remained on their antidepressant medications. Two rates are reported, Effective Acute Phase Treatment: Adults who remained on an antidepressant medication for at least 84 days (12 weeks) and Effective Continuation Phase Treatment: Adults who remained on an antidepressant medication for at least 180 days (6 months). Effective medication treatment of major depression can improve a person's functioning and well-being and can reduce the risk of suicide. With proper management of depression, the overall economic burden on society can be alleviated, as well.
Acute Phase- Measure starts 3/1-5/23
Continuation Phase- June-December
3. **SAA:** Assess adults 18 years of age and older who have schizophrenia or schizoaffective disorder who were dispensed and remain on an antipsychotic

medication for at least 80 percent of their treatment period. Using antipsychotic medications as prescribed reduces the risk of relapses or hospitalization.

4. **SSD: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications:** *Assesses adults 18–64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year. Heart disease and diabetes are among the top 10 leading causes of death in the United States.¹ Because persons with serious mental illness who use antipsychotics are at increased risk of cardiovascular diseases and diabetes, screening and monitoring of these conditions is important. Lack of appropriate care for diabetes and cardiovascular disease for people with schizophrenia or bipolar disorder who use antipsychotic medications can lead to worsening health and death. Addressing these physical health needs is an important way to improve health, quality of life and economic outcomes downstream*

| | FUH Adult | FUH Children | SAA | SSD |
|-----------------|-------------------------|-------------------------|-------------------------|-------------------------|
| Jan-March 2024 | 53.24% | 66.28% | 82.25% | 36.32% |
| April-June 2024 | 53.63% | 63.57% | 66.18% | 54.66% |
| July-Sept 2024 | 53.12% | 65.19% | 54.09% | 54.21% |
| Oct-Dec 2024 | 51.81% (Preliminary) | 63.47% (Preliminary) | 47.99% (Preliminary) | 68.47% (Preliminary) |
| 2023 | 50.34% | 63.64% | 51.91% | 71.94% |
| Goal | 58% | 70% | 66.28% | 80.99% |

*Not all claims' data is in for Oct-Dec

| | AMM Acute | AMM Continuation |
|----------------|-----------|------------------|
| March-May 2024 | 45.29% | n/a |
| June-Dec 2024 | n/a | 16.76% |
| 2023 | 43.88% | 19.64% |
| Goal | 66.93% | 50.71% |

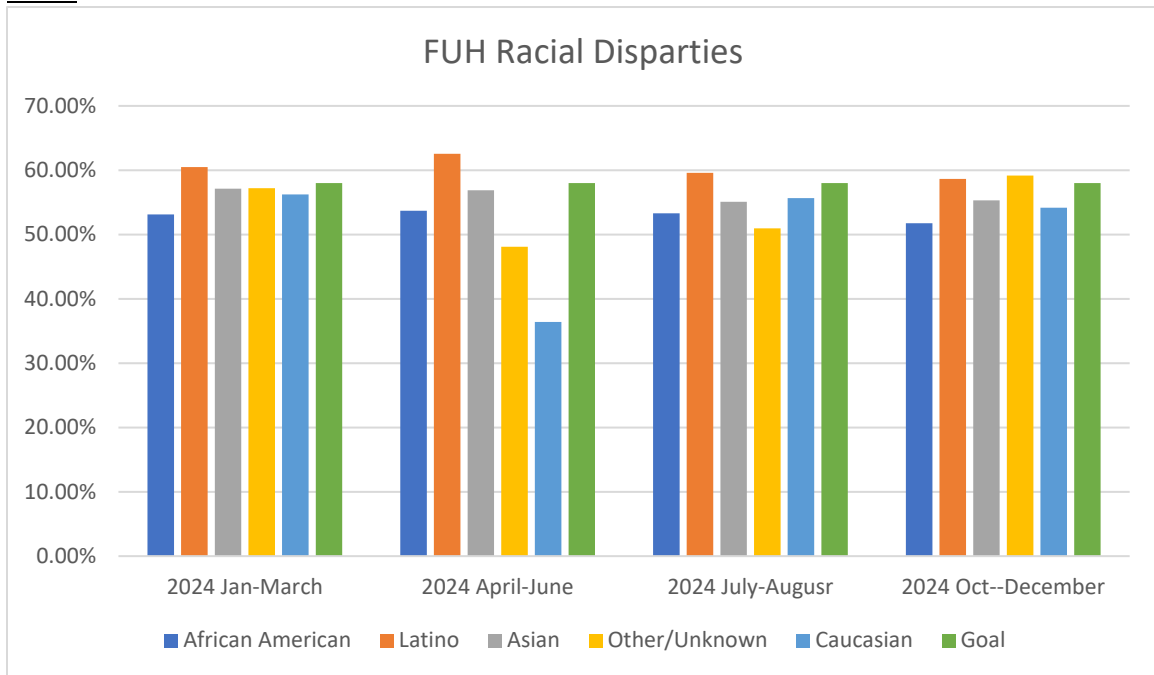
- **Analysis of Data and Plan:**
- Notable CRSP trends: DWIHN has 5 CRSP that have the largest population of members that affect the trends with HEDIS measures. DWIHN also has a large population of members who are not assigned to a CRSP.
- **Up-trending Measures:** FUH, SSD
 - What has helped:
 - There has been a big focus to meet FUH within multiple departments.
 - 3 CRSP agencies have hired hospital liaisons to help engage members while in the hospital.
 - QI and IHC meet with CRSP every 45 days to discuss scores and what they are doing to meet the goal

- CCM and Crisis are in the hospitals to focus on members who do not have an CRSP assigned.
- CRSP are sent HEDIS Scores quarterly.
- DWIHN, Health Department and Team Wellness joined together to host a health and wellness fair where individuals could have their labs drawn on location. This led to an increase in the scores of SSD June of 2024. Team Wellness has the largest population of members and has a FQHC.
- Plans:
- **Down-trending Measures:** AMM, SAA
 - Barriers: Monitoring medication compliance is a difficult measure. CRSP do not fill the medication therefore it is hard to track. With the creation of the HEDIS Score card CRSP can pull off the names of individuals in measure. If a member is 1 day late filling the meds this will give a non-compliance score. This does not mean the member is not taking medications. If members have Medicare, then this will not be tracked.
 - Current Interventions: Meeting with CRSP to monitor scores monthly
 - Next steps: DWIHN to develop training for all HEDIS measures and how they relate to FUH. Work with QI to put CRSP providers on plans of action on how they will meet the scores and improve member outcomes.
 - Send out educational training through Communications.
- **Improvement Plans submitted by CRSP:** Team Wellness, All Well Being, Guidance Center, Services to Enhance Potential
- **Outcomes of Improvement Plans:** Team Wellness has improved scores in the past year.

Racial Disparity HEDIS Analysis:

- **HEDIS Measures with Disparity Gap FUH**

- **Data:**



- **Analysis of Data:**

- CRSP Trends: Most CRSP in the DWIHN network have a higher population of African American members. In the beginning of 2024 Q1 started an HSAG quality plan to address this issue as DWIHN saw a gap between African American and Caucasian. In the first three months of 2024 was a 3% disparity as DWIHN met with providers the number of Caucasian members meeting the goal decreased. DWIHN then educated that all races need to be ensured treatment. For the months of July-August the difference between African American and Caucasian was 3% disparity.
- Potential reasons for disparity: Research has shown that African Americans have a higher rate of racial disparity. CRSP providers believe that they serviced more African American members so there was not a disparity.

- **Plans:**

- Current interventions: Meeting with the 5 largest CRSP providers to discuss FUH and racial disparities.
- Barriers: CRSP providers struggle with HEDIS measures over all. This is a new way of tracking outcomes, and they have difficulty understanding and putting it into practice. Most CRSP providers wait for DWIHN to give them the data verses looking at the data prior to meetings.

Next Steps:

- IHC, Clinical departments and QI to develop a training on all HEDIS measures and how they relate to FUH and racial disparities. All HEDIS measures can be sorted for race.
- Put all HEDIS measures into policy and procedures which will allow DWIHN to then require CRSP's to have plans on how to meet measures.

Activity 4: MI Health Link

Goal: DWIHN has a goal to process all referrals received from the five ICO organizations within 15 days of referral. Process means to have new and existing clients outreached to by Access department, Network Providers and or IHC Care Coordination staff and submit outcome of referral back to ICO with allotted timeframe. DWIHN and the IHC department's ultimate goal is to get all referred clients in services despite their level of care determination. The process involves educating ACCESS Department and Network Providers quarterly on how to discuss mild to moderate services with beneficiaries that do not qualify for level three services. In addition to providing support to beneficiaries who need to understand services of behavioral health directly through care coordination

How many Referrals:

Number of Referrals: 62 (referrals are down from the ICO, all have been notified)

Voided: 27

Reasons Voided:

- Unable to reach- 8
- Referred in Error- 5
- Declined service-13
- Pending screening from Access: 13

ICO Care Coordination:

Focused HEDIS Measures: IHC department conducted a meeting with each ICO to discuss inpatient hospitalization, gaps in care, follow up after hospitalization and shared member updated contact information for period

| ICO Plan Name | Aetna | Amerihealth | HAP | Meridia n | Molina |
|--|--------------|--------------------|------------|----------------------|---------------|
| Number of cases reviewed this month | 7 | 9 | 12 | 4 | 8 |
| Gaps in care closed in 30 days | 2 | 4 | 5 | 3 | 4 |
| Cases carried over to next month | 4 | 5 | 3 | 1 | 4 |

Special Care Coordination Project: IHC is in a special project for care coordination activities with two Medicaid Health Plans Blue Cross Complete and Priority Health. This project exists to reduce care gaps for members served and improve HEDIS measures for the population of members that present with deficits.

Focused HEDIS Measures: Diabetes monitoring and medication monitoring (SDD, AMM, SAA)

| Plan Name | BCC | Priority |
|------------------|------------|-----------------|
| | | |

| | | |
|---|----|----|
| Number of cases reviewed this month | 25 | 15 |
| Gaps Closed with/out MHP | 5 | 3 |
| Number of Cases Presented in Meeting | 20 | 12 |
| Number of UTR | 8 | 6 |
| Total Number of Successful Outcomes | 6 | 4 |
| Number of cases to carry over next month | 6 | 2 |

Data Sharing with MHP: IHC Manager has been assigned oversight of MHP/PIHP Data Sharing Coordination staff, all 8 MHP plan meetings have occurred in. Joint Care Plans between DWIHN and the Medicaid Health Plans were developed and/or updated, and outreach completed to members and providers to address gaps in care.

| Plan Name | Molina | Meridian | Priority | Aetna | Amerihealth | HAP | BCC | United |
|---|---------------|-----------------|-----------------|--------------|--------------------|------------|------------|---------------|
| Number of cases reviewed this month | 9 | 11 | 7 | 8 | 5 | 9 | 7 | 7 |
| Gaps Closed with/out MHP | 3 | 4 | 1 | 2 | 1 | 1 | 2 | 2 |
| Total Number of Successful Outcomes | 3 | 4 | 3 | 1 | 0 | 2 | 4 | 4 |
| Number of cases to carry over next month | 3 | 3 | 2 | 4 | 3 | 6 | 1 | 1 |

Number of Care Plans Opened in CC360/Number Possible: To meet the baseline of 26%, 40 cases need to be open for 2025. Currently there are 19 adults and 3 children open.

FUH: 32 African American men outreached, 15 made FUH appointment

FUA: 11 outreached, 1 made FUA apt

Barriers to meeting Goals of department: None at this time

What is working well: Staff are meeting metrics for Medicaid Health Plan Cre Coordination Assisted 11 members with re-scheduling missed appts. Provided 7 members with the crisis center information. 3 members assisted with arranging transportation with BH CRSP and connecting them to their MHP. Mailed out 19 BH outreach letters to members with BH care gaps.

Ongoing Audits:

Molina, AmeriHealth, HAP CareSource, Aetna, Meridian

**Program Compliance Committee Meeting
Utilization Management – Monthly Report
Marlena J. Hampton, MA, LPC – Director of Utilization Management
February 12, 2025**



Main Activities During This Period:

- UM Program Description and Evaluation
- Higher Levels of Care Updates
- Outpatient Authorization Updates

Progress On Major Activities:

Activity 1: UM Program Description and Evaluation

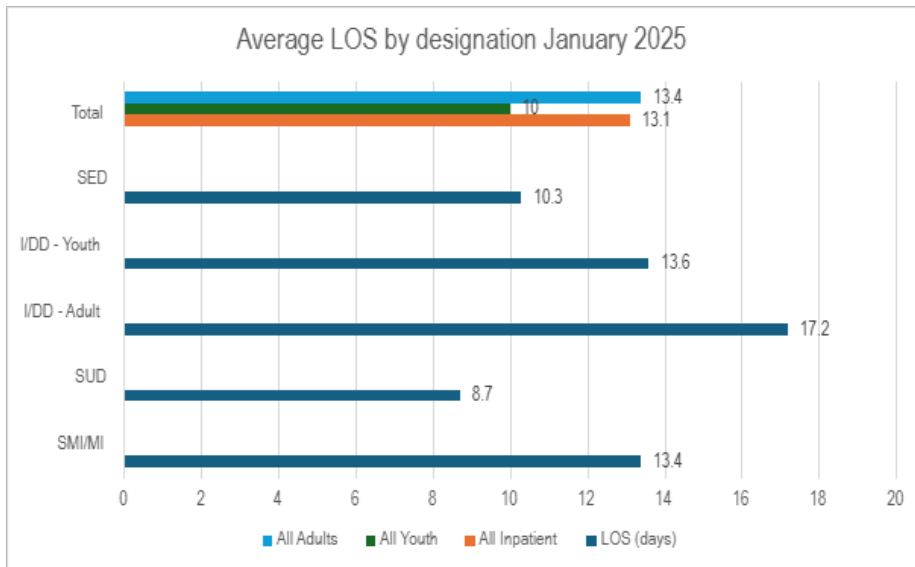
- *Description:* The UM Program Description provides a detailed explanation of the department's infrastructure, goals, and objectives. As a part of continuous quality improvement, the Utilization Management (UM) Program is evaluated annually and incorporated into the Quality Assurance Performance Improvement Plan (QAPIP).
- *Current Status:* The FY24 UM Program Evaluation was approved by the Quality Improvement Steering Committee (QISC) on January 28, 2025. It will be presented to the Program Compliance Committee (PCC) on February 12, 2025. The UM Program Description and its corresponding policies & procedures are still actively under review. Anticipated presentation of updates to PCC in March 2025, following review by the UM Committee and QISC.
- *Significant Tasks During Period:*
 - Completion of the FY24 UM Program Evaluation
 - Continued update of the UM Program Description and corresponding documents
- *Major Accomplishments During Period:* The UM Program Evaluation has been presented to and approved by the Utilization Management Committee (UMC) and Quality Improvement Steering Committee (QISC). The Director is meeting with UM Administrators, Quality, Strategic Operations, Integrated Healthcare, PIHP Crisis Services, and Health Homes (CCBHC) to ensure that the Program Description aligns with feedback from HSAG review, new guidelines from NCQA, MI Health Link ICO requirements, and PIHP/CMHSP contractual requirements.
- *Needs or Current Issues:* Utilization Management is present in all service areas, which necessitates frequent updates to our policies, procedures, and documentation. In anticipation of several directives being implemented by the Centers for Medicare and Medicaid (CMS) in 2025 & 2026, many reviewers and accrediting bodies are making extensive changes to their own guidelines. These changes have exposed significant areas for growth within our current description and evaluation, resulting in the director revamping the program description and evaluation. Additionally, changes in UM leadership over time have resulted in a less cohesive and untimely presentation of our department's structure, goals, and values.
- *Plans:* Director of Utilization Management, with support of VP of Clinical Operations, Director of Strategic Operations, and available consultants, continues review of the UM Work Plan, which will promote timeliness and influence the next steps in presenting Utilization Management in its best light.

Activity 2: Higher Levels of Care Updates

- *Current Status:* The Higher Levels of Care (HLOC) team manages the pre-authorized services of members requiring admission to acute inpatient psychiatric units, crisis residential services, and partial hospitalization programs. The UM Appeals Coordinator completes post-service clinical reviews for these levels of care.

A total of 1,032 admissions including Inpatient, MI Health Link, Partial Hospital and Crisis Residential were managed between 1/1/2025 and 1/30/25. This is an 8.3% decrease from 1,126 admissions managed in December 2024. As of 1/30/2025, the team managed a total of 628 new admissions across the provider network (including MI Health Link members). This is an 8.9% decrease from 690 new admissions in December 2024. Of the 1,032 total admissions, 200 members (19%) are unassigned to a Clinically Responsible Service Provider (CRSP).

- *Significant Tasks During Period:*
 - Review of Internal Auditing Tool for UM Clinical Specialists
 - Active Participation in Clinical Consultation for High Priority (e.g., At-Risk, Complex, or Recidivistic) Youth and Adults
- *Major Accomplishments During Period:*
 - UM HLOC Administrator has assumed reporting responsibilities and will now begin goal setting for this line of business and its staff.
 - Invitation from Integrated Healthcare Department to participate in data science pilot targeting inpatient psychiatric admissions.
- *Needs or Current Issues:*
 - Review of criteria and referral processes for state hospitalization and Intensive Community Transition Services (ICTS) program.
 - As noted in the graph below, members on inpatient units with a primary disability designation of Intellectual/Developmental Disability (I/DD) have a longer average length of stay than other designations. This is a consistent finding, despite lower admission numbers for this population. It is hypothesized that there are fewer staff in emergency departments to make an appropriate level of care determination, fewer qualified staff and physicians on inpatient units to manage symptoms & behaviors, and limited discharge planning resources.



- *Plans:* The UM Director and HLOC Administrator will review a sample of treatment episodes for this population, particularly those who may be recidivistic. Goals will include audit of pre-admission reviews, consultation with Adult & Children’s Initiatives, review of service utilization and CRSP connection, and communication with UM Committee to determine if a specific project or improvement plan is warranted.

Activity 3: Outpatient Authorization Updates

- *Description:* DWIHN Utilization Management reviews standard and expedited authorization requests for several lines of business, including Outpatient and SUD.
- *Current Status:* Based on historic over & underutilization data, Utilization Management develops Service Utilization Guidelines (SUGs) for behavioral health requests – a group of pre-approved services for members with similar needs. The remaining authorization requests are manually approved by UM staff. The process also includes review of assessments, the person-centered planning process, and the Individual Plan of Service (IPOS). In addition to SUGs, the department periodically revisits internal procedures to improve efficiency of utilization review and decrease/eliminate delays in service delivery or authorization.
- *Significant Tasks During Period:*
 - Initiation of non-clinical Quality Impact Assessment (QIA) for timeliness of non-urgent, preservice authorization decisions, with the goal of decreasing decision time to seven (7) calendar days. UM Director and Administrator receive relevant NCQA standards and schedule meeting with Quality and consultants for technical assistance.
 - Communication with Health Homes Department on incorporation of CCBHC requirements into UM program, including SUGs and post-service reviews.

- *Major Accomplishments During Period:*
 - Collaboration with Customer Service Due Process Manager to update member adverse benefit determination notices to reflect HSAG review feedback and Integrated Care Organization (ICO) reporting requirements.
- *Needs or Current Issues:* Beginning in 2026, payers will be required to make decisions for all standard, non-urgent requests within seven (7) calendar days. We currently are allotted fourteen (14) days to make the same determinations. Utilization Management, with support from the VP of Clinical Operations, Chief Medical Officer, and IT Department, are actively working to implement process and procedural changes to meet this new requirement for all authorization requests.
- *Plans:*
 - The Director will review the most frequently requested services, review trends, and determine the need for an update of Service Utilization Guidelines.
 - The Director and Administrator will develop standard, written procedures for staff to promote uniform dispositions & response to authorization requests.

Additional Updates:

- **Things the Department is Doing Especially Well:**
 - Self-Directed Services (SD) Team is invited to participate in Partners Advancing Self-Determination (PAS), a collaboration with MDHHS to offer free state-level technical assistance, training, and support to advance self-directed services in our community.
 - Habilitation Supports Waiver (HSW) continues to exceed MDHHS requirement of 95% program slot utilization.
 - Collaboration with the Health Homes Department on the implementation of CCBHC requirements into UM program.
- **Identified Opportunities for Improvement:**
 - Collaboration with other DWIHN departments on common reporting and projects, particularly PIHP Crisis Services.
 - Implementation of Annual Health Equity Analysis of UM Policies and Procedures.
- **Progress on Previous Improvement Plans:**
 - Director of Utilization Management continues intensive review of UM policies, procedures, and program description. Goals include alignment of documentation with NCQA, HSAG, and PIHP/CMSHP contract requirements & feedback.
 - The department has submitted its HSAG Corrective Action Plan for approval.

**DETROIT WAYNE INTEGRATED HEALTH NETWORK
BOARD ACTION**

Board Action Number: 21-64R3 Revised: Requisition Number:

Presented to Full Board at its Meeting on: 2/19/2025

Name of Provider: Detroit Wayne Integrated Health Network

Contract Title: COVID-19 MH BG Supplemental

Address where services are provided: 'None'

Presented to Program Compliance Committee at its meeting on: 2/12/2025

Proposed Contract Term: 2/1/2025 to 3/14/2025

Amount of Contract: \$ 174,620.00 Previous Fiscal Year: \$ 483,340.00

Program Type: Continuation

Projected Number Served- Year 1: 500 Persons Served (previous fiscal year): 2000

Date Contract First Initiated: 10/1/2020

Provider Impaneled (Y/N)?

Program Description Summary: Provide brief description of services provided and target population. If propose contract is a modification, state reason and impact of change (positive and/or negative).

The board action is to request approval to utilize carryover funding from FY24, awarded in support of BA 21-64R3 - Detroit Wayne Integrated Health Network's (DWIHN's) COVID-19 Mental Health Block Grant Supplemental Funding for Mental Health Connections, Training, and Outreach.

DWUHN will implement projects focusing on connecting individuals to care through services and education. Strong emphasis will be placed on the use of systems navigator and data. DWUHN will enter into several comp source agreements with vendors to execute the approved projects. This is for operation of a warm line, mental health awareness training, to address any mental health issues for individuals, and events.

Healthy Choices Community Center Counseling LLC/Kimberly Walton - Reach Us Detroit Agents/Training - \$48,000

\$42,438k Downriver Community Conference - Training/Events

Other (event space other support services): \$30,000

Indirect Cost \$22,776

Employee Travel and Training \$11,406

Educational Supplies \$20,000

The carryover not to exceed amount is \$174,620 with the time extended to March 14, 2025.

Outstanding Quality Issues (Y/N)? N If yes, please describe:

Source of Funds: Block Grant

Fee for Service (Y/N): N

| Revenue | FY 24/25 | Annualized |
|----------------------|---------------|---------------|
| Block Grant | \$ 174,620.00 | \$ 174,620.00 |
| | \$ | \$ |
| Total Revenue | \$ | \$ |

Recommendation for contract (Continue/Modify/Discontinue): Continue

Type of contract (Business/Clinical):

ACCOUNT NUMBER: 64933.822608.07100

In Budget (Y/N)?

Approved for Submittal to Board:

James White, Chief Executive Officer

Stacie Durant, Vice President of Finance

Signature/Date:

Signature/Date:

James White

Stacie Durant

Signed: Friday, February 7, 2025

Signed: Thursday, February 6, 2025

2/7/2025 10:49:07 AM

2/6/2025 10:24:41 AM

Board Action #: 21-64R3

DETROIT WAYNE INTEGRATED HEALTH NETWORK BOARD ACTION

Board Action Number: 23-15R2 Revised: Y Requisition Number: 14,187

Presented to Full Board at its Meeting on: 2/19/2025

Name of Provider: WIT, Inc

Contract Title: DWC Training Platform - Contract Extension2

Address where services are provided: None

Presented to Program Compliance Committee at its meeting on: 2/12/2025

Proposed Contract Term: 1/1/2025 to 9/30/2025

Amount of Contract: \$ 1,926,915.47 Previous Fiscal Year: \$ 1,517,948.00

Program Type: Continuation

Projected Number Served- Year 1: 60,000 Persons Served (previous fiscal year): 60000

Date Contract First Initiated: 10/1/2018

Provider Impaneled (Y/N)?

Program Description Summary: Provide brief description of services provided and target population. If propose contract is a modification, state reason and impact of change (positive and/or negative).

Detroit Wayne Integrated Health Network (DWIHN) is requesting approval to extend terms of service to 9/30/25 with additional funds of \$408,967.47. Approximately \$60,000 was included in the budget. A budget adjustment is forthcoming for the balance.

Comparable Source contract extension between the Detroit Wayne Integrated Health Network (DWIHN) and WIT, Inc for an **amount to not exceed \$1,926,915.47.**

WIT has provided the primary operations/services package for the operations of Detroit Wayne Connect (DWC)(formerly VCE). The system, referred to as "TAP" supports the entire training product for DWC. This includes:

- Support for all Computer-Based-Training for DWC Customers, including the entire DWIHN network of organizations and staff
- Support for all Event Planning needs for face-to-face training and other supporting communications and events
- The registration process for staff participating in training
- The tracking of all training for individuals and organizations in the DWIHN network
- The billing process for DWC customers
- The system used for management of DWC website

Outstanding Quality Issues (Y/N)? N If yes, please describe:

Source of Funds: Multiple

Fee for Service (Y/N): Y

| Revenue | FY 24/25 | Annualized |
|----------------------|-----------------|-----------------|
| MULTIPLE | \$ 1,926,915.47 | \$ 1,926,915.47 |
| | \$ | \$ |
| Total Revenue | \$ | \$ |

Recommendation for contract (Continue/Modify/Discontinue): Modify

Type of contract (Business/Clinical): Business

ACCOUNT NUMBER: 64934.827211.00000

In Budget (Y/N)? N

Approved for Submittal to Board:

James White, Chief Executive Officer

Stacie Durant, Vice President of Finance

Signature/Date:

Signature/Date:

James White

Stacie Durant

Signed: Tuesday, January 28, 2025

Signed: Friday, January 24, 2025

DETROIT WAYNE INTEGRATED HEALTH NETWORK BOARD ACTION

Board Action Number: 23-57R4 Revised: Y Requisition Number:

Presented to Full Board at its Meeting on: 2/19/2025

Name of Provider: Bizanalytix Technologies LLC

Contract Title: Claims Audit and Utilization Review Systems (CAURS) and Information Technology Consulting

Address where services are provided: 6837 Dulles Dr. Powell, OH 43065

Presented to Program Compliance Committee at its meeting on: 2/12/2025

Proposed Contract Term: 3/1/2023 to 2/28/2026

Amount of Contract: \$ 579,600.00 Previous Fiscal Year: \$ 327,600.00

Program Type: Continuation

Projected Number Served- Year 1: 3 Persons Served (previous fiscal year): 0

Date Contract First Initiated: 3/1/2023

Provider Impaneled (Y/N)? N

Program Description Summary: Provide brief description of services provided and target population. If propose contract is a modification, state reason and impact of change (positive and/or negative).

This revised board action is requesting to exercise the second of two, one-year renewal options, extending the contract for CAURS to February 28, 2026 for an additional \$84,000 (2nd of two, one-year renewal options).

The revision also includes renewing Development and Consulting services effective 3/1/25 - 2/28/26 in the amount of \$96,000 and \$72,000 for retroactive services from 6/1/24-2/28/25.

The revised not to exceed contract not to exceed amount totals \$579,600 through February 28, 2026.

The Claims Audit and Utilization Review System (CAURS) unlike claim processing subsystems that process one claim at a time, CAURS can be used to analyze post payment data for multiple claims at a time to identify suspicious provider billing patterns along with conducting audit both internally as well as externally working with providers. DWIHN is able to identify adjudication and billing errors, and overpayments.

The reports generated by the system will be used to assist in the detection of program fraud and abuse, monitor quality of services, and provide a function for the development of program policy.

Outstanding Quality Issues (Y/N)? N If yes, please describe:

Source of Funds: Multiple

Fee for Service (Y/N): N

| Revenue | FY 24/25 | Annualized |
|----------------------|-----------------|-------------------|
| Multiple | \$ 579,600.00 | \$ 579,600.00 |
| | \$ | \$ |
| Total Revenue | \$ | \$ |

Recommendation for contract (Continue/Modify/Discontinue): Continue

Type of contract (Business/Clinical): Business

ACCOUNT NUMBER: 00000.137003.00000

In Budget (Y/N)? Y

Approved for Submittal to Board:

James White, Chief Executive Officer

Stacie Durant, Vice President of Finance

Signature/Date:

Signature/Date:

James White

Stacie Durant

Signed: Friday, February 7, 2025

Signed: Tuesday, February 4, 2025

DETROIT WAYNE INTEGRATED HEALTH NETWORK BOARD ACTION

Board Action Number: 25-24R Revised: Y Requisition Number:

Presented to Full Board at its Meeting on: 2/19/2025

Name of Provider: Acorn Health

Contract Title: Autism Service Providers

Address where services are provided: 'None'

Presented to Program Compliance Committee at its meeting on: 2/12/2025

Proposed Contract Term: 10/1/2024 to 9/30/2025

Amount of Contract: \$ 92,649,972.00 Previous Fiscal Year: \$ 91,807,643.00

Program Type: Continuation

Projected Number Served- Year 1: 2,600 Persons Served (previous fiscal year): 2,473

Date Contract First Initiated: 10/14/2024

Provider Impaneled (Y/N)? Y

Program Description Summary: Provide brief description of services provided and target population. If propose contract is a modification, state reason and impact of change (positive and/or negative).

Requesting revision to board action for DWIHN Board to approve 3 new ABA Providers to receive a (1) one year contract for FY25 (October 1, 2024 - September 30, 2025) to deliver Applied Behavior Analysis (ABA) and Autism Evaluations. **The total projected budget for autism services for FY25 remains unchanged and is not to exceed \$92,649,972.**

The 3 new ABA Providers are: Akoya Behavioral Health, Brightview Care, and 8th Palace (DBA KDcare Community ABA Services).

21 Current ABA Providers: Acorn Health of Michigan, LLC, Advanced ABA Care, Affable Home Healthcare (DBA Attendant Care Autism Services), Autism Spectrum Therapies of Michigan (DBA Total Spectrum), Behavior Frontiers, Centria Healthcare, Chitter Chatter P.C., Dearborn Speech and Sensory Center, Inc. (DBA Metro EHS), Emagine Health Services, LLC, Gateway Pediatric Therapy, HealthCall of Detroit, Illuminate ABA Services, LLC, IOA, LLC, Lumen Pediatric Therapy, LLC, Open Door Living Association Inc., Patterns Behavioral Services Michigan, Inc, Peak Autism Center, Positive Behavior Supports Corp., SEB Connections (DBA Merakey Inc.), Strident Healthcare, Zelexa, LLC

3 Current Independent Evaluator Providers: Social Care Administrator's, LLC (DBA McCrory Center), Sprout Evaluation Center, LLC, The Children's Center of Wayne County.

The amounts listed for each provider are estimated based on prior year activity and are subject to change. Amounts may be reallocated amongst providers without board approval.

Outstanding Quality Issues (Y/N)? Y If yes, please describe:

Source of Funds: Medicaid, General Fund

Fee for Service (Y/N): Y

| Revenue | FY 24/25 | Annualized |
|----------------------|-------------------------|-------------------------|
| Medicaid | \$ 92,149,972.00 | \$ 92,149,972.00 |
| State General | \$ 500,000.00 | \$ 500,000.00 |
| Total Revenue | \$ 92,649,972.00 | \$ 92,649,972.00 |

Recommendation for contract (Continue/Modify/Discontinue): Continue

Type of contract (Business/Clinical): Clinical

ACCOUNT NUMBER: 64940.827010.00000

In Budget (Y/N)? Y

Approved for Submittal to Board:

James White, Chief Executive Officer

Stacie Durant, Vice President of Finance

Signature/Date:

Signature/Date:

James White

Stacie Durant

Signed: Tuesday, February 4, 2025

Signed: Tuesday, February 4, 2025

2/4/2025 10:35:52 AM

2/4/2025 10:31:47 AM

DETROIT WAYNE INTEGRATED HEALTH NETWORK BOARD ACTION

Board Action Number: 25-08 Revised: Requisition Number:

Presented to Full Board at its Meeting on: 2/19/2025

Name of Provider: Detroit Wayne Integrated Health Network

Contract Title: CCBH-25: ACT/ IDDT and Behavioral Health Workforce Stabilization Support

Address where services are provided: Provider Network

Presented to Program Compliance Committee at its meeting on: 2/12/2025

Proposed Contract Term: 10/1/2024 to 9/30/2025

Amount of Contract: \$ 606,282.00 Previous Fiscal Year: \$ 606,282.00

Program Type: New

Projected Number Served- Year 1: 1,600 Persons Served (previous fiscal year): 1600

Date Contract First Initiated: 10/1/2023

Provider Impaneled (Y/N)?

Program Description Summary: Provide brief description of services provided and target population. If propose contract is a modification, state reason and impact of change (positive and/or negative).

This board action is requesting the approval to receive and disburse MDHHS incentive grants directed towards attracting, recruiting and retaining ACT and dual ACT/IDDT team members, and rewarding those already performing this work and DWIHN staff that have remained with the organization during and beyond the COVID pandemic.

DWVHN will enter into several comparable source agreements with vendors to carryout the approved projects. Funds can be reallocated between providers based on utilization up to the amount not to exceed \$538,282 for the fiscal year ended September 30, 2025 related to the ACT/IDDT Providers \$538,282

The board action also include the MDHHS Behavioral Health Workforce Stabilization Support \$68,000. The total amount of the board action is \$606,282 for the fiscal year September 30, 2025.

Outstanding Quality Issues (Y/N)? N If yes, please describe:

Source of Funds: Block Grant

Fee for Service (Y/N): N

| Revenue | FY 24/25 | Annualized |
|----------------------|-----------------|-------------------|
| Block Grant | \$ 606,282.00 | \$ 606,282.00 |
| | \$ | \$ |
| Total Revenue | \$ | \$ |

Recommendation for contract (Continue/Modify/Discontinue): Continue

Type of contract (Business/Clinical): Clinical

ACCOUNT NUMBER: MULTIPLE

In Budget (Y/N)? Y

Approved for Submittal to Board:

James White, Chief Executive Officer

Stacie Durant, Vice President of Finance

Signature/Date:

Signature/Date:

James White

Stacie Durant

Signed: Monday, February 3, 2025

Signed: Monday, February 3, 2025

2/3/2025 5:38:42 PM

2/3/2025 3:07:17 PM

DETROIT WAYNE INTEGRATED HEALTH NETWORK BOARD ACTION

Board Action Number: 25-55 Revised: Requisition Number:

Presented to Full Board at its Meeting on: 2/19/2025

Name of Provider: Starfish Family Services

Contract Title: Michigan Child Collaborative Care Program (MC3) and Behavioral Health Consultant

Address where services are provided: 3000 Hiveley Road Inkster MI 48141'

Presented to Program Compliance Committee at its meeting on: 2/12/2025

Proposed Contract Term: 10/1/2024 to 9/30/2025

Amount of Contract: \$ 102,521.00 Previous Fiscal Year: \$ 96,636.00

Program Type: Continuation

Projected Number Served- Year 1: 850 Persons Served (previous fiscal year): 840

Date Contract First Initiated: 6/1/2015

Provider Impaneled (Y/N)? Y

Program Description Summary: Provide brief description of services provided and target population. If propose contract is a modification, state reason and impact of change (positive and/or negative).

This board action is requesting the approval of a one year contract for an amount not to exceed \$102,521. The Michigan Child Collaborative Care Program and Behavioral Health Consultant Project provides behavioral health consultation for local primary care providers with MC3 child, adolescent and prenatal psychiatrists. Starfish Family Services provides local oversight, in collaboration with MC3 program, of the Behavioral Health Consultant as they implement MC3 in Wayne County as well as work in concert with other regional Behavioral Health Consultants.

A sum of an amount not to exceed \$92,362 will be provided to Starfish Family Services to offer behavioral health consultant services for the FY 2025 period. This provider was selected because they were already implementing integrated health care services through a Flynn Grant. When the grant ended, MDHHS asked that DWIHN continue to use this organization. **The remaining \$10,159 is allocated for DWIHN administrative costs.** Starfish Family Services Behavioral Health Consultant will act as the liaison with the primary care physician staff and the University of Michigan psychiatric staff.

Services include:

- Regional Outreach to eligible providers to ensure utilization of the MC3 program;
- Linkage between Primary Care Providers and MC3 Psychiatrist;
- Coordination of care for children, adolescents, and perinatal women;
- Behavioral Health Consultant provides consultation services in designated primary care site; and
- Collection of required data and local utilization to facilitate the project evaluation.

Outstanding Quality Issues (Y/N)? N If yes, please describe:

Source of Funds: Other

Fee for Service (Y/N): N

| Revenue | FY 24/25 | Annualized |
|----------------------|-----------------|-------------------|
| State Grant | \$ 102,521.00 | \$ 102,521.00 |
| | \$ | \$ |
| Total Revenue | \$ | \$ |

Recommendation for contract (Continue/Modify/Discontinue): Continue

Type of contract (Business/Clinical): Clinical

ACCOUNT NUMBER: 64933.822608.01021

In Budget (Y/N)? Y

Approved for Submittal to Board:

James White, Chief Executive Officer

Stacie Durant, Vice President of Finance

Signature/Date:

Signature/Date:

James White

Stacie Durant

Signed: Tuesday, January 28, 2025

Signed: Thursday, January 16, 2025

Executive Summary

Director of Quality Improvement

Quality Assurance Performance Improvement Plan (QAPIP) Description FY 2023-2025

The QAPIP Plan Description for the Fiscal Years 2023 to 2025 provides a comprehensive overview of the strategic initiatives we intend to implement during this two-year period. These initiatives are designed to address key areas for improvement while aligning with our organizational goals. To ensure regulatory compliance and keep the plan current, our bylaws require a thorough annual review. This review process allows us to assess our progress, identify areas needing adjustments, and incorporate any new regulations or best practices that have emerged.

In this updated version of the plan, the Board will certainly notice the improvements in overall quality. While this report will not cover every single update in this presentation, it will emphasize that significant enhancements have been made in each section. The updated plan now includes more detailed information about our objectives, targeted strategies, expected outcomes, and metrics for measuring success. As you review the updated document, you will see these improvements in clarity and overall quality.

QAPIP Annual Evaluation FY2024

The QAPIP Annual Evaluation is a report prepared at the end of each Fiscal Year. It provides a comprehensive assessment of the performance outcomes from the previous year, evaluating our goals and objectives. The report analyzes the effectiveness of various initiatives and strategies implemented during that time. It includes key metrics, highlights our successes, and identifies areas for improvement, ensuring transparency and accountability in our operations. For a complete list of our goals and outcomes, please refer to page 90 of the QAPIP Evaluation, which offers a clear overview of how we measured against our strategic objectives. Below, I've summarized key focus areas for fiscal year 2025 and highlighted specific initiatives where DWIHN excelled during FY2024.

Key Focus Areas FY2025:

- **Adult Recidivism.** We need to evaluate the current rates of repeat admissions among adults and explore effective strategies to reduce these rates, including outpatient prevention programs and support services.
- **Performance Improvement Projects.** We had six (6) Performance Improvement Projects where we were unsuccessful at meeting the established goals. It is essential to assess the effectiveness of our current performance improvement initiatives. We should identify any gaps in these projects and consider new approaches to enhance overall performance and outcomes.
- **Compliance with Home and Community-Based Services.** We must ensure that our services meet all regulatory requirements and effectively support individuals in their home and community environments. This includes reviewing our compliance measures and identifying any areas needing improvement.

QAPIP Annual Evaluation FY2024

Specific initiatives in which DWIHN truly excelled during the year:

- **Performance Indicators (PI) Data**
 - PI#1 measures (Pre-Admission Screening within three hours for both children and adults). DWIHN exceeded the 95% standard for children and adults each quarter over the past year.
 - PI#3 assesses (Timeliness of access to services). DWIHN had some of the highest rates among all the PIHPs in the state.
 - PI#4a (Hospital after hospitalization), and 4b (SUD Detox Discharge Follow-Up). DWIHN exceeded the 95% standard each quarter for the past year.
 - PI#10, (Inpatient recidivism rates for children). This standard was met each quarter apart from Q3.
- **External Quality Reviews (HSAG)**
 - **Performance Measures Validation (PMV) and Network Adequacy Validation (NAV);** DWIHN achieved full compliance for both the PMV and NAV this year, with no plan for correction. This marks the third consecutive year of full compliance on the PMV and the first year for the NAV.
 - **PIP: Reducing the Racial Disparity of African Americans in follow-up within 7 days;** DWIHN preliminary data for calendar Year 2024 shows a disparity gap of 4.46%. The baseline data is 4.51%.

Executive Summary

Director of Quality Improvement

QAPIP Work Plan FY2025

The QAPIP Work Plan FY2025, located on page 60 of the QAPIP Plan Description, offers a detailed overview of our performance objectives for the upcoming fiscal year. This work plan highlights the goals we have successfully achieved as well as those that still need improvement. It is designed to help us stay focused on enhancing our overall performance in the coming year.



DWIHN
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Detroit Free Press
DETROIT HEALTHCARE NETWORK

Utilization Management Annual Program Evaluation FY 2024

Marlena J. Hampton, MA, LPC
Director of Utilization Management
February 12, 2025



Reporting Elements

- I. Status of Utilization Management Program Goals
- II. Opportunities for Improvement in FY 2025



Six pillars



Pillar 1
Customer



Pillar 2
Quality



Pillar 3
Advocacy



Pillar 4
Talent
Engagement



Pillar 5
Access



Pillar 6
Finance



Information Technology



Customer Service Pillar

- **UM Program Description Goal A:** Utilize Provider and Practitioner Satisfaction Surveys related to service access and Utilization Management, make recommendations for improvement regarding service provision, treatment experiences and outcomes.

2024 Goal Status: **Partially Met**

- **UM Program Description Goal B:** Enhance provider satisfaction by ensuring a more meaningful experience through use of customer service driven language to improve network relationships.

2024 Goal Status: **Met**



Customer Service – Results & Opportunities



Results

- Department coordination of care efforts identified as “average” in provider satisfaction survey.
- 64% of respondents rated the ability to reach and have access to knowledgeable UM staff from “good” to “excellent.” (N=37)

Opportunities

- Provide clearer definition of Utilization Management and its functions.
- Consolidate department communication, including reintroduction of dedicated phone line w/voice mail.
- Create inboxes or other forms of communication unique to each line of business.



CS Highlight: Self-Directed Services

Self-Directing Services (SD) is a partnership between DWIHN and members using specialty mental health services.

- It is a method of service delivery that shifts budget authority and control of services to the person, as identified in their Individual Plan of Service (IPOS).
- Based on services authorized in the IPOS, the member will select qualified service providers of their choice. The costs of services will be outlined in an individual budget and managed by the person through a Financial Management Service(FMS).
- There are currently about 1,281 members who self-direct their services.
- Team identified goals for FY 25 include data and education on the use of support brokers.



Access Pillar

- **UM Program Description Goal C:** Evaluate DWIHN’s UM Program Description to assure effective and efficient utilization of behavioral health services identifying any barriers, analyzing metrics, utilization trends and quality of care concerns.

2024 Goal Status: **Partially Met**

- ***UM Program Description Goal D:*** Monitor the use of specialty behavioral health waiver programs: Autism- Spectrum-Disorder (ASD) benefit, Habilitation and Supports Waiver (HAB), Children’s Waiver Program (CWP) and Serious Emotional Disturbances Waiver (SED) through the development and on-going review of DWIHN policies and procedures and monthly monitoring reports.

2024 Goal Status: **Met**



Access Pillar (cont.)

- **UM Program Description Goal E:** Analyze other populations served, examining services received and services available to identify any gaps.

2024 Goal Status: **Met**



Access - Highlights & Opportunities

Highlights

- Habilitation Supports Waiver (HSW) program consistently exceeds MDHHS requirement of 95% slot utilization, resulting in allotment of 41 additional slots on 10/1/24. We are now able to serve 1,125 members.
- Revision of the General Fund Benefit Grid
- Interdepartmental collaboration to explore targeted interventions for managing recidivism.
- MHWIN updates: provider notifications are now automatically sent, when a request is returned for revisions or additional information.

Opportunities

- Health Equity Analysis of UM Policies and Procedures
- Final review and entry of SUD Service Utilization Guidelines
- Monitoring & update of outpatient workflow/procedures in preparation for changes in decision timelines for all standard, non-urgent requests
- Improved depth of reporting for higher levels of care, including greater collaboration with Crisis Services



UM Health Equity Analysis

- The Centers for Medicare and Medicaid (CMS) postulates that prior authorization policies and procedures may have a disproportionate impact on underserved populations and may delay or deny access to certain services.
- In response, a final rule is established to ensure that organizations analyze their utilization management (UM) policies and procedures from a health equity perspective.
- Requirements:
 1. At least one member of the UM committee has expertise in health equity
 2. The UM committee conducts annual health equity analysis of prior authorization policies and procedures used
 3. The results of the analysis be made publicly available on the plan's website.
- Goal: To create additional transparency and identify disproportionate impacts of UM policies and procedures on enrollees.
- Progress/Next Steps: DWIHN's DEI Director has joined the UM Committee, as of 8/1/24. UM Director will initiate a subgroup with DEI Director and relevant departments to focus on how this analysis will be completed



Finance Pillar

- **UM Program Description Goal F:** Promote collaboration and provide guidance to the system by identifying patterns of behavioral health service utilization by funding source and by monitoring over and underutilization of services using dashboards.

2024 Goal Status: **Partially Met**

- **UM Program Description Goal G:** Develop a system that helps track over- and underutilization

2024 Goal Status: **Partially Met**



Finance - Highlights & Opportunities

Highlights

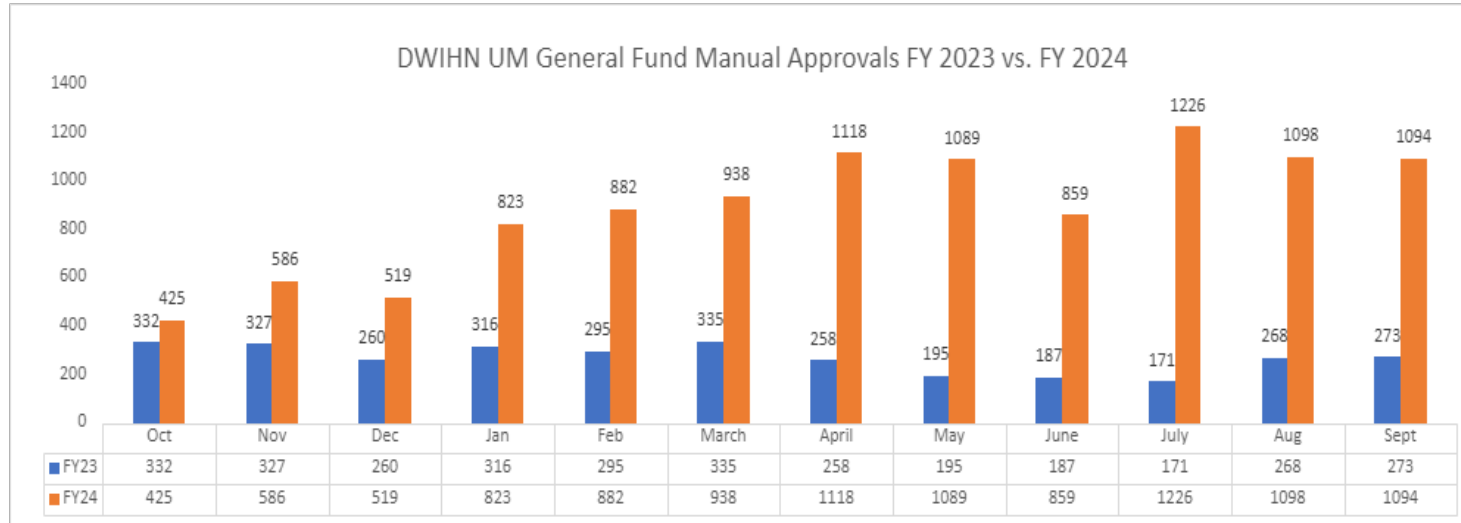
- Revision of the General Fund Benefit Grid
- Addition of ACT Services Utilization to UM Committee Reporting

Opportunities

- Develop a clear procedure & timeline for tracking over and underutilization.
- Intensive review of utilization data and adjust SUGs for FY 25
- Monitoring authorization requests & conferring with CRSPs for members with Medicaid spenddown (deductible).



General Fund Exception



Actions & Next Steps

- Reducing benefit plan to a menu of essential services
- Educating DWIHN departments & provider network on CCBHC and managing Medicaid spenddown (if applicable)
- Develop a progress report for VPs of Clinical Operations & Finance



Talent Management (formerly Workforce) Pillar

- **UM Program Description Goal H** - Assure fair and consistent UM/review decisions based on MCG, Local Coverage Determination (LCD), National Coverage Determination (NCD) and/or American Society of Addiction Medicine (ASAM) medical necessity criteria by monitoring the application of the applied criteria and service authorizations for behavioral health services (including substance use disorders) using a standard inter rater reliability process system wide.

2024 Goal Status: **Met**



Talent Management - Highlights

- Milliman Care Guidelines (MCG) criteria is used by crisis screening entities, ACT programs, and UM staff to determine the appropriate level of care for our members.
- DWIHN UM and its delegates are tested annually via MCG's interrater reliability (IRR) module to ensure consistent application of the guidelines and medical necessity criteria.



Quality Pillar

- **UM Program Description Goal I:** Monitor the effectiveness of processes that promote clinical review procedures established from accrediting and regulatory agencies by evaluating the efficiency of targeted metrics during UM activities through interdepartmental collaboration.
- **UM Program Description Goal J:** Provide oversight of delegated UM functions through use of policies that reflect current practices, standardized/inter-rater reliability procedures and tools, pre-service, concurrent and post-service (retrospective) reviews, data reporting (i.e. timeliness of UM decisions and notifications), outcome measurements and remedial activities.

2024 Goal Status: **Partially Met**



Quality - Highlights & Opportunities

Highlights

- All delegated entities met the timeliness threshold of 90% for urgent, preservice decisions.
- Monthly audits of Pre-Admission Review (PAR) documents, including feedback on findings and training opportunities for screening entities.

Opportunities

- Consolidate process for annual review and reporting for UM delegates, in conjunction with Crisis Services.
- Increase dialogue with screening entities regarding needs and performance improvement activities.



Timeliness of UM Decision-Making

| | Michigan Peer Review Organization |
|--------------|-----------------------------------|
| Numerator* | 54 |
| Denominator# | 55 |
| Rate | 98.2% |

| | COPE | The Guidance Center | New Oakland Family Centers | The Children's Center** |
|-------------|--------|---------------------|----------------------------|-------------------------|
| Numerator | 10,013 | 1,551 | 1,006 | 104 |
| Denominator | 10,294 | 1,561 | 1,066 | 106 |
| Rate | 97.3% | 99.4% | 94.4% | 98.1% |



Advocacy Pillar

UM Program Description Goal K: Promote need for enhanced use of Social Determinants of Health in making clinical decisions within standardized guidelines as part of the clinical review process.

2024 Goal Status: **Met**



Advocacy - Highlights

- DWIHN continues its membership in the Michigan Consortium for Healthcare Excellence.
- Milliman Care Guidelines (MCG) criteria, used to determine member medical necessity for higher levels of care, continues to expand their Social Determinants of Health module within their Indicia product.



The Foundation: Information Technology

- **MHWIN Continued Stay Review/Discharge Form** - Updates included data points for involuntary admissions, addition of information buttons with instructions for each section, discharge summaries being fully completed by the provider.
- **Updates to UM SSRS Reporting** - During FY24, the UM production queue has been updated to include additional reporting for inpatient length of stay and recidivism.
- **Outpatient Authorization Queue** - MHWIN now sends reminders to providers following returned authorization requests. Additionally, if no response is received, the case will be denied by the system at the end of 14 days.
- **Service Utilization Guidelines** – The Service Utilization Guidelines module has been updated to include SUD ASAM criteria, in anticipation of introducing SUGs for this line of business.



Department Goals & Opportunities for FY 2025

- Incorporating CCBHC requirements into UM program, including SUGs, by end of the 1st Quarter.
- Annual Health Equity Analysis of UM Policies and Procedures
- Review over and underutilization reports, establish schedule of reporting prioritized data for FY25.
- Procedural & IT updates to meet CY 2026 requirement for all standard, non-urgent request decisions within seven (7) calendar days.
- Consolidate process for annual review and reporting for UM delegates.
- Collaborate with other DWIHN departments on common reporting and projects.
- Increased focus on trends & impact, after reestablishing baselines.

