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FULL BOARD
Wednesday, March 16, 2022
707 W. Milwaukee
2nd Floor
Detroit, Michigan 48202
1:00 P.M
AGENDA

I. CALL TO ORDER

II. ROLL CALL

III. APPROVAL OF THE AGENDA

IV. MOMENT OF SILENCE

V. APPROVAL OF BOARD MINUTES – Full Board Meeting – February 16, 2022

VI. RECEIVE AND FILE – Approved Finance Committee Minutes – February 14, 2022
Approved Program Compliance Committee Minutes –February 9, 2022

VII. ANNOUNCEMENTS
A) Network Announcements
B) Board Member Announcements

VIII. PUBLIC AFFAIRS ASSOCIATES (PAA) – Legislative Update

IX. BOARD COMMITTEE REPORTS
A) Board Chair Report
1) Update Board Member Appointments - City of Detroit and Wayne County
2) National Council for Wellbeing – NatCon22 April 11th -13th 2022 National Harbor, Washington D.C.
3) Chamber of Commerce Policy Conference - May 31 – June 3, 2022 Mackinac Island, Michigan
4) Community Mental Health Association of Michigan Annual Summer Conference – June 6th – June 8th – Grand Traverse, Michigan
5) Community Mental Health Association of Michigan (CMHAM) Metro Region Officer Vacancy

B) Executive Committee
1) Board Study Session Recap - February 23, 2022
2) Update Annual Report to the Commission
3) Update Annual Meeting
4) Metro Region Meeting – DWIHN Host (April, 2022)

C) Finance Committee
D) Program Compliance Committee
E) Recipient Rights Advisory Committee

X. SUBSTANCE USE DISORDER OVERSIGHT (SUD) POLICY BOARD REPORT

XI. SUBSTANCE USE DISORDER OVERSIGHT (SUD) POLICY BOARD BYLAWS

XII. AD HOC COMMITTEE REPORTS
A) Policy/Bylaw Committee

XIII. PRESIDENT AND CEO MONTHLY REPORT

XIV. QUALITY ASSURANCE PERFORMANCE IMPROVEMENT PLAN (QAPIP) ANNUAL EVALUATION FY 2021 *(Program Compliance)*

XV. QUALITY ASSURANCE PERFORMANCE IMPROVEMENT (QAPIP) WORK PLAN FY 2022 *(Program Compliance)*

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XVI. UNFINISHED BUSINESS

Staff Recommendations:

A. BA #21-71 (Revision) Leadership Training, American Society of Employers *(Finance)*
B. BA #22-12 (Revision 3) DWIHN FY 2021/2022 Operating Budget *(Finance)*
C. BA #22-16 (Revised) Substance Use Disorder (SUD) Prevention Funding – DWIHN's Provider Network *(Program Compliance)*
D. BA #22-17 (Revision) Substance Use Disorder (SUD) Treatment Funding FY2022 *(Finance)*
E. BA #22-17 (Revision 1) Substance Use Disorder (SUD) Treatment Services Network FY2022 *(Finance)*

XVII. NEW BUSINESS

Staff Recommendations:

A. BA #22-46 – Behavioral Health Home – Arab Community Center for Economic and Social Services (ACCESS) *(Program Compliance)*
B. BA #22-58- Temporary Mobile Office Unit *(Executive Committee)*

XVIII. PROVIDER PRESENTATION – Detroit Recovery Project

XIX. REVIEW OF ACTION ITEMS

XX. GOOD & WELFARE/PUBLIC COMMENT/ANNOUNCEMENTS

Members of the public are welcome to address the Board during this time for no more than two 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 general public 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).

XXI. ADJOURNMENT

DETROIT WAYNE INTEGRATED HEALTH NETWORK
FULL BOARD MEETING
Meeting Minutes
Wednesday, March 16, 2022
1:00 pm.

BOARD MEMBERS PRESENT

Angelo Glenn, Chairperson
Kenya Ruth, Vice Chairperson
Dora Brown, Treasurer
Dr. Cynthia Taueg, Secretary
Dorothy Burrell
Michelle Jawad
Commissioner Jonathan C. Kinloch
William Phillips

BOARD MEMBERS EXCUSED: Lynne F. Carter, M.D.; Mr. Bernard Parker; and Mr. Kevin McNamara

BOARD MEMBERS ATTENDING VIRTUALLY: Mr. Parker did not join the meeting as noted on the attendance sheet.

GUEST(S): Ms. Rebecca Belcher, Public Affairs Associates (PAA)

CALL TO ORDER
The meeting was called to order at 1:06 p.m. by Mr. Angelo Glenn, Chairperson

ROLL CALL
Roll call was taken by the Board Secretary, Dr. Taueg and a quorum was present.

APPROVAL OF THE AGENDA
Mr. Glenn, Chairperson welcomed everyone to the meeting and called for a motion on the agenda.

It was moved by Commissioner Kinloch and supported by Ms. Jawad to take Items XIV. Quality Assurance Performance Improvement Plan (QAPIP) Annual Evaluation FY 2021; Item XV. Quality Assurance Performance Improvement (QAPIP) Work Plan FY 2022; Item XVI. Unfinished Business and Item XVII. New Business after the Recipient Rights Advisory Committee report. There was no further discussion. **Motion carried unanimously.**

MOMENT OF SILENCE
The Chairperson called for a moment of silence. Moment of Silence taken.

APPROVAL OF BOARD MINUTES
The Chair called for a motion on the Board minutes from the Full Board meeting of February 16, 2022. **It was moved by Ms. Ruth and supported by Ms. Burrell to accept the Full Board minutes of February 16, 2022. Motion carried unanimously.**

RECEIVE AND FILE
The approved Finance Committee minutes from the meeting of February 14, 2022 and the approved Program Compliance Committee minutes from the meeting of February 9, 2022 were received and filed**.**

ANNOUNCEMENTS

Network Announcements

T. Devon, Director of Communications noted that there will be a Rental Assistance and Community Resource Fair on March 30th 2022 from 11:00 a.m. to 3:00 p.m. in Inkster, Michigan. The Fair is geared towards helping the community with rental and utility payments and tax and water assistance. The event is in partnership with Starfish Family Services; Wayne Metro; Inkster Housing Commission; MDHHS; PACE and Pathways to Potential.

Board Announcements

There were no Board announcements.

PUBLIC AFFAIRS ASSOCIATES (PAA)

Ms. Rebecca Belcher of Public Affairs Associates (PAA), provided a verbal legislative report and updated the Board on the Harbor dollars, the surplus in the budget which at this time was reported as $70 million dollars; the water situation; and the passing of series of supplemental bills which is moving slowly in Lansing. She also provided a detailed overview of the Senate Bills 597 and 598. Several members of PAA are expected to attend the Mackinac Policy Conference in May. The Board Chair thanked Ms. Belcher for her report and the work provided by PAA.

BOARD COMMITTEE REPORTS

Board Chair Report

Board Chair, Glenn requested an update on the City of Detroit and Wayne County appointments. It was reported by Ms. B. Blackwell, Chief of Staff that the City of Detroit is in the process of making a new nomination for the vacancy that exists that would replace Ms. Perry-Mason as well as working on Board members whose terms are set to expire on March 31st. It was also reported that Wayne County is in process of reviewing their appointments as they also have two board members whose terms are set to expire on March 31st. She will keep the board informed on the status of the appointment and re-appointments.

The National Council for Wellbeing – NatCon22 is scheduled from April 11th-13th 2022 at National Harbor in Washington, DC. Mr. Glenn and Ms. Ruth are scheduled to attend along with Mr. Doeh; Ms. Blackwell and a number of staff members.

The Chamber of Commerce Policy Conference is scheduled for May 31st through June 3rd on Mackinac Island. There are several Board members and staff members that will be attending the conference and DWIHN will be well represented. PAA members are also planning to attend the conference.

Community Mental Health Association of Michigan Annual Summer Conference -June 6th – June 8th will be held in person at Grand Traverse. The Board Chair and Vice Chair have expressed an interest in attending. Board members were encouraged to attend and to contact the Board Liaison with their interest.

Community Mental Health Association of Michigan Annual (CMHAM) Metro Region Officer Vacancy. It was reported by Ms. Blackwell that Mr. Glenn will be on the ballot for the position of 1st Vice President and that board members have to be present to vote and there is no proxy voting. Mr. Doeh gave an overview of the Association's 1st Vice President position.

There was no further discussion on the Board Chair report. The report was received and filed.

Executive Committee

The Board Chair A. Glenn reported. A verbal report was provided. It was reported that the Executive Committee met on Monday, March 14, 2022. The Board Study Session was held in person on Wednesday, February 23, 2022. Ms. Blackwell reported that the topics that were covered included the System Redesign;

Incentive Plans; Self-Determination; the Care Center and the CCBHC. It was a very good study session and robust discussions were held on many of the topics.

The Annual Report to the Commission as directed by the Board bylaws will be presented on Thursday, March 17, 2022 to the Commission. Mr. Doeh, CEO; Ms. Blackwell, Chief of Staff plan to give the report and Board Chair, Mr. Glenn plans to attend. The report will give an overview of the Network's performance over the last year and highlight our programs and services that have been provided in the community and to the people we serve.

Finance Committee

Ms. Brown, Chair of the Finance Committee, gave a verbal report of the highlights from the Finance Committee and noted the committee met on Wednesday, March 2, 2022. It was reported that Direct Care Worker (DCW) cost settlement was $12.2 million; MDHHS requires funds received in excess of expenses be returned; total revenue received and expenses incurred were $50.4 million and $38.1 million, respectively. DWIHN spent SUD funds allocated that are not allowed to be carried over. MDHHS provided a $4.4 million supplemental General Fund allocation to increase the amount to $25.4 million; General Fund is $4.4 million less than FY20. Due to PHE, GF reductions were not a major concern however PHE expected to end on April 16, 2022. Continued reductions will result in DWIHN likely unable to meet the requirements of the MHC. The liquidity is strong and cash flow is sufficient to support operations.

The committee reviewed and moved four board actions BA #21-71(Revision); BA#22-12 (Revision); BA#22-17 (Revision); and BA#22-17 (Revision 1) all under Unfinished Business full board for approval. There was no further discussion. The report was received and filed.

Program Compliance Committee

Dr. Taueg, Chair provided a verbal report. It was reported that the Committee met on Wednesday, March 9, 2022. The Committee received reports from the Chief Medical Officer which reported that Behavioral Health Outreach has continued outreach efforts for behavioral health services, with special focus on Children's services this year and DWIHN has continued to show an upward trend for the majority of our performance indicators. Master level clinicians' shortages continue to be a reported barrier by several providers and a contributing factor for indicator 2A (completion of biopsychosocial within 14 days of a non-emergency request for services). Customer Service has continued advocacy and outreach for mental health as well as COVID vaccination through Constituent Voice's "What's Coming Up Videos". Children's Initiative reported that a total of 12, 021 students are actively receiving School Success Initiatives (SSI) services from 11 Children's providers. Therapists are in 72 schools (25 schools in Detroit and 47 schools in Out-Wayne County). The SSI's Redesign was presented at the November Board meeting and the three goals (Coordination w/Teen Health Centers, Increased Accessibility of Services and Implemented Standardization of Services) have been accomplished. Clinical Practical Improvement reported that staff continue to monitor the merger of Northeast Guidance Center and Central Network Services as well as the newly announced merger of Community Care Services with Hegira, Inc. to ensure services and supports received by members served continue uninterrupted. Staff will continue to assist providers who are impacted by workforce challenges to identify recruitment and retention strategies. It was also reported that there were 30 successfully employed Returning Citizens Competitively Employed for FY 21-22 (Q1) in the community through various providers of DWIHN's Provider Network. Integrated Health Care reported that Hepatitis C in the SUD population is on the rise. A report on the Customer Pillar was provided. It was reported that completion of the goals under the Customer Pillar range from 85% to 100% completion and the committee received a

Presentation on "Putting Children First" Initiative. It was also reported there was a 79% reduction in hospital admissions and there is a plan to look at extending the Med drop program.

The Committee reviewed the Quality Assurance Performance Improvement Plan (QAPIP) Annual Evaluation FY2021 and the FY2022 Quality Assurance Performance Improvement Work Plan. The committee moved both plans to full board for approval and both are on the agenda. The Chief Clinical Officer's report updated the committee on the COVID numbers and noted there has been an increase in the use of intensive stabilization services. The Committee reviewed and moved to Full Board for approval BA#22-16 (Revised) and under New Business BA#22-46. There was no further discussion on the report. The report was received and filed.

Recipient Rights Advisory Committee

Ms. Ruth, Chair of the Recipient Rights Advisory Committee reported there was no report as the committee did not meet for the month of March.

AD HOC COMMITTEE REPORTS

Policy/Bylaws Committee

There was no report.

QUALITY ASSURANCE PERFORMANCE IMPROVEMENT PROGRAM (QAPIP) ANNUAL EVALUATION FY 2021

Ms. A. Siebert, Director of Quality Improvement reported. It was noted that the QAPIP Evaluation assesses the results, improvements and outcomes DWIHN has made with respect to the Annual Work Plan for FY2021. An overview was provided of the objectives of the Customer, Quality and the Access Pillars that were met and those that were not met and the changes that were being made to enhance the QAPIP to ensure stronger alignment with regulatory requirements of Michigan Department of Health and Human Services (MDHHS) and National Committee for Quality Assurance (NCQA). A PowerPoint presentation was provided for the record. Most activities planned in FY 20-21 Work Plan is at a 71% completion, which is an increase from the previous fiscal year at 50%. The activities that were partially met and/or not met will be considered for continuation in the QAPIP FY 21/22 Work Plan. There was no further discussion.

The Chair called for a motion on the Quality Assurance Performance Improvement Plan (QAPIP) Annual Evaluation FY2021.

It was moved by Ms. Ruth and supported by Commissioner Kinloch approval of the Quality Assurance Performance Improvement Plan (QAPIP) Annual Evaluation FY2021. There was no further discussion. **Motion carried.**

QUALITY ASSURANCE PERFORMANCE IMPROVEMENT (QAPIP) WORK PLAN FY2022

Ms. Siebert reported that the QAPIP Work Plan FY 22 includes a detailed description of the FY 20/21 activities that were partially met and/or not met which will be considered for continuation and new goals for FY 22. An overview of the 2022 Work plan goals and objectives were given and included but not limited to maintaining NCQA accreditation; continuing coordinated regional response to COVID-19 pandemic, including expansion of the use of telehealth for a broad array of supports/services; establishing an effective Crisis Response System and Call Center and continuously improve the quality, appropriateness, availability, accessibility, coordination and continuity of health care services to members across the continuum of care. The complete QAPIP Workplan was provided in the report and for the record.

It was moved by Ms. Ruth and supported by Commissioner Kinloch approval of the Quality Assurance Performance Improvement Plan (QAPIP) Work Plan FY2022. There was no further discussion. **Motion carried.**

Mr. Glenn, the Board Chair noted that the agenda had been changed and the Board actions would be taken before the report of the SUD Oversight Policy Board and the report of the CEO.

The Chair called for a motion on the Board actions listed under unfinished business.

It was moved by Dr. Taueg and supported by Ms. Ruth to bundle and approve the Board Actions listed under Unfinished Business.

UNFINISHED BUSINESS
Staff Recommendations:

A. BA #21-71 (Revision) – Leadership Training, American Society of Employers. J. Connally reported. Staff requesting board approval of a modification to our agreement with the American Society of Employees (ASE) for training services. As a result of hiring additional management staff, we have incurred additional costs in pre-employment testing and background checks. We will also be conducting a second round of manager training. We are requesting additional funds in the amount of $75,000 bringing the total contract to $181,000 with an extension of time through September 30, 2023. It was noted that information on the number of persons to be trained; the number of persons previously trained and the contract dates had been added to the Board action as requested by the Finance Committee. There was no further discussion.

B. BA #22-12 (Revision 3) – DWIHN FY 2021/2022 Operating Budget. Staff requests board approval to amend the FY 2022 Operating Budget to certify State General Fund revenue of $4,494,180 per MDHHS Supplemental General Fund Appropriation; certify Federal Grant Fund revenue of $1,254,060 per American Rescue Plan grant award; certify Federal Grand Fund revenue of $267,302 per the Women's Post-Partum Pilot Program grant award; decertify Local Grant fund revenue of $121,650 to align the budget with the FY 2022 Jail Program grant award from Wayne County and to include a newly created position for Physician Consultant at $141,000 maximum salary for FY 2022 to handle appeals. The cost of this additional position will be transferred from the reserve account. There was no further discussion.

C. BA #22-16 (Revised) Substance Use Disorder (SUD) Prevention Funding – DWIHN's Provider Network. Staff requests board approval to amend the FY 22 SUD Prevention Services Board action by an additional $6,000.00 in PA 2 funds for the Detroit Association of Black Organizations (DABO) to service Families Against Narcotics (FAN) Detroit Hope Not Handcuffs program in the Detroit Police Department's 2nd Precinct with the assistance of the Commander and the secured permission of the Executive Deputy Chief. Through Hope not Handcuff's a person struggling with any substance use disorder can come to any of the participating police agencies for assistance. The FY22 SUD Prevention Services program of $6,484,938.00 is increased by $6,000.00 to $6,490,938.00 and consists of Federal Block grant revenue of $4,475,938.00 and Public Act 2 Funds of $2,015,000.00 is designated to PA2. There was no further discussion.

D. BA #22-17 (Revision) Substance Use Disorder (SUD) Treatment Funding FY 2022. Staff requests board approval to increase the amount by $39,848.20 from the initial amount of $7,830,900.00 to $7,870,748.20. The action is requesting to allocated the additional Public Act 2 funds of $1,748.20 for FASTSIGNS to pay for services to replace old logos and lettering with the most current and up to date logo and lettering for DWIHN. Also, additional Public Act 2 funds of $38,100.00 are allocated to pay

for communication services through Ask the Messengers which will air 30-minute educational programming on TV 20 from March 1, 2022 through September 30, 2023. The revised FY 22 Treatment Services program totals $7,870,748.20 and consists of Block Grant funds of $6,761,900.00 and Public Act 2 funds of $1,108,848.20. There was no further discussion.

E. BA#22-17 (Revision 1) Substance Use Disorder (SUD) Treatment Services Network FY2022. This revised board action is a request to increase the FY 2022 SUD Treatment program to $8,081,948.20 by adding PA2 funds by $211,200.00 to increase our branding efforts for the Mental Health Care-Putting Children First campaign. The additional PA2 funds will be distributed as follows and have a contract term of March 1, 2022 through September 30, 2022. Scrips Media ($150,000); Fox 2 ($10,000) Targeted Social Media Campaign ($20,000); Mind Matters ($5,000); Comcast/Effect TV ($5,000); Metro Parent ($5,000); MEA-TV ($5,000); MEA-TV Radio ($10,000); Recovery Live Global ($1,200); to Interview DWIHN Providers) total costs $211,200.00. The revised cost of the FY 2022 SUD Treatment Program of $8,081,948.20 includes Federal Block Grants funds of $6,761,900 and PA2 funds of $1,302,048.20. There was no further discussion.

There was no further discussion on the board actions listed under unfinished business. **The motion carried for approval on BA#21-71 (Revision); BA#22-12 (Revision 3); BA #22-16 (Revised); BA#22-17 (Revision); and BA #22-17 (Revision 1).**

NEW BUSINESS

Staff Recommendations:

A. BA #22-46 – Behavioral Health Home – Arab Community Center for Economic and Social Services (ACCESS) The Chair called for a motion on Board Action #22-46. **It was moved by Ms. Jawad and supported by Ms. Ruth approval of Board Action #22-46.** E. Peterson reporting. Staff requesting the approval of a six-month contract effective April 1, 2022 through September 30, 2022 for approximately $965,175 with five providers, ACCESS; Community Network Services; The Guidance Center; Hegira Health and Team Wellness for the Behavioral Health Home Program (BHH). MDHHS funds the program with a PMPM payment structure and funds are pass through to the aforementioned providers. A budget adjustment certifying the additional revenue is forthcoming. There was no further discussion. **Motion carried.**

B. BA #22-58 – Temporary Mobile Office Unit – The Chair called for a motion on BA #22-58. **It was moved by Commissioner Kinloch and supported by Ms. Ruth approval of BA#22-58.** M. Maskey, Facilities Director reporting. Staff requesting board approval to enter into an agreement with WillScot for the leasing of temporary mobile office units that will be set up in Lot A during Milwaukee building construction and temporary closure. The mobile office will provide DWIHN staff with the ability to access the network and to provide functions such as mail service, printing, scanning and storage. We are requesting a not-to-exceed amount of $131,332.29 for a term beginning March 9, 2022 and ending June 30, 2023. The facilities department reached out for quotes and WillScot was the only company that could provide a large enough office unit to meet the occupancy needs of staff. Discussion ensued regarding the mobile units; placement of the units; timing of the units and staff parking. **Motion carried.**

SUBTANCE USE DISORDER OVERSIGHT (SUD) POLICY BOARD REPORT

Mr. Tom Adams, SUD Oversight Policy Board Chair reported. A written report was provided for the record. It was reported the SUD Oversight Policy Board met on Monday, February 21, 2022. It was reported that the SUD Oversight Policy Board received a Presentation by Mr. D. Lawrence, Account Manager, Digital Health Pear Therapeutics. Information was provided regarding the State of Michigan Initiative that will assist providers in treating SUD for outpatient members 24/7 using their smartphones or tablets. Ms. Gray,

Legal Counsel presented the amendments to the Bylaws. A report was provided by Mr. Doeh, CEO which included information of future plans and goals for the agency including the temporary closing of the building due to renovations. Also provided updates on the movement of the Shirkey and Whiteford bill. The SUD Oversight Policy board reviewed BA #20-10S – this board action requested PA2 Funding in the amount of $121,200 for a media campaign to increase efforts to reach parents and young people with its branding campaign "Mental Health Care – Putting Children First." This board action was approved.

The Chair appointed Mr. Glenn; Ms. Martin; Chief Riley and T. Fielder to the Nominating Committee. The nominations were accepted and they will present recommendations at the March meeting.

Informational reports were provided by the SUD Director; Prevention Manager; Treatment Administrator; and the Opioid Health Home Administrator. A report was also provided by the State Opioid Response (SOR) Coordinator. There was no further discussion. The report was received and filed.

SUBSTANCE USE DISORDER (SUD) OVERSIGHT POLICY BOARD BYLAWS

Ms. M. Gray, Legal Counsel reported. A copy of the SUD Oversight Policy Board Bylaws was provided for the record. It was noted that there were changes made in the SUD Oversight Policy Board Bylaws in the areas that pertained to meetings by remote communications. The changes made were to place the SUD Oversight Policy Board Bylaws in alignment with the changes made to the Open Meetings Act (OMA). There was no further discussion.

The Chair called for a motion on the Substance Use Disorder Oversight Policy Bylaws.

It was moved by Ms. Brown and supported by Mr. McNamara approval of the changes made to the SUD Oversight Policy Board Bylaws. There was no further discussion. **Motion carried.**

PRESIDENT AND CEO MONTHLY REPORT

Mr. Doeh reported. He also provided a written report for the record. He briefly updated on several items from his written report. On the Crisis Center, we should know something from the City as far as the all clear for us to move forward. This is also true for the Woodward building. He thanked Rev. Holley and his team for continuing to allow us the use of the space during our outreach efforts and hosting some of our programs. This will be a real investment; it just wasn't a suitable space in the short term for hosting our board meetings or office space.

Mr. Doeh provided a brief update on the provider stability plan. The 5% rate increase and over $25 million that we have provided in retention payments were as a result of our financial position. We continue to work with both small and large providers across all business lines.

We continue to work with several health plans on our pilot project. Mr. Singla has been able to bring about a platform that we are using from an integration standpoint with our partners, but also within our network to give us a complete sense of how we can migrate physical and behavioral health services. From a performance standpoint, we have a number of health plans we work with and we have something called a performance bonus incentive with the health plans. We haven't previously been able to garner those dollars that are out there, but for the last fiscal year we were able to garner more than $4 million, which goes a long way in how we blend physical and behavioral health services with those health plans, i.e. follow up after hospitalization.

Mr. Doeh provided a brief update on mobile services. We have developed a contractual relationship with Wayne Health to provide those mobile services as opposed to people having to come to buildings. This has been going quite well and we want to make sure that relationship is maintained. In the past year, we applied for a federal grant to be able to provide those services within our system

next year. So far, we're hearing that both the House and Senate have approved within the budget on the federal level for Detroit Wayne to receive $1.4 million in grant dollars to provide mobile health care.

There was no further discussion on the report of the CEO. The report of the CEO was received and filed.

PROVIDER PRESENTATION – Detroit Recovery Project presentation has been rescheduled and will be presented at the next Full Board meeting at the request of the Provider.

REVIEW OF ACTION ITEMS
It was requested that staff provided the Board with a 1-2-page report on DWIHN accomplishments including grants that could be provided to legislators. It was requested that the report be ready for the Mackinac Policy Conference in May.

GOOD AND WELFARE/PUBLIC COMMENT
The Board Chair, Mr. Glenn read the Good and Welfare/Public Comment statement. There were no members of the public for Good and Welfare or Public Comment.

ADJOURNMENT
There being no further business, the Board Chair, Mr. Glenn called for a motion to adjourn. **It was moved by Ms. Brown and second by Ms. Jawad to adjourn. The motion carried unanimously and the meeting adjourned at 2:05 p.m.**

Submitted by:
Lillian M. Blackshire
Board Liaison

FINANCE COMMITTEE

MINUTES | **FEBURARY 14, 2022** | **11:00 A.M.** | **707 W. MILWAUKEE ST. DETROIT, MI 48202 (HYBRID/ZOOM)**

MEETING CALLED BY	I. Mr. Kevin McNamara, Vice Chair called the meeting to order at 11:00 a.m.
TYPE OF MEETING	Finance Committee Meeting
FACILITATOR	Mr. Kevin McNamara, Vice Chair
NOTE TAKER	Nicole Smith, Administrative Assistant
ATTENDEES	**Finance Committee Members Present:** Mr. Kevin McNamara, Vice Chair Ms. Kenya Ruth Mr. Bernard Parker Commissioner Jonathan C. Kinloch **Committee Members Excused:** Ms. Dora Brown, Chair (attended virtually) **Board Members Present:** Mr. Angelo Glenn **Board Members Excused: None** **Staff:** Mr. Eric Doeh, CEO; Ms. Stacie Durant, CFO; Ms. Yolanda Turner, Deputy Legal Counsel; Mr. Manny Singla, CIO **Guests:** None

AGENDA TOPICS

II. Roll Call Ms. Lillian Blackshire, Board Liaison

DISCUSSION	Roll Call was taken by Ms. Blackshire and a quorum was present.

III. Committee Member Remarks
The Vice Chair, Mr. McNamara, called for any Committee remarks. There were no committee member remarks.

IV. Approval of Agenda
The Vice Chair, Mr. McNamara called for a motion on the agenda. There were no changes or modifications requested to the agenda. **Motion:** It was moved by Mr. Parker and supported by Ms. Ruth approval of the agenda. **Motion carried.**

V. Follow-up Items:
There were no follow up items noted on the agenda.

VI. Approval of the Meeting Minutes

The Vice Chair, Mr. McNamara called for a motion on the Finance Committee minutes from the meeting of Wednesday, January 5, 2022. **Motion:** It was moved by Mr. Parker and supported by Commissioner Kinloch approval of the Finance Committee minutes with any necessary corrections from the meeting of Wednesday, January 5, 2022. There were no corrections to the minutes. **Motion carried**. Minutes accepted as presented.

VII. Presentation of the Monthly Finance Report

S. Durant, CFO presented the Monthly Finance report. A written report ending December 31, 2021 was provided for the record. Network Finance accomplishments and noteworthy items were as follows:

In January 2022, DWIHN transferred $59,500,000 in excess cash to the three investment managers and First Independence Bank. Investments will be made in accordance with our investment policy and PA20.

Cash and Investments – comprise of funds held by three (3) investment manager, First Independence CDARS, Comerica, and Flagstar accounts.

Due from other governments – comprise various local, state and federal amounts due to DWIHN. The account balance primarily related to $4.2 million and $7.5 million for MDHHS performance incentive and HRA payment, respectively. In addition, there is $6.0 million due from MDHHS for SUD and MH block grant.

Accounts receivable and allowance for uncollectible – Approximately $2.1 due from Molina for MHL; and $1.5 million due from Wayne County for the December match payment. In addition, $2.6 million due from CLS for estimated FY21 and prior year cost settlement. DWIHN recorded $.5 million in an allowance for two SUD providers due to length of amount owed and likelihood of collections.

IBNR Payable – represents incurred but not reported (IBNR) claims from the provider network; historical average claims incurred through December 31, 2021, including DCW hazard pay, was approximately $179.6 million however actual payments were approximately $116.5 million. The difference represents claims incurred but not reported and paid of $63.1 million.

Due to other governments – includes $8 million due to MDHHS for death recoupment and $2.3 million for of the 1st quarter IPA tax payable due January 30, 2022. In addition, the amount includes $1.8 million due to MDHHS for FY20 general fund carryover in excess of 5% and $1.3 million for State facilities.

Federal revenue/grant program expenses – variance due to several grants not accrued due to timing of receiving invoices. In addition, the budget assumes revenues are incurred consistently throughout the year.

State revenue and contracts – Various related to excess DCW hazard pay received from MDHHS that will be cost settled at year end.

Autism, SUD, Adult, IDD, and Children services – $23.72.79 million variance due to impact of COVID on certain lines of business and timing in services (i.e. summer programs).

(Action) Mr. McNamara requested documentation to show the DWIHN investments and interest rates. S. Durant acknowledged the request and noted the reports would be included in the yearly audit report.

The Vice Chair, Mr. McNamara noted the Monthly Finance Report ending December 31, 2021 was received and filed.

VIII. Unfinished Business – Staff Recommendations:

a. **Board Action #22-12 (Revision 2) – DWIHN FY 2021 -2022 Operating Budget** – S. Durant, CFO reporting. Staff requests board approval to amend the FY 2022 Operating Budget to add recently awarded federal Substance Abuse and Mental Health Services Administration ("SAMHSA") grant of $3,725,575 for the Michigan "Tri-County Strong" Crisis Counseling & Training Program. In addition, the budget amendment includes increasing the budget for seven (7) newly created positions at $717,632 (salary/fringes). The Vice Chair, Mr. McNamara called for a motion on Board Action #22-12. **Motion**. It was moved by Commissioner Kinloch and supported by Ms. Ruth approval of Board Action #22-12 (Revision 2) to Full Board. There was discussion regarding the Diversity, Equity & Inclusion Officer position and the total cost of the salaries and fringe benefits for the positions in the board action. **Motion carried.**

IX. New Business – Staff Recommendations:

a. **Board Action #22-52 – PCE/MHWIN Maintenance Contract Renewal** – M. Singla, CIO reporting. This board action is requesting approval of a nineteen-month contract with Peter Chang Enterprises Inc. (PCE) for an amount not to exceed $1,530,000. The contract period is March 1, 2022 through September 30, 2023. The contract with PCE is for hosting and maintenance of the MHWIN, DWIHN Electric Medical Record system, which serves Substance Use Disorder Module and Twillio Text Message system. The Vice Chair, Mr. McNamara called for a motion on Board Action #22-52. **Motion**. It was moved by Mr. Parker and supported by Mr. Glenn approval of BA#22-52. **Motion carried.**

X. Good and Welfare/Public Comment – The Chair read the Good and Welfare/Public Comment statement. There were no members of the public to address the committee and there were no written comments.

Committee member Mr. Parker acknowledged the Governor's budget increase to be used for Mental Health Services. Discussion ensued regarding the increase in the Governor's budget and DWIHN's advocacy. Mr. Doeh noted there was work in progress; discussions have taken place with legislators and there has been advocacy towards getting approval of the Governor's budget.

XI. Adjournment – There being no further business; The Vice Chair, Mr. McNamara called for a motion to adjourn. **Motion:** It was moved by Mr. Parker and supported by Ms. Ruth to adjourn the meeting. **Motion carried**. The meeting adjourned at 11:40 a.m.

FOLLOW-UP ITEMS	
a.	

PROGRAM COMPLIANCE COMMITTEE

MINUTES **FEBRUARY 9, 2022** **1:00 P.M.** ***VIRTUAL MEETING***

MEETING CALLED BY	I. Dr. Lynne Carter, Program Compliance Vice-Chair at 1:26 p.m.
TYPE OF MEETING	Program Compliance Committee
FACILITATOR	Dr. Lynne Carter, Vice-Chair
NOTE TAKER	Sonya Davis
TIMEKEEPER	
ATTENDEES	**Committee Members:** Dr. Lynne Carter; William Phillips with Dr. Cynthia Taueg (attending virtually) **Committee Members Excused:** Dorothy Burrell and Michelle Jawad **Board Member(s):** Angelo Glenn, Board Chair **Staff:** Jacquelyn Davis; Judy Davis; Eric Doeh; Monifa Gray; Shirley Hirsch; Nichole Hunter; Melissa Moody; Ebony Reynolds; April Siebert; Manny Singla; Andrea Smith; Yolanda Turner and June White;

AGENDA TOPICS

II. Moment of Silence

DISCUSSION	The Vice-Chair called for a moment of silence.
CONCLUSIONS	Moment of silence was taken.

III. Roll Call

DISCUSSION	The Vice-Chair called for a roll call.
CONCLUSIONS	Roll call was taken by Board Liaison, Lillian Blackshire at 1:26 p.m. and there was no quorum. Roll Call was re-taken at 1:45 p.m. and there was a quorum.

IV. Approval of the Agenda

DISCUSSION/ CONCLUSIONS	The Vice-Chair called for approval of the agenda. **Motion:** It was moved by Mr. Phillips and supported by Mr. Glenn to approve the agenda. Dr. Carter asked if there were any changes/modifications to the agenda. There were no changes/modifications to the agenda. There were no changes/modifications to the agenda. **Motion carried**

V. Follow-Up Items from Previous Meetings

DISCUSSION/ CONCLUSIONS	***There were no follow-up items from previous meetings to review.***

VI. Approval of Meeting Minutes

DISCUSSION/ CONCLUSIONS	The Vice-Chair called for approval of the January 12, 2022 meeting minutes. **Motion:** It was moved by Mr. Glenn and supported by Mr. Phillips to approve the January 12, 2022 meeting minutes. Dr. Carter asked if there were any changes/modifications to the meeting minutes. There were no changes/modifications to the meeting minutes. **Motion carried.**

VII. Reports

DISCUSSION/ CONCLUSIONS	A. **Chief Medical Officer** – ***Deferred to March 9, 2022*** B. **Corporate Compliance Report** – Nichole Hunter of the Allen Law Group is filling in as the Corporate Compliance Director until a replacement has been named. Ms. Hunter submitted and gave highlights of the Corporate Compliance update. Ms. Hunter reported: 1. ***Update on Provider Audits:*** a. Compliance was in the process of auditing a provider relative to billings by one of the provider's clinicians with respect to T1017. The provider is in the due diligence phase of merging with another entity which is anticipated to be completed by March 2022. In December 2022, Corporate Compliance is still in the process of obtaining copies of a thorough compilation of the clinician's billing of T1017 to determine whether inappropriate billing occurred and if recoupment is necessary. This investigation is ongoing. b. Compliance was in the process of auditing a provider to determine whether double billing occurred after the closure of one of its facilities – January 24, 2022 – it was found that no evidence of double billing occurred and will be marked as closed. c. Compliance has been working with Customer Service to counsel a Provider to determine whether a resident of Michigan that has been living in Indiana has met the requirements mandated under MDHHS to continue residency in Michigan for receipt of services in the state. This matter was reported to the OIG in July 2021, the OIG recommended that the Provider seek counsel directly from MDHHS prior to ceasing services. 2. ***New Audit*** – Corporate Compliance received a referral to conduct an audit at the request of the OIG on February 2, 2022. A provider may have overbilled one member and documents are being reviewed to determine the next steps. 3. ***Update on Provider Location Closures*** - Approximately 11 residential sites are in the process of closing for reasons that span from operational funding, low member residency, and/or lack of staff to support the program since January 1, 2022. Dr. Carter opened the floor for discussion. Discussion ensued. The Vice-Chair has noted that the Corporate Compliance report has been received and placed on file.

VIII. Quarterly Reports

A. **Managed Care Operations** – June White, Director of Managed Care Operations submitted and gave highlights of the Managed Care Operations' quarterly report. Ms. White reported that there were over 400 contracts sent out for signature to our Provider Network for the new fiscal year. Providers continue to struggle with staff shortages to maintain staff in homes as well as staff in general. A closure recap was provided for the first quarter which noted there were 2 Licensed Residential homes that closed; 3 Unlicensed Private Home Services; 1 Clubhouse; 4 outpatient services; SUD services. There was one merger of Provider Organization.

DWIHN continues to support the Provider Network through training and education; Providing IT equipment; issuing a direct care wage increase; and continuing to meet with providers to find solutions. These are just some of the supports that DWIHN is providing.

Managed Care Operations has cleaned up staff records in MHWIN; added ADA site accommodations in fields in MHWIN with hours of operations for MDHHS requirements. They have also met with 5 CRSP providers regarding the 14-day intake calendar slots where providers are experiencing staff shortages in the intake department for new intakes and reviewed all changes to the Provider Manual for 2022 which will be finalized by the end of Feb. 2022. An overview of their goals was also highlighted which included monitoring compliance and non-compliant providers in regards to recipient rights complaints, timely billing and proper utilization of service codes as well as improving relationships with providers through training and one on one provider quarterly virtual visits. Dr. Carter opened the floor for discussion. There was no discussion.

B. **Residential Services** – Shirley Hirsch, Director of Residential Services submitted and gave highlights of the Residential Services' quarterly report. Ms. Hirsch reported that during the 1st quarter of 2022 - there were 513 referral requests compared to 931 for the first quarter of 2021. For the month of January, there were 164 AMI requests and 63 IDD Requests. An area that we are concentrating on are Youth Aging Out of services. Highlights of Department goals were shared with the committee – which included the hiring of a Residential Care Coordinator along with the development of staff metrics and the review of department processes. Dr. Carter opened the floor for discussion. Discussion ensued.

C. **Substance Use Disorder** - Judy Davis, Director of Substance Use Disorder submitted and gave highlights of the Substance Use Disorder's quarterly report. Mrs. Davis reported that SUD has a number of initiatives that address the Prescription and Heroin efforts. Data collection shows that heroin and alcohol use are higher in our region. SUD is continuing The Barbershop Initiative. This initiative connects barbers and their clients with Naloxone training and health information and services to address men's health issues such as high blood pressure; oral health; healthy eating; substance use disorder and prostate cancer. The Naloxone Initiative program through December 31, 2021 has saved 790 lives since its inception. There were 25 Naloxone trainings provided from October to December 2021; There were 74 successful Narcan saves and 6 unsuccessful attempts (saves) in Region 7 during the 4th Quarter. The MDOC Program reported that there were 49 probationers/parolees served by DWIHN SUD Programs. DWIHN continues to provide harm reduction strategies to the community as appropriate which include fentanyl strips and deterra bags.

	DWIHN continues to train first responders; its providers, drug court staff/inmates/jail staff and the community on how to reverse an opioid overdose. The medical examiners provisional data suggest that drug overdose deaths declined by 9.3% between April 2020 to April 2021 in Wayne County. Dr. Carter opened the floor for discussion. Discussion ensued. The Vice-Chair noted that the Managed Care Operations', Residential Services' and Substance Use Disorder's quarterly reports have been received and placed on file.

IX. Strategic Plan Pillar - Access

DISCUSSION/ CONCLUSIONS	Jacquelyn Davis, Clinical Officer submitted and gave an update on the Strategic Plan Access Pillar report. Ms. Davis reported: 1. Four high level goals. Overall at 85%, same as the last report in October 2021; however, we are on track. 2. The detailed report shows a total of 16 goals with a completion rate of 85%, There has been some movement in activities though due adding task and revisions to completion dates the completion rate is the same. A. Create Infrastructure to support a holistic care delivery system: 75% (decreased by 1% from last report) due to revision in completion date. **Update on the goal for Risk Assessment/Score** -DWIHN rolled out a reengagement/disenrollment module to ensure CRSP are being scored for individuals actively engaged in services. **Build Relationships with Healthcare Community Leaders:** Currently collaborating with 2 health plans. Established a data exchange and currently monitoring 15 members per month. Sent and received all contracts back from providers. The BHH program is on track to launch in April 2022. All 5 providers have been certified using the BHH certification tool. B. **Create Integrated Continuum of Care for Youth:** 86% complete - no change from last report and on track. An update that wasn't included in the last report for Deliver Integrated model of Care for Children – though DWIHN wasn't awarded the InCK grant from CMS in December 2019, there are 2 programs that Children's Initiatives oversees via the System of Care Block Grant: SKIPP-Screening Kids in Primary Care Plus, and Michigan Child Collaborative Care MC3, completed Phase 3 of the School Success Initiative which was presented to the Board in November 2021. C. **Establish an effective crisis response system:** 82% complete - increased by 4% from last report. Update: Dates have been revised to reflect changes in plans for the Crisis Care Center. New enhancements are being made to MH-WIN to notify CRSP when someone presents to the ED so they can get involved early in the crisis episode. D. **Implement Justice Involved Continuum of Care:** 98% complete - Same as previous report. A team has been reviewing supplemental training to identify gaps. The recommendations for additional educational topics to the Justice System will be noted in the plan. Dr. Carter opened the floor for discussion. Discussion ensued. The Vice-Chair noted that the Strategic Plan Access Pillar has been received and placed on file.

X. Quality Review(s) -

DISCUSSION/	**Quality Assurance Performance Improvement Plan (QAPIP) Description Plan FY 2021-23 Update** – April Siebert, Director of Quality Improvement submitted

CONCLUSIONS	and gave highlights of the QAPIP Description FY 2021-23 Update. Ms. Siebert presented a PowerPoint presentation on the QAPIP FY 2021-23 description changes including page numbers of where the changes will occur. There were eight changes made to the QAPIP Description. These changes have been made to enhance the QAPIP to ensure stronger alignment with regulatory requirements of MDHHS and NCQA. The QAPIP Program Description has also been included for review of the identified changes. The Vice-Chair called for a motion on the QAPIP Description Plan FY 2021-23 Update. **Motion:** It was moved by Mr. Phillips and supported by Mr. Glenn to move the QAPIP Description Plan FY 2021-23 Update to Full Board for approval. Dr. Carter opened the floor for discussion. Discussion ensued. **Motion carried.**

XI. Chief Clinical Officer's (CCO) Report

DISCUSSION/ CONCLUSIONS	Melissa Moody, Chief Clinical Officer submitted and gave highlights of her Chief Clinical Officer's report. Mrs. Moody reported: 1. **COVID-19 & Inpatient Psychiatric Hospitalization** – There were 468 inpatient hospitalizations and 32 COVID-19 Positive cases in January 2022. 2. **COVID-19 Intensive Crisis Stabilization Services** – There were 185 members that received Intensive Crisis Stabilization Services from COPE (36% increase) and 181 members received Intensive Crisis Stabilization Services from Team Wellness (36% increase) in January 2022. 3. **COVID-19 Recovery Housing/Recovery Support Services** – A total of 19 members received Recovery Housing/Support Services in January 2022. 4. **COVID-19 Pre-Placement Housing** – There were 14 members serviced for Pre-Placement Housing in January 2022. This has been consistent the last couple of months. 5. **Residential Department (COVID-19 Impact)** – There were 60 members that tested positive for COVID-19 with two (2) related deaths in January 2022. There were 57 residential staff that tested positive COVID-19 with one (1) related death from October 1, 2021 – present. 6. **Vaccinations – Residential Members** – There was no change in the number of vaccinations in January 2022 compared to December 2021. 7. **COVID-19 Michigan Data** – ***State of Michigan*** (64.6%-first dose initiated and 58.2%-fully vaccinated) – The total number of confirmed cases in Michigan is 1,999,416 with 30,170 confirmed deaths; ***Wayne County*** (72.4%-first dose initiated and 65.7%-fully vaccinated) – The total number of confirmed cases in Wayne County is 239,281 with 3,690 confirmed deaths; and ***City of Detroit*** (47%-first dose initiated and 39%-fully vaccinated) – The total number of confirmed cases in the City of Detroit is 120,156 with 3,033 confirmed deaths. 8. **Health Home Initiatives** – ***Behavioral Health Home (BHH)*** – The kick-off with MDHHS is scheduled for March 3, 2022. All identified Health Home partners have completed their BHH's certification. The National Council is currently providing Case to Care Management training for both our Health Home partners and DWIHN's internal staff; ***Certified Community Behavioral Health Clinic-State Demonstration (CCBHC)*** – This model launched on 10/1/21 and the Guidance Center currently has 2,668 members receiving CCBHC services and 2,489 members have been enrolled in the MDHHS WSA enrollment system; ***Certified Community Behavioral Health Clinic – SAMHSA Expansion Grant*** – DWIHN is currently working on this expansion grant opportunity to provide additional CCBHC services to individuals we support. It is anticipated that this grant initiative, if awarded, will be implemented Fall 2022; and ***Opioid Health Home*** – DWIHN currently has 206 enrolled members receiving this

	comprehensive array of integrated healthcare services. This is a 22% increase in enrollment since October 2021. There are currently seven (7) Health Home Partners providing OHH services in Region 7. Dr. Carter opened the floor for discussion. Discussion ensued. The Vie-Chair noted that the Chief Clinical Officer's report has been received and placed on file.

XII. Unfinished Business

DISCUSSION/ CONCLUSIONS	A. **BA #21-36 (Revised2)** – Independent Evaluator for Autism Spectrum Disorder (ASD) – Children's Center of Wayne County, Inc. – The Vice-Chair called for a motion of BA #21-36 (Revised 2). **Motion:** It was moved by Mr. Phillips and supported by Mr. Glenn to move BA #21-36 (Revised 2) to Full Board for approval. Staff requesting board approval to add the Children's Center of Wayne County, Inc. – Sprout Evaluation Center, LLC as an additional ASD Evaluator to meet the demand for Autism screening for children in Wayne County. Dr. Carter opened the floor for discussion. There was no discussion. **Motion carried.**

XIII. New Business: Staff Recommendation(s)

DISCUSSION/ CONCLUSIONS	A. **BA #22-47** – Mental Health First Aid (MHFA)/Question, Persuade, Refer (QPR) – *Vendors' list included in board action* – Staff requesting board approval to enter into a contract with various vendors for the continuation of the MHFA and QPR. Dr. Carter opened the floor for discussion. There was no discussion. B. **BA #22-49** – Tri-County Strong Crisis Counseling Program (CCP) – *Vendors' list included in board action* – Staff requesting board approval to enter into a contract with nine (9) various vendors for an amount not to exceed $3,725,575.00 to implement a virtual and face-to-face crisis counseling program designed to serve victims of flooding in the tri-county area. Dr. Carter opened the floor for discussion. There was no discussion. C. **BA #22-53** – Sleeping Bags/Coats – The Empowerment Plan - Staff requesting board approval for the use of $88,100.00 in PA 2 funding for 700 sleeping bags/coats for our Co-Occurring homeless consumers. This will allow providers to provide active outreach and support individuals who are experiencing homelessness and substance use disorder throughout Wayne County. Dr. Carter opened the floor for discussion. There was no discussion. D. **BA #22-54** – Jail Plus – DWIHN's Provider Network– The Wayne County Department of Health, Human and Veteran's Services (HHVS), Clinical Services Division, Adult Community Corrections is requesting board approval of a sub-recipient Intergovernmental Agreement (IGA) between the County of Wayne and DWIHN to add value to our contracted services not funded via the Community Corrections' grant, including access to its' network of providers for intensive wrap-around service, utilization of its' Access Management System for immediate client placement. Judy Davis, Director of Substance Use Disorder informed the committee that the amount for Black Family Development should be $82,500.00 instead of $85,000.00 and the amount for Detroit Recovery Project should be $113,500.00 instead of $116,000.00. These corrections will be made before going to Full Board for approval. **(Action)** Dr. Carter opened the floor for discussion. There was no discussion.

	E. **BA #22-55** - American Rescue Plan Act (ARPA) – DWIHN's Provider Network – The Michigan Department of Health and Human Services (MDHHS) awarded the SUD Department $1,129,060.00 from the ARPA grant with an additional $125,000.00 for administrative cost and unmet needs. The funding will provide prevention, intervention, treatment and recovery support continuum services to include various evidence-based services and supports for individuals, families and communities. Dr. Carter opened the floor for discussion. There was no discussion. The Vice-Chair bundled the board actions and called for a motion on BA #22-47; BA #22-49; BA #22-53; and BA #22-54 (including corrections for Black Family Development ($82,500.00 instead of $85,000.00) and for Detroit Recovery Project ($113,500.00 instead of $116,000.00)) and BA #22-55. **Motion:** It was moved by Mr. Phillips and supported by Mr. Glenn to move BA #22-47; BA #22-49; BA #22-53; BA#22-54 (including corrections for Black Family Development ($82,500.00 instead of $85,000.00) and for Detroit Recovery Project ($113,500.00 instead of $116,000.00)) and BA #22-55 to Full Board for approval. Dr. Carter opened the floor for further discussion. There was no further discussion. **Motion carried.**

XIV. Good and Welfare/Public Comment

DISCUSSION/ CONCLUSIONS	***There was no Good and Welfare/Public Comment to review.***

ACTION ITEMS	Responsible Person	Due Date
1. **New Business (Staff Recommendation)** – BA #22-54 – Make corrections to this board actions to show correct amount for Black Family Development ($82,500.00 instead of $85,000.00) and Detroit Recovery Project ($113,500.00 instead of $116,000.00) before going to Full Board for approval.	Judy Davis	**COMPLETED**

The Vice-Chair called for a motion to adjourn the meeting. **Motion:** It was moved by Mr. Phillips and supported by Mr. Glenn to adjourn the meeting. **Motion carried.**

ADJOURNED: 2:41 p.m.
NEXT MEETING: Wednesday, March 9, 2022 at 1:00 p.m.

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Thomas Adams, Chair
Substance Use Disorder (SUD) Oversight Policy Board (OPB)
Monday February 21, 2022 Report

Presentations given by:

a. David Lawrence , Account Manager, Digital Health Pear Therapeutics

II. Information was provided regarding the State of Michigan initiative that will assist providers in treating SUD for outpatient members 24/7 using their smartphone or tablets

b. Monifa Gray, Legal Counsel, presented on amendments to the bylaws and information was included in the SUD board member's meeting packet

c. Report was provided by the CEO, Eric Doeh included information on future plans and goals for the agency, including the temporary closing of the building due to renovations. Also provided updates on the movement of Senator Shirskey and Whiteford bill

Board Action 20-10S
This board action was approved and supported no abstentions
Tiffany Devon presented BA 20-10S from PA 2 funding for a media campaign to increase efforts when it comes to reaching parents and young people with its branding campaign, Mental Health Care-Putting Children First.

Here is a cost breakdown: Scripps Media Contract Terms: Cost: $150,000 Fox 2 ; Cost: $10,000 Targeted Social Media Cost: $20,000 Mind Matters Cost: $5,000 Comcast/Effect Cost: $5,000 Metro Parent Cost: $5,000 MEA-TV Cost: $5,000 MEA TV Cost: $10,000 Recovery Live Global Contract Terms: Cost: $1,200 TOTAL: $211,200

The Chair, made appointments to the Nominating Committee. He appointed Mr. Angelo Glenn, Ms. Margo Martin, Chief William Riley, and Mr. Thomas Fielder. They accepted the positions and will present recommendations at the next meeting in March.

Informational:
SUD Interim Director's Report
Treatment Services Administrator
Prevention Services Manager Report
State Opioid Response (SOR) Coordinator Report
SUD Opioid Health Home Administrator's Report

Report Submitted by SUD Board Chairman Thomas Adams

BYLAWS

OF THE

DETROIT WAYNE INTEGRATED HEALTH NETWORK

SUBTANCE USE DISORDER OVERSIGHT POLICY BOARD

ARTICLE I- NAME; FORMATION; PURPOSE

1.1 **NAME.** The name of this entity is the Detroit Wayne Integrated Health Network Substance Use Disorder Oversight Policy Board, referred to as the "Board" in these bylaws.

1.2 **LEGAL BASIS FOR BOARD FORMATION.** The Detroit Wayne Integrated Health Network (the "DWIHN"), formally known as the Detroit Wayne Mental Health Authority (DWMHA) is a community mental health authority formed under Section 204 the Michigan Mental Health Code (Public Act 258 of 1974, as amended the "Code"), as well as a Prepaid Inpatient Health Plan ("PIHP") under contract with the Michigan Department of Health and Human Services ("MDHHS") to manage the provision of mental health, intellectual/developmental disability, and substance use disorder ("SUD") services to residents of Wayne County, Michigan. The Code provides that a community mental health entity shall establish a substance use disorder oversight policy board through a contractual agreement between the department-designated community mental health entity and each of the counties served by the community mental health services program (MCL 330.1287). The DWIHN entered into a written Intergovernmental Agreement with Wayne County to establish the Board, effective October 1, 2014 (the "Intergovernmental Agreement"). These Bylaws were adopted by the Board and approved by the DWIHN's Board effective November 10, 2014.

Subject to applicable law, the Board shall adhere to the rules, policies and procedures as established by the DWIHN Board, and contained in its Policy Manual.

1.3 **PURPOSE.** In accordance with the Code and the Intergovernmental Contract, the purposes of the Board are as follows:

1.3.1 Approval of any portion of the DWIHN's budget that contains 1986 PA 2 (MCL 211.24e(11)) funds ("PA 2 Funds") for the treatment, prevention, and recovery of substance use disorders which shall be used only for substance use disorder treatment, prevention and recovery in the Counties from which the PA 2 Funds originated; and

1.3.2 Advise and make recommendations regarding the DWIHN's budgets for substance use disorder treatment, prevention and recovery using non PA 2 Funds funding sources; and

1.3.3 Advise and make recommendations regarding contracts with substance use disorder treatment, prevention and recovery providers; and

1.3.4 Advise and make recommendations regarding any other matters as agreed to by Wayne County and the DWIHN, and assigned to the Board by the DWIHN; and

1.3.5 To have such other and further powers and duties as may be permitted by law, by the Intergovernmental Agreement, by the DWIHN's Substance Use Disorder Oversight Policy Board Guidelines, and the MDHHS Substance Use Disorder Oversight Policy Board Guidelines.

ARTICLE II - NUMBER AND SELECTION OF BOARD MEMBERS

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2.1 NUMBER AND SELECTION OF MEMBERS. The Board shall consist of twelve (12) members. The Wayne County Commission shall appoint six (6) persons ("County Appointees") to serve as a member of the Board. The remaining six (6) members shall be appointed by the DWIHN Board of Directors ("DWIHN Appointees"). Appointed members shall represent the diversity of the DWIHN's service area and shall be consistent with the provisions of the DWIHN's Substance Use Disorder Oversight Policy Board Guidelines and the recommendations of the MDHHS Substance Use Disorder Oversight Policy Board Guidelines.

2.1.1 County Appointees shall be appointed by the Board of Wayne County Commissioners no later than during the Commission's last regular March meeting, in order to permit such individuals to begin to serve their terms no later than April 1st.

2.1.2 The Board shall nominate prospective DWIHN Appointees, pursuant to

majority vote. Annual Board nominations shall be presented to the DWIHN Board of Directors by the Board Chairperson (or his or her designee) for consideration, and potential approval, at the DWIHN Board of Directors' regular February meeting. A minimum of two (2), and no more than four (4), DWIHN Appointees to the Board shall be members of the DWIHN Board of Directors.

2.1.3 New members shall be appointed by the DWIHN Board of Directors no later than during its regular March meeting, in order to permit such individuals to begin to serve their terms no later than April 1st.

2.2 **TERM.** The members of the Board shall serve for a term of membership of three (3) years, and may be reappointed to additional or successive terms in the discretion of the respective appointing entity. The current list of appointments, their appointing entity and term of membership are included as Exhibit A of these Bylaws, which shall be updated on annual basis or as necessary.

2.3 **MEMBER REMOVAL AND RESIGNATION.** Each Board member may be removed from the Board for neglect of duty or misconduct in office, by a majority vote of the appointing entity's governing board. It is the responsibility of the Board, upon direction from the DWIHN's Board of Directors, or upon its own cognizance, to make a determination as to whether an appointing entity should be formally notified regarding a Board member's neglect of duty or misconduct. The Board Chairperson is responsible for informing the appointing entity of any lack of participation or attendance by an appointed Board member. A Board member's removal shall become effective upon receipt by the Board of a duly adopted written resolution of the appointing entity. A Board member may resign at any time by providing notification to his or her appointing entity and the Board. The resignation will become effective upon receipt of notice.

2.4 **VACANCIES.** A vacancy on the Board shall be filled for the unexpired term by the appointing entity in the same manner as the original appointment.

2.5 **CONFLICT OF INTEREST.** Board members shall adhere to all conflict of interest and ethics laws applicable to public officers and public servants. Accordingly, Board members shall comply with The DWIHN's Conflict of Interest Policy and its Standards of Conduct

2.6 **COMPENSATION.** Board members will be eligible for a stipend, and mileage expenses where allowable, as fixed by the DWIHN Board. A Board member may

not receive more than one stipend per day from the DWIHN regardless of the number of meetings attended by the Board member on that day.

2.7 **ATTENDANCE.** Each Board member shall attend all regular Board meetings and is expected to use good faith efforts to attend all meetings of any committee on which such Board member is serving. Requests to be excused from meetings shall be made prior to the meeting to the Board Chairperson or his/her designee.

2.8 **ORIENTATION.** New Board members shall receive an orientation about the DWIHN and their positions. Board member orientation shall include, but not be limited to; a review of these Bylaws, the DWIHN's Conflict of Interest Policy and any other policies which apply to Board members.

ARTICLE III - MEETINGS AND VOTING

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3.1 **CONDUCT OF MEETINGS.** Meetings will be held, a minimum of six (6) times per calendar year, or as needed to perform the functions of the Board. The first meeting of the Board after the annual appointments of the County and the DWIHN shall be the Board's annual meeting. All meetings of the Board shall be held at the principal offices of the DWIHN, or at such other place as shall be determined by the Board members, and stated in the notice of meeting. The Board shall follow Robert's Rules of Order at all meetings of the Board, in so far as they do not affect, alter or amend these Bylaws.

3.2 **OPEN MEETINGS.** All Board meetings shall be governed by, and conducted in accordance with the provisions of Act 267 of the Michigan Public Acts of 1976, commonly known as the "Open Meetings Act." Written notice of the time, place and purposes of each meeting of the members of the Board shall be given to each Board member and the public in accordance with the Open Meetings Act.

3.3 **VOTING.** Each member of the Board shall have one vote. Proxy voting is not permitted. A vote of the majority of members of the Board present at a meeting at which a quorum has been achieved is required for the Board to take official action.

3.4 **QUORUM.** A majority of members of the Board appointed and serving shall constitute a quorum for the transaction of ordinary business of the Board In the event the Board shall meet and a quorum is not present, the Board, with the approval of those present, may adjourn the meeting to a later day and time provided that proper notice to members and the public is given.

3.5 **MEETING BY REMOTE COMMUNICATION.** Telephonic and/or Electronic participation at Board meetings is permissible only if all applicable requirements of the Open Meetings Act, as amended, have been met. In person participation at Board meetings is strongly encouraged. However, on a limited basis, if allowable under the Open Meetings Act, and upon reasonable notice to the Director of Substance Use Disorder Initiatives and Board Chairperson,

a Board member may participate in a Board meeting through the means of a telephonic device, Skype or other video conferencing technology ~~when the technology becomes available~~. The person conducting the meeting (chairperson or vice chairperson) shall be physically present at the designated location of the meeting. The telephonic device, Skype or other video conferencing utilized at the location shall allow people in attendance to hear all of the meeting participants. Participation at a meeting pursuant to this section constitutes presence at the meeting for quorum, voting, and per diem purposes provided all applicable requirements of the Open Meetings Act have been met. ~~Open Meetings Act provisions, and t~~The same quorum requirements as noted in Article III, Section 3.4 shall apply. Board members not present in person, and participating by telephonic ~~device~~ or other means, may not participate in any closed session of the Board.

3.6 **MINUTES.** The DWIHN shall provide the Board with support to take notes and prepare minutes of the Board meeting as required by the Open Meetings Act. The Chairperson shall verify that such support will be available prior to each Board meeting, and may appoint a member to prepare such notes and minutes in the absence of such support being available. The minutes shall include all the actions and decisions of the Board. Copies of each resolution or other matter acted upon by the Board, as well as the official minutes, shall be maintained in a location designated by the DWIHN and copies of the approved, affirmed minutes shall be provided to Wayne County upon request or as needed.

ARTICLE IV - BOARD OFFICERS

4.1 **OFFICERS.** The officers of the Board shall be a Chairperson, a Vice Chairperson and a Secretary/Treasurer. Only Board members may serve as an officer. The person elected Chairperson shall preside at all meetings of the Board. In the absence of the Chairperson, the person elected Vice-Chairperson shall preside. In the absence of the Chairperson and Vice-Chairperson, the person elected Secretary/Treasurer shall preside. The Chairperson of the Board, and or his or her designee, shall report regularly to the DWIHN Board of Directors.

4.2 **ELECTION AND TERM OF OFFICE.** Officers shall be elected from among the Board members for a term of one (1) year (or until their successors have been elected) by the Board at its annual meeting. Any Board member interested in serving as an officer shall submit their name and the position they are interested in to the Chairperson and/or the Nominating Committee prior to the Board's annual meeting.

4.3 **REMOVAL OF BOARD OFFICERS.** Any officer of the Board may be removed from office with or without cause by the vote of a majority of the Board members elected and serving during a regular or special meeting of the Board.

4.4 **VACANCIES.** In the event of the death, resignation, removal or other inability to serve of any officer, the Board shall elect a successor who shall serve until the expiration of the normal term of such officer or until his or her successor has been elected.

ARTICLE V - COMMITTEES

5.1 **COMMITTEES.** The Board may establish and define the responsibilities of such standing or special committees from time to time as it shall deem to fulfill the purposes of the Board set out in Article I, Section 1.3. The Chairperson shall, in consultation with the Board, select membership of any committee formed. Open Meetings Act provisions, and the same quorum requirements as noted in Article III, Section 3.4, shall apply. Once a quorum is established, it is not broken, if a member of that committee leaves before the meeting ends, and at least three members remain in attendance.

5.2 **NOMINATING COMMITTEE.** The Nominating Committee shall consist of four members of the Board, and its purpose shall be to nominate Board Officers. The Nominating Committee shall be appointed by the Chairperson of the Board, shall meet annually or as necessary to fill an officer vacancy, and shall function, as set forth below.

The Chairperson shall annually appoint members to the Nominating Committee, prior to the January regular Board meeting. The Chairperson's slate of appointments shall be submitted for Board confirmation at the Board's regular January meeting and, if not approved, alternative slates of nominees shall be proposed until Nominating Committee members have been selected. The Nominating Committee shall report a recommended slate of officers at the annual meeting. The Board shall accept or reject the slate of officers by majority vote. If the Board rejects the slate of nominees, nominations for individual officer positions may be taken on the floor.

ARTICLE VI- MISCELLANEOUS

6.1 INDEMNIFICATION. Unless otherwise prohibited by law, the DWIHN shall indemnify any Board member or officer or any former Board member or officer ("indemnitee") against costs, expenses and liabilities incurred by the indemnitee in connection with any claim, action, suit or proceeding to which she or he is made a party by reason of her or his actions as a Board member or officer, undertaken in good faith and within her or his scope of authority. There shall be no indemnification in relation to matters as to which the indemnitee shall be adjudged to be guilty of a criminal offense or liable to the DWIHN for damages arising out of her or his gross negligence or self-dealing.

6.2 COMPLIANCE WITH LAWS. The Board and its members shall fully comply with all applicable laws, regulations and rules applicable to its operation, including without limitation the Code, the Open Meetings Act and the Michigan Freedom of Information Act (1976 PA 422).

6.3 AMENDMENT. An amendment to the Bylaws may be proposed by any Board member to the Board, and recommended to the DWIHN Board upon an affirmative vote of the Board members. DWIHN Board approval is required for the amendment to become effective.

Adopted: November 10, 2014
Revised and Approved: January 12, 2015
Revised and Approved: August 2020

EXHIBIT A

Board Members and Terms of Office

~~Name~~	~~Appointing Entity~~	~~Date of Appointment~~	~~Termination of Appointment~~
~~Thomas Adams~~	~~Wayne County Commission~~	~~April 1, 2018~~	~~March 31, 2021~~
~~Dr. Cynthia L. Arfken~~	~~DWIHN Board of Directors~~	~~July 17, 2019~~	~~March 31, 2022~~
~~Thomas Fielder~~	~~Wayne County Commission~~	~~July 25, 2019~~	~~March 31, 2022~~
~~Angelo Glenn~~	~~DWIHN Board of Directors~~	~~April 1, 2018~~	~~March 31, 2021~~
~~William Riley~~	~~DWIHN Board of Directors~~	~~April 1, 2019~~	~~March 31, 2022~~
~~William Ventola~~	~~DWIHN Board of Directors~~	~~April 1, 2019~~	~~March 31, 2022~~
~~Ghada Abdallah~~	~~DWIHN Board of Directors~~	~~April 1, 2018~~	~~March 31, 2021~~
~~Jewel Ware~~	~~Wayne County Commission~~	~~April 1, 2018~~	~~March 31, 2021~~
~~Kevin McNamara~~	~~DWIHN Board of Directors~~	~~March 19, 2018~~	~~March 31, 2022~~
~~James Perry~~	~~Wayne County Commission~~	~~April 1, 2017~~	~~March 31, 2020~~
~~Monique Stanton~~	~~Wayne County Commission~~	~~July 25, 2019~~	~~March 31, 2022~~
~~Margo Lane Martin~~	~~Wayne County Commission~~	~~February 8, 2018~~	~~March 31, 2020~~

Name	Appointing Entity	Date of Appointment	Termination of Appointment
Dr. Cynthia L. Arfken	DWIHN Board of Directors	April 1, 2022	March 31, 2025
Angelo Glenn	DWIHN Board of Directors	April 1, 2021	March 31, 2024
Chief William Riley	DWIHN Board of Directors	April 1, 2022	March 31, 2025
Maria Avila	DWIHN Board of Directors	April 1, 2021	March 31, 2024
Jonathan Kinloch	DWIHN Board of Directors	April 1, 2021	March 31, 2024
Kevin McNamara	DWIHN Board of Directors	March 19, 2022	March 31, 2025

Adopted: November 10, 2014
Revised and Approved: January 12, 2015
Revised and Approved: August 2020

Thomas Adams	Wayne County Commission	April 1, 2021	March 31, 2024
James Perry	Wayne County Commission	February 3, 2022	March 31, 2024
Thomas Fielder	Wayne County Commission	July 25, 2019	March 31, 2022
Ronald Taylor	Wayne County Commission	July 25, 2019	March 31, 2022
Margo Lane Martin	Wayne County Commission	February 3, 2022	March 31, 2024
Darryl Woods	Wayne County Commission	September 1, 2021	March 31, 2024

~~EXHIBIT B~~

Adopted: November 10, 2014
Revised and Approved: January 12, 2015
Revised and Approved: August 2020

President and CEO Report to the Board
Eric Doeh
March 2022

DWIHN continues to focus on a number of important issues including the legislation that is before both the House and the Senate. Senate Bills 597 and 598 were both on the Senate floor last week and received a third reading, meaning that the next stage is a voice vote. It appears that Sen. Shirkey does not have the votes. DWIHN's leadership has continued to meet with legislators, stakeholders, provider network and the people we serve in our advocacy efforts regarding these bills. A recent EPIC-MRA poll found that 67% of Michigan voters prefer the public metal health system to be managed by the public entities as opposed to the health plans.

Financially, DWIHN is in a good position. The 5% rate increase and over $25 million that we have provided in retention payments were a result of our financial position. Our Medicaid savings is positioned well, as well as our Medicaid Internal Service Fund (ISF). We continue to make significant progress with our infrastructure transformation, our Care Center and our new administrative building. We are awaiting final approval from the City of Detroit so that we could move forward with construction in early April.

We have seen tremendous improvements in our performance bonus incentive. This is joint metrics with the health plans. For fiscal year 2021, DWIHN earned a total performance incentive of 91.39%, which is approximately $4.38 million.

Mental Health Care – Putting Children First

In light of recent events and DWIHN's continued effort to provide readily accessible supports and services to children and families, DWIHN has launched its "Putting Children First" initiative. This initiative works to ensure all children have the supports and services they need, but also focuses on several specialty populations, including Children Age 0-6, Transition Age Young Adults, Foster Care, Juvenile Justice, Pediatric Integrated Health Care, Schools, and Diversity, Inclusion, Equity. This is a multi-faceted approach emphasizing Access to Care, Prevention, Crisis Intervention and Treatment. DWIHN is currently meeting with schools, juvenile justice partners, Tri-County representatives, and providers on a collaborative approach to providing resources, training and support to children and their families. A comprehensive workplan was shared with the Program Compliance Committee during the March meeting.

Finance

Detroit Wayne Integrated Health Network (DWIHN) Finance Department has completed the fiscal year ended September 30, 2021 Financial Status Report (FSR) and the following is a summary of the results:

- Medicaid savings of $39.8 million or 5% of total Medicaid revenue. This is the maximum allowed prior to the 50/50 risk corridor (i.e. lapsed funds);

- Medicaid Internal Service Fund (ISF) of $59.7 million or 7.5%. This is the maximum amount allowed per the Pre-paid Inpatient Health Plan (PIHP) contract with the Michigan Department of Health and Human Services (MDHHS). DWIHN is in full contractual compliance with the requirements set forth;
- General Fund carryover of $1.5 million or 5% of total General Fund revenue. This is the maximum amount allowed per the Community Mental Health Services Provider (CMHSP) contract with the MDHHS;
- Public Act 2 (PA2) balance of $6.5 million; an increase of $1.8 million as compared to the prior year;
- Direct Care Worker (DCW) cost settlement of $12.2 million; MDHHS requires funds received in excess of expenses to be returned; local revenue received and expenses incurred were $50.4 million and $38.1 million, respectively;
- DWIHN spent Substance Use Disorder (SUD) funds allocated that are not allowed to be carried over.

MDHHS provided a $4.4 million supplemental General Fund allocation to increase the amount to $25.4 million; General Fund is $4.4 million less than FY20. Due to the Public Health Emergency (PHE), General Fund reductions were not a major concern, however the PHE is expected to end on April 16, 2022. Continued reductions will result in DWIHN likely unable to meet the requirements of the Mental Health Code (MHC).

ADVOCACY

DWIHN has been working with our lobbyist firm, Public Affairs Associates (PAA), to meet with various legislators and other leadership in Lansing and MDHHS to discuss the state of behavioral healthcare services in Michigan. Information and updates have been shared with our Provider Network, stakeholders and persons served on a regular basis about COVID-19, essential clinical services and supports and funding updates from MDHHS.

DWIHN has collaborated with CMHAM and other CMHs around the state to creating a joint advocacy effort that would address the redesign efforts. These efforts include targeted social media posts, a refined video featured persons served, EPIC-MRA polls to gauge the public sentiment and electronic and print media messaging.

Advocacy efforts with legislators over the last several weeks has been focused on meeting with key Senators, urging them to oppose SB 597 and 598. At this point, a number of Republican Senators remain opposed to these bills, with others leaning toward opposition.

A January 2022 EPIC-MRA poll found 67% of Michigan voters prefer the public mental health system to be managed by public entities who specialize in mental health care vs. turning the system over to private, for-profit companies.

FACILITIES

Milwaukee Tasks	Completion Date
Community Engagement Meeting	3/3/2022
Milwaukee Care Center Building Permit Plan Review	3/10/2022
Department Packing/Closeout	3/16/2022
Community Engagement Meeting	3/17/2022
Furniture Sale	3/24/2022
Milwaukee Building – Limited Access for Staff Begins	3/25/2022
Building Equipment/Material Removal	3/31/2022
Milwaukee Care Center Construction RFP	4/1/2022
Milwaukee Care Center Construction Vendor Presented for Board Approval	4/20/2022
Milwaukee Care Center Construction Commence	5/2/2022
Office and Boardroom Tasks/Community Meeting Space	**Completion Date**
Considine Center Space Acquisition	3/1/2022
Mobile Onsite Office Board Action and Board Meeting Location Update – Executive Committee	3/14/2022
Installation of Mobile Onsite Office	3/21/2022
Building Equipment/Material Removal	3/31/2022
Woodward Tasks	**Completion Date**
Community Engagement Meeting	2/10/2022
Woodward Admin Building Permit Plan Review	2/24/2022
Zoning Board Hearing	3/2/2022
Woodward Admin Building Zoning Approval	3/10/2022
Woodward Admin Building Construction Contract Award	3/25/2022
Woodward Admin Building Construction Commence	4/1/2022

Additional Items of Note:
St Regis Hotel will host all DWIHN Full Board, Committee and SUD Oversight Policy Board Meetings from April 2022–2023.

DWIHN will continue to work with Considine Little Rock Life Center and host our Community Outreach meetings throughout our construction period at the facility. Considine will also serve as a resource for other community engagement events for DWIHN programs and services.

INFORMATION TECHNOLOGY

Therefore Document Management System:

This is a collective effort project among all IT units. This project will take us to a digital solution to accommodate retention requirements, and reduce the need for physical storage. Continued working with different DWIHN business entities to coordinate scanning of paper into the document management system, as well as restructuring business processes utilizing this system.

Applications and Data Management:

- IT staff attended PowerBI training
- Worked on PowerBI dashboards for the Call Center management team
- Developed several comprehensive new Power BI dashboards for use across many departments within DWIHN

Infrastructure:

- Monitor configurations and issuance
- IT Equipment checks for entire organization
- Boardroom continuous improvement for Audio Video configuration

Construction projects:

- Infrastructure requirements gathering for site locations
- Compliance /Security
- Network Fiber connectivity between Milwaukee and Woodward
- Infrastructure/ Nutanix upgrade
- Offsite storage

HUMAN RESOURCES

Development training for DWIHN Senior Management staff began in June 2021 in the following areas: Optimize Performance Through Effective Supervision; Communicate for Success; Ready, Set, Goals; Praise and Recognition to Motivate; Redirect and Coach to Inspire; Handle Difficult Behavior and Discipline; Delegate with Results; Continuous Process Improvement; Lead Effective Meetings; Manage Time and Priorities; Build Teams; and Be a Change Agent. Training for mid-level managers and supervisors began in March 2022 and will offer the same topics. Diversity, Equity and Inclusion training is planned for March as well.

DWIHN continues to hire staff to augment our already exceptional workforce. During the month of February, we hired eight full or part-time employees, including our new Director of Strategic Operation, who began on February 28, 2022, and Compliance Officer, who began on March 7, 2022. As part of our preparation for additional integrated services, we are also adding a strategic administrator to assist in implementing and expanding behavioral health homes, certified community behavioral health clinics, and opioid health homes.

The Department of Human Resources is also working to complete the scanning project that will scan all necessary DWIHN files. As of the date of this letter, we have scanned over 400 boxes.

CHIEF CLINICAL OFFICER

Health Home Initiatives:

Behavioral Health Home (BHH): This model focuses on care coordination and health education for Medicaid recipients that have an eligible diagnosis, to ensure persons have both their physical and behavioral healthcare needs met. MDHHS held a BHH kick-off on March 1-2, 2022 for PIHPs and Health Home Partners (HHPs). This reviewed the BHH model, funding, and enrollment. DWIHN has been meeting with our five (5) identified HHPs on a regular basis to provide training and technical support. The National Council is currently providing Case to Care Management training for both our identified health home partners and DWIHN internal staff. The official implementation date for BHH is April 1, 2022.

Certified Community Behavioral Health Clinic - State Demonstration (CCBHC): A CCBHC site provides a coordinated, integrated, comprehensive services for all individuals diagnosed with a mental illness or substance use disorder. It focuses on increased access to care, 24/7/365 crisis response, and formal coordination with health care. This State demonstration model launched on 10/1/2021. The Guidance Center currently has 2,713 members that have been enrolled in the CCBHC services (a 9% increase in enrollment since January 2022). CCBHC Medicaid recipients are funded using a prospective payment model. DWIHN has requested ARPA funds and additional general funds for CCBHC non-Medicaid recipients.

Opioid Health Home (OHH): This model focuses on comprehensive care coordination and health education for Medicaid recipients that have an eligible Opioid Use diagnosis, to ensure persons have both their physical and behavioral healthcare needs met. DWIHN currently has 258 enrolled members receiving this comprehensive array of integrated healthcare services. This has been a 25% increase in OHH enrollment since January 2022.

INTEGRATED HEALTHCARE

The State has established Performance Bonus Incentive Pool (PBIP) where they withhold 0.75% of payments for the purpose of establishing a PBIP that has joint metrics with Mental Health Plans (MHP), Pay for Performance Narrative that is completed by PIHP IHC Department and PIHP only metrics. They released their results for FY 21 almost a month ago:

Total Performance Incentive Earned: 91.39% of available amount (FY 20 = 74.46%)

- PIHP/MHP Joint Metrics: Score 71/100 or 71% (FY 20 = 49%)
- PIHP Only Metrics: Score 200/200 or 100% (FY 20 = 100%)

Care Coordination data sharing involves developing and updating Joint Care Plans between DWIHN and the Medicaid Health Plans. IHC staff continued to collaborate with the Medicaid Health Plans regarding increasing the number of members reviewed during the meetings. The monthly average of cases reviewed during the first quarter of FY 22 was 48.

IHC continues to offer and provide Complex Case Management services to DWIHN members as part of DWIHN's NCQA accreditation. For the month of February, there are currently none active cases, three new case opened, seven case closures, and no pending cases. Four cases were closed due to meeting their treatment goals, and 3 was unable to reach. Care Coordination services were provided to 15 additional members in February who either declined or did not meet eligibility for

CCM services. Follow up after hospitalization was competed with 43 consumers to help identify needs.

QUALITY

DWIHN has continued to show upward trend for majority of our Michigan Mission Based Performance Indicators. Performance incentives have been attached to them and are starting to go live now so we are expecting to see further improvements. For 4th Quarter 2021 reporting, DWIHN met the overall MDHHS thresholds for PI#1 (pre-admission screening within 3 hours- 95.59%), #4a (Hospital Discharges Follow-Up- 95.45%), #4b (Detox Discharges Follow-Up- 98.33%) and #10 (Inpatient Recidivism- 14.51%).

MDHHS will be conducting a review of our waiver and substance use disorder services starting mid-March and Quality team is working to meet the pre-review requirements. BHDDA completed part of their review of Critical incidents report and time frames. They recognized and appreciated Region 7 (DWIHN's) improved performance in FY 21 where 6 incidents were out of the compliance time frame versus 28 in FY 20.

HSAG and MDHHS has completed the review of DWIHN's remediation plan to address the deficiencies identified during the SFY 2021 Compliance Review activity. Each action plan was assigned a designation of Accepted, Accepted with Recommendations or Not Accepted. The Quality Team continues to conduct internal meetings no less than twice per month with each assigned unit to ensure the plans of action are successfully implemented and the noted deficits have been remediated. HSAG has requested DWIHN submit status update reports on March 30 and September 30, 2022.

UTILIZATION MANAGEMENT

The UM team partnered with Procedure Code Work Group (PCWG) to ensure that DWIHN's fee schedule is consistent with updates from MDHHS. DWHIN updated the fee schedules and service utilization guidelines with the updated information. DWIHN's UM Department provided training and guidance to the ASD Network on the changes.

Out of the 1,122 authorization approvals in February, 97.59% were approved within 14 days of the request and 2.41% were approved 15 days or more after the submission. The UM Department continues to review and update the Service Utilization Guidelines to allow for auto approval of medically necessary services and decrease the number of authorizations requiring manual review. The Department also provided authorization guidance for providers who service children to support the network with the authorization process, help reduce the number of errors and decrease any delays in service provision. There were 26 MI Health Link authorizations received in February compared to 35 authorizations during the month of January. One hundred percent (100%) of these requests were processed within the appropriate timeframes.

February 2022 UM Outcomes:

- Autism: There are 2,239 members currently receiving this benefit. There were 369 authorization requests, and of those requests, 251were manually approved. The remainder of authorization requests were approved using the Standard Utilization Guidelines.

- Habilitation Supports Waiver: There are 1,084 slots assigned to the DWIHN and 1,022 were filled which is a utilization rate of 94.3%. This is just short of the 95% utilization goal.
- State Hospital: There were 2 State Hospital admissions in February. State hospital admissions continue to be restricted to forensic referrals, but community referrals may be prioritized if hospital or residential placement options have been exhausted.
- Inpatient Admissions: There were 579 admissions for psychiatric inpatient treatment which reflects a 14.34% decrease from January 2022. There were 13 members (2.25%) in February who readmitted within 30 days of a prior hospitalization compared to 57 members in January. The Average Length of Inpatient admissions for February was 8.19, a decrease from 12-day average in January 2022.
- The UM Department received results for an audit conducted by Median Healthcare (formally Michigan Complete) and scored a 98.39%. The audit did not result in any corrective action plans.

Clinical Practice Improvement

Evidence-Based Supported Employment (EBSE): To date there have been 197 referrals and 174 admissions into Supported Employment services. As a result, there has been 101 competitively employed in the community in a variety positions including, but not limited to, wait staff, janitor, Amazon Driver, office manager, caregiver, stock worker, and assembly/ production worker with an average hourly wage of $14.00. Twenty-two members successfully transitioned from EBSE services as their employment goals were met.

Med Drop: Med Drop is a program that assists individuals with medication management by providing and assisting to administer their medications in their own home. DWIHN currently has 37 individuals in the Med Drop program and expanding these services to a variety of high-risk populations. Since Med Drops inception, DWIHN has observed the following outcomes: 79% reduction in the number of psychiatric hospital admissions compared to the number of psychiatric hospital admissions in the 12 months prior to entering the Med Drop Program.

Residential Services

The Residential Department received 254 residential referrals in the month of February. There were also eight homes that were closed in the month of February. All home closures followed a multi-department close out process that included the Residential Team working with members on identifying new residences. The Residential Team continues to track and monitor requests for assistance from providers and resultant timeliness. During the month of February 2022, the Residential Team received 439 requests for assistance through email and phone calls. Seventy-nine percent (79%) were responded to within 24-48 hours, five percent (5%) where connected with other DWIHN departments for resolution, eight percent (8%) required further investigation, and eight percent (8%) where referred to a supervisor for further review and resolution.

There were 1,087 authorization requests in the month of February, and of those, 336 (31%) were returned to CRSPs for additional information/documentation. The Residential Team continues to provide monthly authorization refresher trainings for CRSP providers, in addition, DWIHN meets with CRSPs monthly to review system /process updates, identify potential barriers and discuss resolutions.

DWIHN has started to see a decrease in COVID-19 cases in congregate settings in the month of February. There have been four (4) reported positive cases of Covid-19 and one (1) related death. This is a significant decrease compared to the month of January (60). Currently over ninety percent (90.4%) of persons living in licensed residential settings have been fully vaccinated. Over sixty-seven percent (67.5%) of person living in unlicensed settings have been vaccinated (for a total of 82.3% members vaccinated in congregate settings). Currently 1,272 residential members have received a booster vaccination (up from 739 in January- 72% increase).

CHILDREN'S INITIATIVES

School Success Initiative (SSI): SSI Therapists are in a total of 72 schools (25 schools are in Detroit and 47 schools are in Out-Wayne County). DWIHN met with School Based Health Centers to coordinate status, progress, and discuss school needs. DWIHN created a calendar to schedule intake appointments and providers are coordinating with the Access Department for referral status. The enrollment section has now also included the option to show if a member declines service.

Clinical Services: During Q1 2022 DWIHN served a total of 10,966 children, youth, and families in Wayne County ages 0 up to 20; including both Serious Emotional Disturbance (SED) and Intellectual/Developmental Disability (I/DD) disability designations. Children Providers provided 6,891 members with SED services and 4,075 members with I/DD services.

Home-Based Services: A total of 526 families received Home Based services among 13 Children Providers. There was a 12.5% decrease from the previous quarter of members receiving HB services; primarily due to staff shortages. The average length of stay for members to receive HB services was about 15 months long. Fifteen members with I/DD designations received HB services as well; which was a 66% increase from the previous quarter. Lastly, 19.8% of the members in HB services presented with meaningful and reliable improvement according to CAFAS scores.

Wrap-Around Services: A total of 313 families received Wrap Around services among 9 Children Providers. There were 42 new families who started Wrap Around services. There was a 5.2% decrease of families receiving Wrap Around services compared to the last quarter and a 36.4% decrease of new referrals compared to last quarter. 14 months was the average length of stay for families receiving this service. About 51% of the families who transitioned successfully completed all 4 phases of the Wrap Around model.

SUBSTANCE USE SERVICES

Opioid Initiative: DWIHN continues to train providers, health care workers, jail staff, drug court staff, community organizations and members of our community on how to use Naloxone to reverse opioid overdose. Since 10/1/2021, DWIHN has provided twenty-five (25) Narcan trainings. DWIHN has two mobile units that provide: SUD screenings for services, referrals to treatment, peer services, drug screenings, therapy, and relapse recovery services, Naloxone distribution and training. The Barbershop Men's Health Initiative is another initiative that connects barbers and the clients to Narcan training and information on men's health. DWIHN's Naloxone Initiative programs have saved 1,034 lives since its inception.

Women's Pregnant and Post-Partum Pilot Program: DWIHN recently received additional funding to provide integrated services that support family-based services for pregnant and postpartum women (and their minor children) with a primary diagnosis of SUD, including Opioid Use

disorders. This includes outreach, screening & assessment, Peer Recovery supports, case management, and evidence-based practices. DWIHN is currently working with two identified providers on implementation of this program.

Authorizations: There was a reported total of 1,903 SUD authorizations approved during the month of January. Over ninety-nine percent (99) of Urgent Authorizations were authorized within 72 hours and 99% of non-urgent authorizations were approved within 14 days.

CRISIS SERVICES

DWIHN is working closely with Wayne Health on mobile outreach services to establish locations that can focus on behavioral health needs in the community. This included development a work plan that outlines goals with target dates and weekly meetings to compare community opportunities using a data-drive approach.

DWIHN continues to work with the provider network on inputting and utilizing "crisis alerts" that will serve as a beginning of communication for members in crisis, and the newly hired liaisons are working to monitor and troubleshoot with our CRSPs. Automatic notifications in PCE will be in place to notify the CRSP of members in a crisis setting. DWIHN is monitoring crisis plans and AOT orders of members in crisis, and providing support and troubleshooting for the CRSP with regard to having current and updated crisis plans within the system.

DWIHN has developed a plan and procedure for discharge planning and transitions in care to meet the need for support in these areas. Newly hired liaisons are finishing their training, and have been prepared to assume a hybrid role to include discharge planning and coordination for members in transition, as well as continued efforts in the emergency departments.

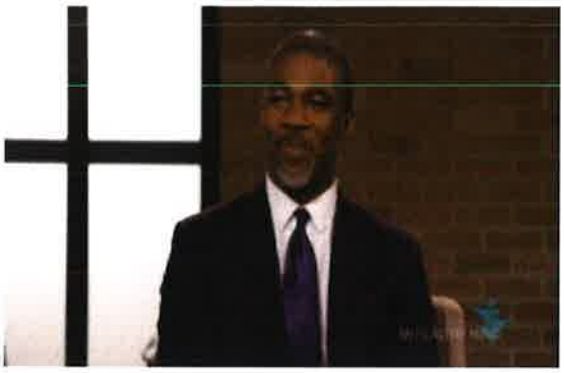
The Juvenile Detention Facility (JDF), MDHHS and DWIHN, as well as other law enforcement agencies, have met to collaborate in order to make communication efficient and to develop processes and procedures for information sharing. DWIHN is represented on the Outcomes Improvement Committee and on the Tri-County Initiative to address threat assessments in schools and other facilities.

COMMUNICATIONS

Television:

WMYD TV20 Detroit - 2/13/22

I was featured on TV 20's MI Healthy Mind. The episode highlighted the support, services and resources DWIHN provides to the community. Ambassador and Constituents' Voice member, Michael Squirewell, also shared his mental health journey and how he found help, hope, and a new life through DWIHN and its Providers after being a member of a notorious gang for many years. Below is a link to the show: *https://youtu.be/VmKp6s-mSH8*

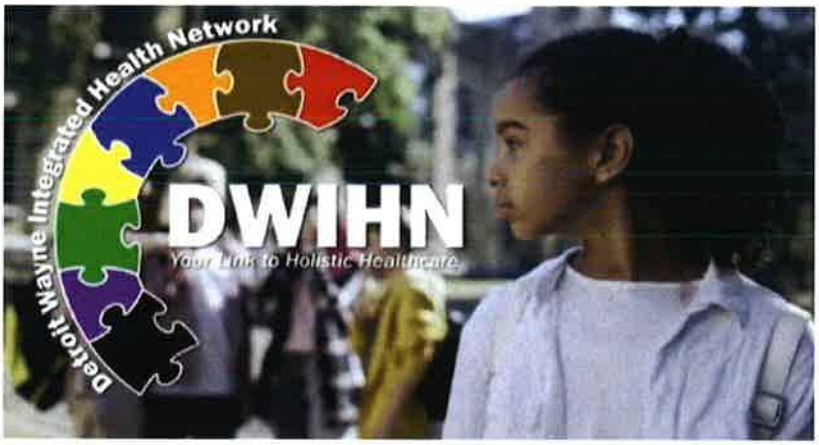


Scripps Media: WXYZ TV 7, TV 20 and Bounce

In February, DWIHN had two Children's Mental Health Care messages airing on 3 stations.

https://www.youtube.com/watch?v=M8b-bYPdKYo
https://www.youtube.com/watch?v=uBgbmjSSxpk

WDIV/ LOCAL 4



Children's Mental Health Care messaging continues on Channel 4.

https://www.youtube.com/watch?v=KRDPSAK7Iqs

Digital:

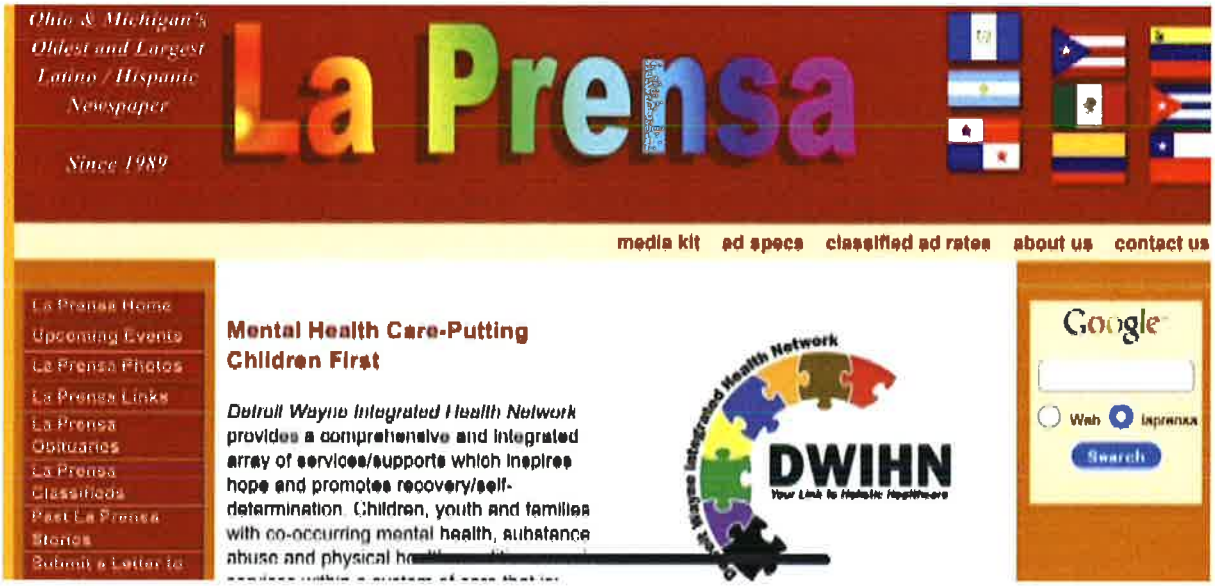
Sports Marketing Agency - 2/24/22

Andrea Smith, DWIHN Director of Workforce Training & Program Development, was a featured guest on the Sports Marketing Agency's new podcast, This Is The "F" Word. The episode explained the importance of destigmatizing mental health care.

https://drive.google.com/file/d/1TnvPegfMq7-BgfZgY4qY2P5yDVDzS0mC/view

Print:

DWIHN had educational messaging in the Hamtramck Review, La Prensa the Latino Press and MI Chronicle.

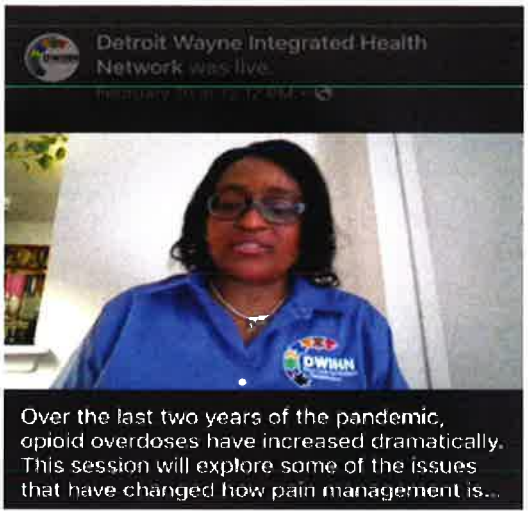


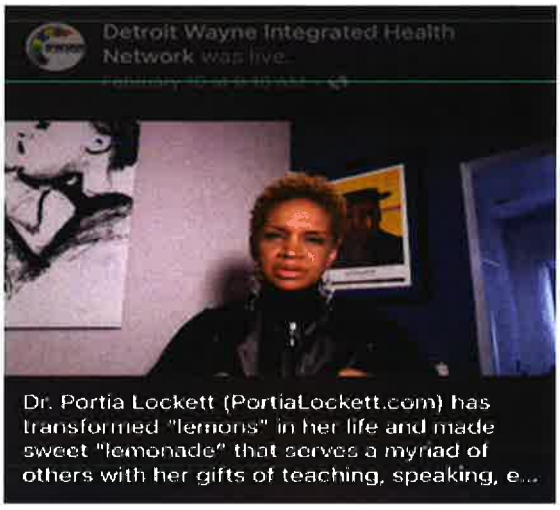
Community Outreach:

February 3, 2022 - Youth United hosted a Youth Move Detroit meeting for youth ages 14-25.

February 10, 2022 - DWIHN hosted a Community Town Hall Meeting for Woodward community stakeholders, updating them on building construction plans.

February 10, 2022 - DWIHN hosted the 7th Annual Trauma Conference that was lived streamed on DWIHN's Facebook account.
https://www.facebook.com/DetroitWayneIHN/videos/531315644994281





February 19, 2022 - I was the keynote speaker for the Men's 3rd Annual Substance Abuse Prevention, Mental Health and Wellness Summit.

Ask the Doc:
DWIHN's Chief Medical Officer, Dr. Shama Faheem, continues to educate the public with her bi-monthly newsletter and digital content which contains information about COVID-19, vaccinations and answers questions that are sent in by staff, people we serve, etc.
https://www.youtube.com/watch?v=oB2f9LfCIME&t=6s

Social Media:
Top Performing Posts: National Caregivers Day, Black History Month facts:

Detroit Wayne Integrated ...
Fri 2/18/2022 8:00 am EST

The Detroit Wayne Integrated Health Network celebrates and salutes all the Providers, direct care staff, and caregive...

Reach **686**

Detroit Wayne Integrated ...
Mon 2/7/2022 7:06 pm EST

As we continue to celebrate Black History Month, please check out our calendar of #BHM events happening this week. The...

Reach **463**

Detroit Wayne Integrated ...
Thu 2/3/2022 2:17 pm EST

Fellow Michigander, District Judge Stephanie Dawkins Davis, has been nominated for the U.S. Court of Appeals....

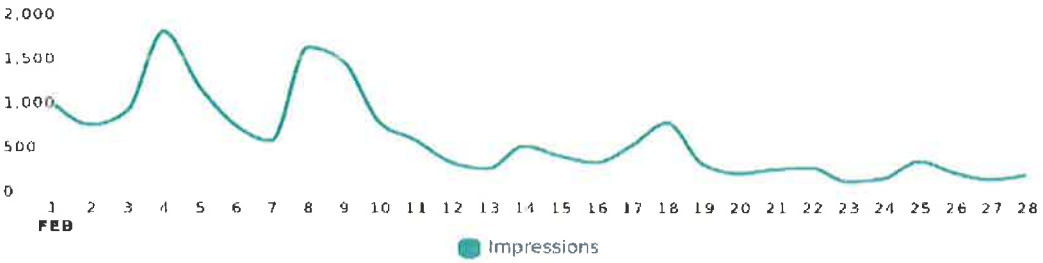
Biden Nominates Black Female M...

Reach **426**

DWIHN social media accounts are consistently growing this past month, LinkedIn had a major increase in impressions.

Impressions
Review how your content was seen by the LinkedIn community during the reporting period.

Impressions, by Day



Impression Metrics	Totals	% Change
Impressions	**16,830**	↗ 62.3%
Average Daily Impressions per Page	601.07	↗ 79.7%
Average Daily Reach per Page	308.43	↗ 87.7%

DETROIT WAYNE INTEGRATED HEALTHNETWORK
BOARD ACTION

Board Action Number: 21-71R Revised: Y Requisition Number:

Presented to Full Board at its Meeting on: 3/16/2022

Name of Provider: American Society of Employees, Inc.

ContractTitle: Leadership Training Services

Address where services are provided: 'None'

Presented to Finance Committee at its meeting on: 3/2/2022

Proposed Contract Term: 3/1/2021 to 9/30/2022

Amount of Contract: $ 181,000.00 Previous Fiscal Year: $ 106,000.00

Program Type: Continuation

Projected Number Served- Year 1: 137 Persons Served (previous fiscal year): 43

Date Contract First Initiated: 10/1/2017

Provider Impaneled (YIN)? 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 Detroit Wayne Integrated Health Network is requested approval of a modification to our agreement with the American Society of Employees (ASE) for training services.

As a result of hiring additional management staff, we have incurred additional costs in pre-employment testing and background checks. We will also be conducting a second round of manager training.

We are requesting additional funds in the amount of $75,000, bringing the total contract to $181,000.00, with an extension of time through September 30, 2023.

Outstanding Quality Issues (YIN)? ..N_ If yes, please describe:

Source of Funds: Multiple

Fee for Service (Y/N): N

Revenue	FY 21/22	Annualized

Multiple	$ 181,000.00	$ 181,000.00
	$ 0.00	$ 0.00
Total Revenue	$ 181,000.00	$ 181,000.00

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

Type of contract (Business/Clinical): Business

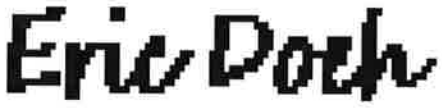
ACCOUNT NUMBER: 64910.817000.00000

In Budget (Y/N)? Y

Approved for Submittal to Board:

Eric Doeh, Chief Executive Officer

Signature/Date:



Signed: Tuesday, March 8, 2022

Stacie Durant, Chief Financial Officer

Signature/Date:

Signed: Tuesday, March 8, 2022

BOARD ACTION TAKEN

The following Action was taken by the Full Board on the 16th day of March, 2022.

- [x] Approved
- [ ] Rejected
- [ ] Modified as follows: _____

- [ ] Executive Director - Initial here: ____

- [ ] Tabled as follows: _____

Signature Lillian M. Blackshire
Board Liaison

Date 3/16/2022

DETROIT WAYNE INTEGRATED HEALTH NETWORK
BOARD ACTION

Board Action Number: 22-12 R3 Revised: Requisition Number:

Presented to Full Board at its Meeting on: 3/16/2022

Name of Provider: Detroit Wayne Integrated Health Network

Contract Title: FY 2021-2022 Operating Budget

Address where services are provided: 'None'

Presented to Finance Committee at its meeting on: 3/2/2022

Proposed Contract Term: 10/1/2021 to 9/30/2022

Amount of Contract: $ 959,311,149.00 Previous Fiscal Year: $ 927,640,119.00

Program Type: Modification

Projected Number Served- Year 1: 70,000 Persons Served (previous fiscal year): 70000

Date Contract First Initiated: 2/11/2022

Provider Impancled (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).

Staff requests DWIHN Board approval to amend the FY 2022 Operating Budget as follows:

1. Certify State General Fund revenue of $4,494,180 per MDHHS Supplemental General Fund Appropriation;

2. Certify Federal Grant Fund revenue of $1,254,060 per American Rescue Plan grant award;

3. Certify Federal Grant Fund revenue of $267,302 per the Woman's Post-Partum Pilot Program grant award;

4. Decertify Local Grant Fund revenue of $121,650 to align the budget with the FY 2022 Jail Plus Program Grant award from Wayne County.

5. To include a newly created position for Physician Consultant (@ $151,000 maximum salary for FY 2022) to handle appeals. The cost of this additional position will be transferred from the reserve account.

The revised FY 2022 Operating Budget, in the amount of $959,311,149 includes revenue of: $25,955,085 (State General Funds); $735,553,673 (Medicaid, DHS Incentive, Medicaid-Autism, Children's/SED Waiver, HAB); $9,886,123 (MI Health Link); $118,163,663 (Healthy MI-Mental Health and Substance Abuse);$17,686,447 (Wayne County Local Match Funds); $4,040,539 (PA2 Funds); $4,988,982 (State Grant portion of OBRA, SUD); $41,755,637 (Federal Grant Funds); $241,000 (Local Grant Funds); $1,000,000 (Interest Income); and $40,000 (Miscellaneous Revenue).

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

Source of Funds: Multiple

Fee for Service (Y/N): N

Revenue	FY 21/22	Annualized
MULTIPLE	$ 959,311,149.00	$ 959,311,149.00
	$ 0.00	$ 0.00
Total Revenue	$ 959,311,149.00	$ 959,311,149.00

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

Type of contract (Business/Clinical): Business

ACCOUNT NUMBER: MULTIPLE

In Budget (Y/N)?

Approved for Submittal to Board:

Eric Doeh, Chief Executive Officer

Signature/Date:

Eric Doeh

Signed: Friday, February 25, 2022

Stacie Durant, Chief Financial Officer

Signature/Date:

Stacie Durant

Signed: Friday, February 25, 2022

BOARD ACTION TAKEN

The following Action was taken by the Full Board on the 16th day of March, 2022.

- [x] Approved
- [ ] Rejected
- [ ] Modified as follows: _____

- [ ] Executive Director - Initial here: ____

- [ ] Tabled as follows: _____

Signature Lillian M. Blackshire
Board Liaison

Date 3/16/2022

DETROIT WAYNE INTEGRATED HEALTH NETWORK
BOARD ACTION

Board Action Number: BA 22-16R Revised: Requisition Number:

Presented to Full Board at its Meeting on: 3/16/2022

Name of Provider: The Detroit Association of Black Organizations Dabo, Inc.

Contract Title: SUD Prevention Funding FY 22 Revised

Address where services are provided: 'None'

Presented to Program Compliance Committee at its meeting on: 3/9/2022

Proposed Contract Term: 10/1/2021 to 9/30/2022

Amount of Contract: $ 6,490,938.00 Previous Fiscal Year: $ 5,632,133.00

Program Type: Continuation

Projected Number Served- Year 1: 250 Persons Served (previous fiscal year): 250

Date Contract First Initiated: 10/1/2021

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).

Requesting board approval to amend the FY 22 SUD Prevention Services board action by an additional $6,000.00 in PA 2 funds for The Detroit Association of Black Organizations (DABO) to service Families Against Narcotics (FAN) Detroit Hope Not Handcuffs program in the Detroit Police Department's 2nd Precinct with the assistance of Commander Brian Mounsey, and secured permission from Executive Deputy Chief Bettison. Through Hope Not Handcuffs a person struggling with any substance use disorder can come to any of the participating police agencies and ask for help.

The FY 22 SUD Prevention Services program of $6.484,938.00 is increased by $6,000.00 to $6,490,938.00 and consists of Federal Block Grant revenue of $4,475,938.00 and Public Act2 Funds of $2,015,000.00 is designated to PA2.

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

Source of Funds: PA2

Fee for Service (Y/N): N

Revenue	FY 21/22	Annualized
SUD Block Grant	$ 4,475,938.00	$ 4,475,938.00
Local Funds - Public Act 2 (PA2)	$ 2,015,000.00	$ 2,015,000.00
Total Revenue	$ 6,490,938.00	$ 6,490,938.00

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

Type of contract (Business/Clinical):

ACCOUNT NUMBER: MULTIPLE

In Budget (Y/N)?

Approved for Submittal to Board:

Eric Doeh, Chief Executive Officer

Signature/Date:

Eric Doeh

Signed: Wednesday, February 23, 2022

Stacie Durant, Chief Financial Officer

Signature/Date:

Stacie Durant

Signed: Thursday, February 17, 2022

BOARD ACTION TAKEN

The following Action was taken by the Full Board on the 16th day of March, 2022.

- [x] Approved
- [ ] Rejected
- [ ] Modified as follows: _____

_____

- [ ] Executive Director - Initial here: ____

- [ ] Tabled as follows: _____

Signature Lillian M. Blackshire
Board Liaison

Date 3/16/2022

DETROIT WAYNE INTEGRATED HEALTH NETWORK
BOARD ACTION

Board Action Number: BA 22-17R Revised: Requisition Number:

Presented to Full Board at its Meeting on: 3/16/2022

Name of Provider: DWIHN Provider Network - see attached list

Contract Title: SUD Treatment Funding FY 22 (Revised)

Address where services are provided: 'None'

Presented to Finance Committee at its meeting on: 3/2/2022

Proposed Contract Term: 10/1/2021 to 9/30/2022

Amount of Contract: $ 7,870,748.20 Previous Fiscal Year: $ 6,291,109.00

Program Type: Continuation

Projected Number Served- Year 1: 2,500 Persons Served (previous fiscal year): 2500

Date Contract First Initiated: 3/1/2022

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 revised board action is a request to increase the amount by $39,848.20 from the initial amount of 7,830,900.00 to 7,870,748.20. The action is requesting to allocate the additional Public Act 2 funds of $1,748.20 for FASTSIGNS to pay for services to replace old logos and lettering with the most current and up-to-date logo and lettering for DWIHN. Also, additional Public Act 2 funds of $38,100.00 are allocated to pay for communication services through Ask the Messengers which will air 30-minute educational programming on TV 20 airing Sundays at 8:00 a.m. from March 1, 2022-Sept. 30, 2023.

The revised FY22 Treatment Services program totals $7,870,748.20 and consists of Block Grant funds of $6,761,900.00 and Public Act 2 funds of $1,108,848.20.

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

Source of Funds: Multiple

Fee for Service (Y/N): N

Revenue	FY 21/22	Annualized
SUD Block Grant	$ 6,761,900.00	$ 6,761,900.00
PA2	$ 1,108,848.20	$ 1,108,848.20
Total Revenue	$ 7,870,748.20	$ 7,870,748.20

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

Type of contract (Business/Clinical):

ACCOUNT NUMBER: VARIOUS

In Budget (Y/N)?

Approved for Submittal to Board:

Eric Doeh, Chief Executive Officer

Signature/Date:

Eric Doeh

Signed: Thursday, February 17, 2022

Stacie Durant, Chief Financial Officer

Signature/Date:

Stacie Durant

Signed: Thursday, February 17, 2022

DETROIT WAYNE MENTAL HEALTH AUTHORITY BUDGET ALLOCATION PAGE

BOARD ACTION NUMBER / Contract Terms	CONTRACTOR / Account Number	PROGRAM	PROPOSED BUDGET
10/01/2021 to 09/30/2022	SUD TREATMENT SERVICES 64932.826600.00000	SUD - Treatment Services	$ 6,761,900.00
	SUD TREATMENT SERVICES 64932.826606.00000	SUD - Local Grant Revenue PA2 Services	$ 1,108,848.20
BA#: 22-17R	**TOTAL**		**$ 7,870,748.20**

BOARD ACTION TAKEN

The following Action was taken by the Full Board on the 14th day of March, 2022.

- [x] Approved
- [ ] Rejected
- [ ] Modified as follows: _____

_____

- [ ] Executive Director - Initial here: ____

- [ ] Tabled as follows: _____

Signature Lillian M. Blackshire Date 3/14/2022

Board Liaison

DETROIT WAYNE INTEGRATED HEALTH NETWORK
BOARD ACTION

Board Action Number: BA 22-17R1 Revised: Y Requisition Number:

Presented to Full Board at its Meeting on: 3/16/2022

Name of Provider: DWIHN SUD Department

Contract Title: Substance Use Disorder Treatment Services Network Fiscal Year 2022

Address where services are provided: None

Presented to Finance Committee at its meeting on: 3/2/2022

Proposed Contract Term: 10/1/2021 to 9/30/2022

Amount of Contract: $ 8,081,948.20 Previous Fiscal Year: $ 6,291,109.00

Program Type: New

Projected Number Served- Year 1: 1,000,000,000 Persons Served (previous fiscal year): 1000000000

Date Contract First Initiated: 3/1/2022

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 a request to increase the FY 2022 SUD Treatment Program to $8,081,948.20 by adding PA2 funds by $211,200.00 to increase our branding efforts for the Mental Health Care-Putting Children First campaign. The additional PA2 funds will be distributed as follows and have a contract term of March 01, 2022 through September 30, 2022:

Scripps Media ($150,000), Fox 2 ($10,000) Targeted Social Media Campaign ($20,000), Mind Matters ($5,000), Comcast/Effect TV ($5,000), Metro Parent ($5,000), MEA-TV ($5,000), MEA-TV Radio ($10,000); Recovery Live Global ($1,200); to Interview DWIHN Providers) TOTAL COST: $211,200.

The revised cost of the FY 2022 SUD Treatment Program of $8,081,948.20 includes Federal Block Grants funds of $6,761,900 and PA2 Funds of $1,302,048.20.

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

Source of Funds: Block Grant,PA2

Fee for Service (Y/N): N

Revenue	FY 21/22	Annualized
SUD Blockgrant	$ 6,761,900.00	$ 6,761,900.00
PA 2	$ 1,320,048.20	$ 1,320,048.20
Total Revenue	$ 8,081,948.20	$ 8,081,948.20

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:

Eric Doeh, Chief Executive Officer

Signature/Date:

Eric Doeh

Signed: Friday, February 25, 2022

Stacie Durant, Chief Financial Officer

Signature/Date:

Stacie Durant

Signed: Friday, February 25, 2022

BOARD ACTION TAKEN

The following Action was taken by the Full Board on the 10th day of March, 2022:

- [x] Approved
- [ ] Rejected
- [ ] Modified as follows: _____

- [ ] Executive Director - Initial here: ____

- [ ] Tabled as follows: _____

Signature Lillian M. Blackshire Date 3/10/2022

Board Liaison

DETROIT WAYNE INTEGRATED HEALTH NETWORK
BOARD ACTION

Board Action Number: 22-46 Revised: N Requisition Number:

Presented to Full Board at its Meeting on: 3/16/2022

Name of Provider: Guidance Center, The, Hegira Health Inc., Arab Community Center for Economic & Social Services, Team Mental Health Services, CNS Healthcare

Contract Title: Behavioral Health Home

Address where services are provided: 6451 Schaefer Road, Dearborn, MI 48126

Presented to Program Compliance Committee at its meeting on: 3/9/2022

Proposed Contract Term: 4/1/2022 to 9/30/2022

Amount of Contract: $ 965,175.75 Previous Fiscal Year: $ 0.00

Program Type: New

Projected Number Served- Year 1: 540 Persons Served (previous fiscal year): 0

Date Contract First Initiated: 4/1/2022

Provider Impancled (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 six month contract effective April 1, 2022 through September 30, 2022 for approximately $965,175 with five providers, ACCESS, Community Network Services, The Guidance Center, Hegira Health and Team Wellness for the Behavioral Health Home program (BHH). MDHHS funds the program with a PMPM payment structure and funds are pass through to the aforementioned providers. A budget adjustment certifying the additional revenue is forthcoming.

BHH will provide comprehensive care management and coordination services to Medicaid beneficiaries with select serious mental illness/serious emotional disturbance (SMI/SED) diagnoses. For enrolled beneficiaries, the BHH will function as the central point of contact for directing patient-centered care across the broader health care system. Beneficiaries will work with an interdisciplinary team of providers to develop a person-centered health action plan to best manage their care. In doing so, this will attend to a beneficiary's complete health and social needs. Participation is voluntary and enrolled beneficiaries may opt-out at any time. BHH is comprised of six core services: Comprehensive Care Management, Comprehensive Transitional Care, Care Coordination, Individual and Family Support Services, Health Promotion, and Referral to Community and Social Support Services.

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

Source of Funds: Medicaid,Other

Fee for Service (Y/N): Y

Revenue	FY 21/22	Annualized
Multiple	$ 965,175.75	$ 965,175.75
	$ 0.00	$ 0.00
Total Revenue	$ 965,175.75	$ 965,175.75

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

Type of contract (Business/Clinical): Clinical

ACCOUNT NUMBER: 64939.827050.00000

In Budget (Y/N)?

Approved for Submittal to Board:

Eric Doeh, Chief Executive Officer

Signature/Date:

Eric Doeh

Signed: Monday, February 28, 2022

Stacie Durant, Chief Financial Officer

Signature/Date:

Stacie Durant

Signed: Monday, February 28, 2022

BOARD ACTION TAKEN

The following Action was taken by the Full Board on the 16th day of March, 2022

- [x] Approved
- [ ] Rejected
- [ ] Modified as follows: _____

- [ ] Executive Director - Initial here: ____

- [ ] Tabled as follows: _____

Signature Gillian M. Blackshire
Board Liaison

Date 3/16/2022

DETROIT WAYNE INTEGRATED HEALTH NETWORK
BOARD ACTION

Board Action Number: 22-58 Revised: N Requisition Number:

Presented to Full Board at its Meeting on: 3/16/2022

Name of Provider: Pending

Contract Title: Temporary Mobile Office Units

Address where services are provided: 'None'

Presented to Executive Committee at its meeting on: 3/14/2022

Proposed Contract Term: 3/16/2022 to 6/30/2023

Amount of Contract: $ 131,332.29 Previous Fiscal Year: $ 0.00

Program Type: New

Projected Number Served- Year 1: 335 Persons Served (previous fiscal year): 0

Date Contract First Initiated: 3/16/2022

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).

DWIHN is requesting approval to inter into an agreement with WillScot for the leasing of temporary mobile office units that will be set up in Lot A during Milwaukee building construction and temporary closure. The mobile office will provide DWIHN staff with the ability to access the network and to provide functions such as mail service, printing, scanning and storage.

We are requesting a not-to-exceed amount of $131,332.29, for a term beginning March 9, 2022 and ending June 30, 2023.

The Facilities Department reached out for quotes and WillScot was the only company that could provide a large enough office unit to meet the occupancy needs of staff.

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

Source of Funds: Multiple

Fee for Service (Y/N): N

Revenue	FY 21/22	Annualized
Multiple	$ 131,332.00	$ 131,332.00
	$ 0.00	$ 0.00
Total Revenue	$ 131,332.00	$ 131,332.00

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

Type of contract (Business/Clinical): Business

ACCOUNT NUMBER: 64922.941000.00000

In Budget (Y/N)? Y

Approved for Submittal to Board:

Eric Doeh, Chief Executive Officer

Signature/Date:

Eric Doeh

Signed: Wednesday, March 9, 2022

Stacie Durant, Chief Financial Officer

Signature/Date:

Stacie Durant

Signed: Wednesday, March 9, 2022

BOARD ACTION TAKEN

The following Action was taken by the Full Board on the 10th day of March, 2022:

- [x] Approved
- [ ] Rejected
- [ ] Modified as follows: _____

- [ ] Executive Director - Initial here: ____

- [ ] Tabled as follows: _____

Signature Lillian M. Blackshire
Board Liaison

Date 3/10/2022

DETROIT WAYNE INTEGRATED HEALTH NETWORK

QAPIP Annual Evaluation

Fiscal Year 2021

QAPIP ANNUAL EVALUATION

- The QAPIP Evaluation assesses the results, improvements and outcomes DWIHN has made with respect to the Annual Work Plan for FY2021.
- The goals and objectives are aligned and evaluated with DWIHN's Strategic Plan Pillars:
  - Customer
  - Access
  - Quality
  - Advocacy
  - Finance
  - Workforce Development
- The next slides will highlight goal accomplishments, goals partially met, not met, and plans for continuation of goals for FY2022.

QAPIP ANNUAL EVALUATION

The goal of the **Customer Pillar** is to improve members experience and satisfaction of service. Several units contribute to the makeup of this Pillar.

- There are six (6) objectives under the Customer Pillar. 4 of 6 objectives were met and 2 not met.
  - National Core Indicators (NCI) Survey
    - The NCI survey is conducted by MDHHS annually. Ongoing COVID-19 issues has delayed the operation of the survey.
  - Provider Practitioner Survey Responses
    - DWIHN's targeted response rate is 50-60% A Response Rate

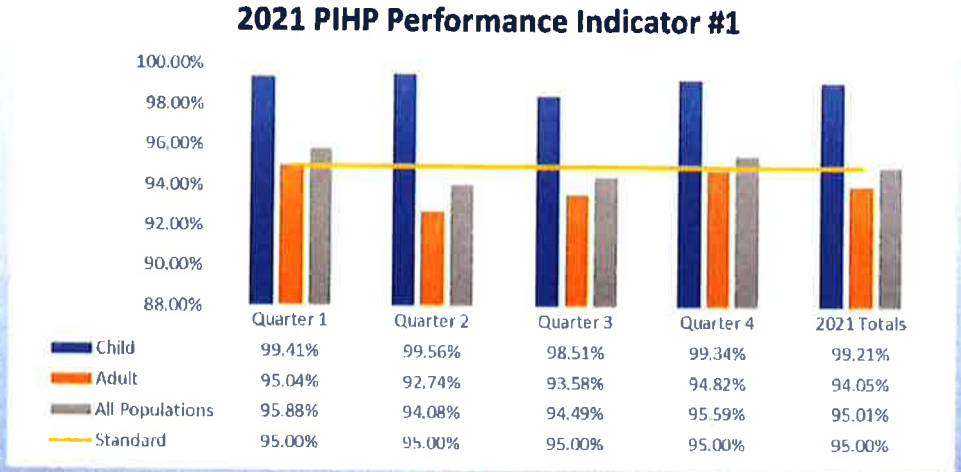
QAPIP ANNUAL EVALUATION

The goal of the Access Pillar is to improve members access to services. DWIHN monitor access to service using the Michigan Mission Based Performance Indicators (MMBPI) data. There are five (5) indicators that have been established by MDHHS that are the responsibility of the PIHP to collect data and submit on a quarterly basis.

- There are (5) objectives under the Access Pillar. 4 of 5 objectives were met and 1 not met.
  - PI#10 - 10/RECIDIVISM OR READMISSION IN 30 days. Standard 15% or less.

INDICATOR 1: PRE-ADMISSION SCREENING WITHIN 3 HOURS (THRESHOLD 95%)

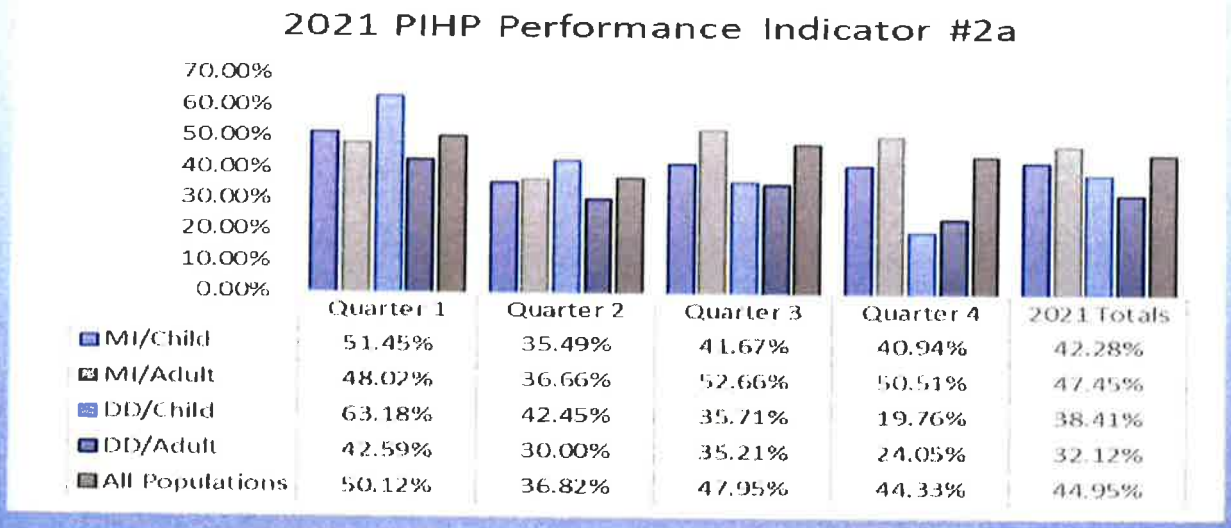
Results: FY21 standard met for <u>all</u> populations (95.01%)



	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2021 Totals
Child	99.41%	99.56%	98.51%	99.34%	99.21%
Adult	95.04%	92.74%	93.58%	94.82%	94.05%
All Populations	95.88%	94.08%	94.49%	95.59%	95.01%
Standard	95.00%	95.00%	95.00%	95.00%	95.00%

INDICATOR 2: COMPLETING BIOPSYCHOSOCIAL WITHIN 14 DAYS (STATE AVG 60%)

No standard/benchmark has been set by MDHHS. This measure allows for no exceptions. Results for All Populations: FY21 Q1(50.12%), Q2 (36.82%), Q3 (47.95%), Q4 (44.33%)



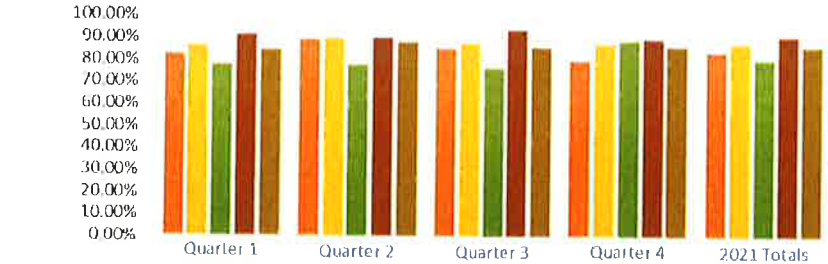
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2021 Totals
MI/Child	51.45%	35.49%	41.67%	40.94%	42.28%
MI/Adult	48.02%	36.66%	52.66%	50.51%	47.45%
DD/Child	63.18%	42.45%	35.71%	19.76%	38.41%
DD/Adult	42.59%	30.00%	35.21%	24.05%	32.12%
All Populations	50.12%	36.82%	47.95%	44.33%	44.95%

INDICATOR 3 STARTING ANY NEEDED ON-GOING SERVICE WITHIN 14 DAYS (STATE AVG. 80%)

No standard/benchmark has been set by MDHHS. This measure allows for no exceptions.

Results for All Populations: Q1(84.84%), Q2 (88.40%), Q3 (86.27%), Q4 (86.46%)

2021 PIHP Performance Indicator #3

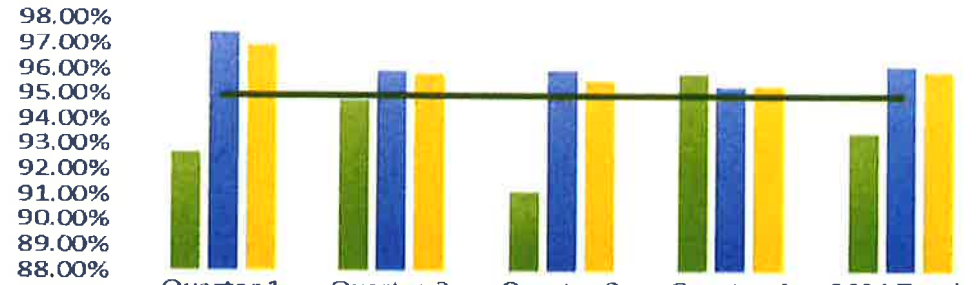


	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2021 Totals
MI/Child	82.70%	89.16%	85.40%	79.84%	84.29%
MI/Adult	86.93%	90.19%	88.44%	87.85%	88.28%
DD/Child	78.38%	78.02%	76.90%	89.38%	81.20%
DD/Adult	91.67%	90.00%	93.75%	89.74%	90.99%
All Populations	84.84%	88.40%	86.27%	86.46%	86.44%

INDICATOR 4A: HOSPITAL DISCHARGE SEEN FOR FOLLOW-UP CARE WITHIN 7-DAYS (THRESHOLD 95%)

Results: FY21 standard met for <u>all</u> populations (96.0%)

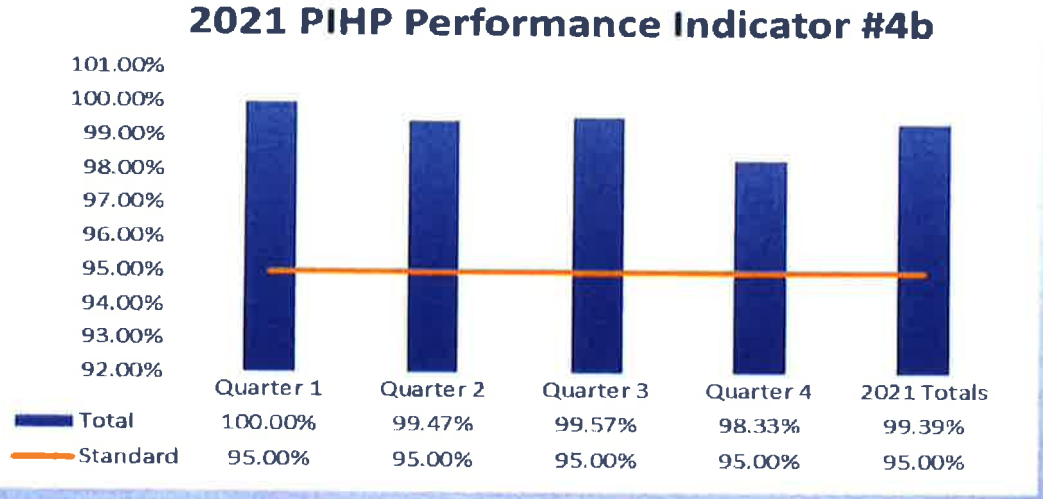
2021 PIHP Performance Indicator #4a



	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2021 Totals
Child	92.75%	94.83%	91.23%	95.92%	93.56%
Adult	97.52%	95.99%	96.06%	95.41%	96.23%
All Populations	97.00%	95.89%	95.66%	95.45%	96.00%
Standard	95.00%	95.00%	95.00%	95.00%	95.00%

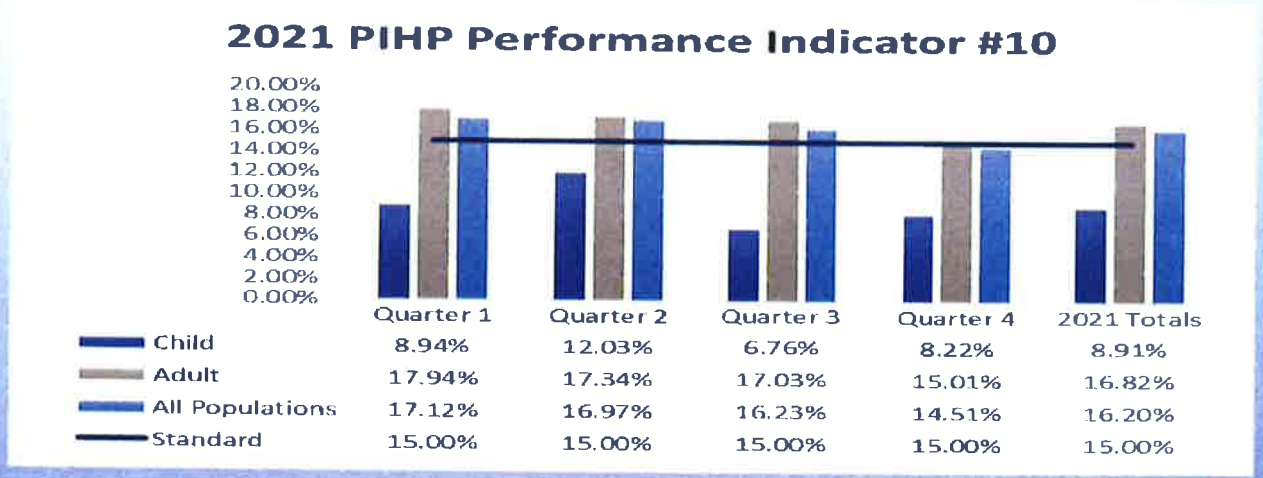
INDICATOR 4B: SUBSTANCE ABUSE DETOX DISCHARGE SEEN FOR 7-DAY FOLLOW-UP CARE WITHIN 7 DAYS (THRESHOLD 95%)

Results: FY21 standard met for all 4 quarters (99.39%)



INDICATOR 10 (30-DAY INPATIENT READMISSION) THRESHOLD (15% OR LESS)

Results: FY21 standard met for the children population. Standard not met for the adult population for all quarters Q1 (17.94%), Q2 (17.34%), Q3 (17.03%), Q4 (15.01)



	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2021 Totals
Child	8.94%	12.03%	6.76%	8.22%	8.91%
Adult	17.94%	17.34%	17.03%	15.01%	16.82%
All Populations	17.12%	16.97%	16.23%	14.51%	16.20%
Standard	15.00%	15.00%	15.00%	15.00%	15.00%

QAPIP ANNUAL EVALUATION

The goal of the **Quality Pillar** is to improve clinical, quality performance and access to member safety and member rights through the use of standardized treatment protocols and guidelines.

- There are (6) objectives under the quality pillar. 5 of the 6 objectives were met and 1 not met.
  - Residential Monitoring
    - Goal was to completed 60% of Residential Providers; Completion 30%.

Year End Monitoring Data FY 2021

118 CRSP Case Records were reviewed this fiscal year with an average 274 staff records were reviewed this fiscal year with an average score of 93%

Review 100% of the Autism Providers
The average scores of these reviews ranged from 77% being the lowest and 91% being the highest
Staff Qualification Reviews ranged from 58% being the lowest and 100% being the highest

Review all the SUD Providers (Treatment and Prevention) with expectation of 3 providers
The average scores of these reviews ranged from 76% being the lowest and 100% being the highest

Staff Qualification Review scores ranged from 68% lowest and 100% highest

1st Q Case Records	2nd Q Case Records	3rd Q Case Records	4th Q Case Records
Overall Score = 92%	Overall Score = 89%	Overall Score = 90%	Overall Score = 93%
Total 33 audits	Total 60 audits	Total 13 audits	Total 13 audits

QAPIP ANNUAL EVALUATION

- The Goal of the **Workforce Pillar** is to lead the organization in innovation by providing effective and efficient Workforce Development needs to the Provider Network.

❑ There was (1) objective under the workforce pillar. The objective met the target goal.

- ❑ DWIHN Approximately 134 Participants Attended A Program End "Virtual Young professional Conference On August 3, 2021, Partnered With Connect Detroit. In Addition, 360 Participants Attended DWIHN's Faith-based Youth Conference On August 19-20, 2021.
- ❑ DWIHN was awarded a two-year grant from MDHHS to build upon prior trauma training and equip the provider workforce with a strong foundation for addressing the complexities of trauma.

QAPIP ANNUAL EVALUATION

The goal of the **Advocacy Pillar** is to provide collaboration in shaping state and regional policies, procedures and practices relative to Quality Improvement and implementation of processes that promote full integration in the community.

- There was (1) objective under the advocacy pillar. The objective was Partially met.
  - Implementation Home and Community Based Settings requirements (aka Final Rule)

QAPIP ANNUAL EVALUATION

The goal of the **Finance Pillar** is to ensure financial stewardship and monitor financial solvency of DWIHN and network providers.

- There was (1) objective under the finance pillar. The objective was Partially Met.
  - Verification of Services (Medicaid Claims Verification Audits)
    - A total of 2,371 claims were randomly selected for verification FY21. Of those claims 1,210 were reviewed and validated for 51.03%, which is a 13.3% increase from the previous Fiscal Year.

QAPIP ANNUAL EVALUATION

External Quality Reviews

- DWIHN has been accredited for three years through the National Committee For Quality Assurance (NCQA). DWIHN received High Marks And Perfect Scores In Several critical areas including Member Experience, Self-management Tools, Clinical Practice Guidelines, Clinical Measurement Activities, Coordination Of Behavioral Healthcare And Collaboration Between Behavioral Health And Medical Care. DWIHN scored 92.49 out of a possible 100 points.

HSAG conducts three (3) mandatory External Quality Reviews (EQR) as required to ensure compliance with regulatory requirements.

- **Performance Improvement Project (*Improving diabetes monitoring for people with schizophrenia and bipolar disorder who are using antipsychotic medications*)**
  - ❑ **Goal not met/outcome (64.28%) Target goal (80%)**
- Performance Measurement **Validation**
  - ❑ Goal met received (100%) with **no POC** required.
- Compliance Review
  - ❑ Goal not met received an score of 77% with a corrective action plan.

QAPIP ANNUAL EVALUATION
OVERALL EFFECTIVENESS

- Overall, most activities planned in the 2020-2021 Work Plan is at a (71%) completion, which is a increase from the previous fiscal year (50%).
- The activities that were Partially Met and or Not Met will be considered for continuation in the QAPIP 2021-2022 Work Plan.

2022 Work Plan Goals and Objectives

In FY 2022, the QAPIP work plan will be reviewing these areas to achieve continuous quality improvement in the quality and safety of clinical care, quality of service and member experience.

- Maintain NCQA accreditation.
- Continue coordinated regional response to COVID-19 pandemic, including expansion of the use of telehealth for a broad array of supports/services.
- Establish an effective Crisis Response System and Call Center.
- Continuously improve the quality, appropriateness, availability, accessibility, coordination and continuity of health care services to members across the continuum of care.
- Continue implementation transition of Home and Community Based Services Waiver.
- Improve member and provider satisfaction.
- Conduct reviews through virtual monitoring to ensure that telehealth services are compliant in accordance with regulatory standards.
- Ensure a high-quality network through credentialing, peer review and contracting processes. •
- Establish and revised/improved regional standardized contract and provider performance monitoring protocols for autism service providers, fiscal intermediary services, specialized residential providers and inpatient psychiatric units.
- Continue to collaborate with providers to share ideas and implement strategies to improve care coordination and quality of service.
- Improve and manage member outcomes, satisfaction and safety.
- Maintain excellent compliance with state and federal regulatory requirements, and accreditation standards.
- Ensure DWIHN's organizational initiatives related to cultural competency and diversity for members and providers meet the needs of DWIHN members.
- Address regional role in statewide training and provider performance monitoring reciprocity activities.
- Continue efforts to participate in children/family outreach by attending community events, schools, and working with children service providers to increase mental health awareness, information, and access to services.
- Continue efforts on children services. In 2022, DWIHN will begin a campaign/initiative called "***Mental Health Care-Putting Children First***". DWIHN is going to extend our scope and resources to reach the over 285,000 school-aged kids we have in Wayne County.
- Support DWIHN in establishing improved performance metrics for services and supports and for MDHHS incentive payment metrics (including follow-up after hospitalization for mental illnesses, follow-up to persons with a SUD diagnosis following contact with an Emergency Room; identification and follow up activities related to health disparities; better support for veterans and expanded population health and performance monitoring metric.
- Demonstrate and communicate DWIHN's commitment to improving progress toward influencing network-wide safe clinical practices.
- Support DWIHN strategic planning efforts related to becoming a Certified Community Behavioral Health Home (CCBHC), Behavioral Health Homes (BHH) and increase Opioid Health Home (OHH) provider services.
- Continue to increase the training of providers, health care workers, jail staff, drug court staff, community organizations and members of our region on how to use Naloxone to reverse opioid overdose.

QAPIP Workplan
FY 2021-2022

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives	Responsible Department	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
	Customer Pillar						
Goal I	**Enhance the quality of services based on Member Experience**						
I.1	ECHO Adult Satisfaction Survey	Customer Service	FY 2021-2022	Increase response rates and improve member access to behavioral health services for the 5 reporting measures scoring < 60% which include:1) Treatment after benefits are used up; 2)Counseling and Treatment; 3). Getting Treatment Quickly; 4). Office Wait and Access; 5). Perceived Improvement is to increase each score to 60% or higher.	Previous issues identified include the five areas scoring less 50% during FY2021.		Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
I.2	National Core Indicator Survey (NCI)	Customer Service	FY 2021-2022	Identify areas for system enhancement to improve access to service and quality of care through the response rate from the NCI Survey. Overall measurable goal is 85% or higher.	No previous issues identified during FY2021. Survey was delayed due to COVID Pandemic.		Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.

QAPIP Workplan
FY 2021-2022

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives	Responsible Department	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
I.3	Provider Survey	Customer Service	FY 2021-2022	Increase response rates and improve service access, service provision, treatment experiences and outcomes in the network. Target goal for the provider and practitioner response rate is 40% or higher.	Previous issues identified is the provider and practitioner low response rate to survey during FY2021		Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
I.4	Grievance/Appeals	Customer Service	FY 2021-2022	Improve outcomes by decreasing no less than 5% for the Delivery of Service and Customer Services to members that were consistently high over the past three (3) fiscal years. Interpersonal relations came in third with a total of 46 complaints.	Previous issues include the three areas identified areas for opportunities as improvement from FY2021.		Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
I.5	Timeliness of Denials & Appeals	Customer Service, Utilization Management	FY 2021-2022	Meet or exceed performance standards set by the state for timely UM decisions making, timeframes and notification. Threshold 90% .	No previous issues identified during FY2021.		Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.

QAPIP Workplan
FY 2021-2022

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives	Responsible Department	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
I.6	Cultural and Linguistic Needs	Customer Service, Managed Care Operations, Quality Improvement and Information Technology	FY 2021-2022	Improve through member accessibility reporting for advancing health equity, quality, and eliminating health care disparities by implementing culturally and linguistically appropriate services. Threshold 95% or higher.	No previous issues identified during FY2021.		Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
Goal II.	**Access Pillar**	**Enhance the Quality of Clinical Care, Safety and Services**					
	Michigan Mission Based Performance Indicators (MMBPI)						
II.1	Indicator 1(a) and 1(b) - Percentage of pre-admission screenings for psychiatric inpatient care (Children and Adults) for whom disposition was completed within three hours	Quality Improvement	FY 2021-2022	Meet or exceed performance standard. Threshold 95% or above.	No previous issues identified during FY2021.		Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.

QAPIP Workplan
FY 2021-2022

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives	Responsible Department	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
II.2	Indicator 2(a) and 2(b) - Percentage of persons (Children and Adults) receiving a face to face meeting with a professional within 14 calendar days of a non-emergency request for service.	Quality Improvement	FY 2021-2022	Performance goal is to achieve comparable scores to the state wide average. No standard/benchmark for performance indicator has been established by MDHHS.	Previous issues identified as DWIHN received lowest scores within the region during FY2021.		Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
II.3	Indicator 3(a) and 3(b) - Percentage of persons (Children and Adults) needed on-going service within 14 days of a non-emergent assessment with a professional.	Quality Improvement	FY 2021-2022	Performance goal is to achieve comparable scores to the state wide average. No standard/benchmark for performance indicator has been established by MDHHS.	No previous issues identified during FY2021.		Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
II.4	Indicator 4a(1) and 4a(2) - Percentage of discharges from a psychiatric inpatient unit (Children and Adults) who are seen for follow up care within 7 days.	Quality Improvement	FY 2021-2022	Meet or exceed performance standard. Threshold 95% or above.	No previous issues identified during FY2021.		Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.

QAPIP Workplan
FY 2021-2022

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives	Responsible Department	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
II.5	Indicator 4b - Percentage of discharges from a Substance Abuse Detox Unit who are seen for follow-up care within 7 days.	Quality Improvement	FY 2021-2022	Meet or exceed performance standard. Threshold 95% or above.	No previous issues identified during FY2021.		Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
II.6	Indicator 10 (a) and 10 (b) - Percentage of readmissions (Children and Adults) to inpatient psychiatric unit within 30 days of discharge.	Quality Improvement	FY 2021-2022	Meet or exceed performance standard. Threshold 15% or less.	Previous issues include decreasing the (Adult) recidivism rate to 15% or less for FY2021.		Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
II.7	Complex Case Management	Integrated Health Care	FY 2021-2022	Ensure members are moving towards optimum health, improved functional capability, and a better quality of life by focusing on their own health goals. Target to receive 80% or greater member satisfaction scores for members who have received CCM services.	No previous issues identified during FY2021.		Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
II.8	Crisis Intervention	Utilization Management	FY 2021-2022	Decrease number of re-hospitalization within 30 days of discharge to 15% or lower.	Previous issues include decreasing the (Adult) recidivism rate to 15% or less for FY2021.		Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.

QAPIP Workplan
FY 2021-2022

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives	Responsible Department	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
	Workforce Pillar						
Goal III.	**Development of maintain a Competent Workforce**						
III.1	Maintain Competent Workforce	Workforce Development, Quality Improvement, Clinical Practices Improvement and Managed Care Operations	FY 2021-2022	Increase the capacity of staff and providers of cultural competencies trainings to work effectively with diverse cultural and linguistic populations through Detroit Wayne Connect (DWC) by 10%.	No previous issues identified during FY2021.		Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
	Finance Pillar						
Goal IV	**Maximize Efficiencies and Control Costs**						
IV.1	Verification of Services	Quality Improvement, Compliance and Finance	FY 2021-2022	Eliminate Fraud, Waste and Abuse in the network by identifying patterns and trends of behavioral health services. Targeted goal is to reduce the number of providers that are on a plan of correction by 25%.	Previous issues identified as completing all of the randomly selected claims cases and reduce the number of providers that are on Plans of Correction during FY2021.		Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
	Quality Pillar						

QAPIP Workplan
FY 2021-2022

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives	Responsible Department	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
Goal V.	**Improve Quality Performance, Member Safety and Member Rights system-wide**						
V.1	Performance Monitoring - Clinically Responsible Service Provider (CRSP)	Quality Improvement	FY 2021-2022	Increase performance rates on regulatory audits. Measurement will include the number of providers reviewed during FY21 with reported outcomes. Target goal to increase number of reviewed providers by 20%.	Previous issues identified were to increase the number of providers reviewed during FY2021.		Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
V.2	Specialized Residential Settings	Quality Improvement	FY 2021-2022	Increase performance rates on regulatory audits. Measurement will include the number of providers reviewed during FY21 with reported outcomes. Target goal to increase number of reviewed providers by 20%.	Previous issues identified were to increase the number of providers reviewed during FY2021.		Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.

QAPIP Workplan
FY 2021-2022

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives	Responsible Department	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V.3	Provider Self Monitoring (Inter-Rater Reliability)	Quality Improvement	FY 2021-2022	Increase performance rates on regulatory audits. Measurement will include the number of providers that participate in self-monitoring during FY21 with reported outcomes. Target goal to increase number of self - reviewed cases by 20%.	Previous issues identified were to increase the number of providers completing self-monitoring reviews during FY2021.		Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
V.4	Autism Services	Quality Improvement and Children's Initiatives	FY 2021-2022	Increase overall scores (76%) for the clinical record review for autism providers by 14%.	No previous issues identified during FY2021.		Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
V.5	Critical/Sentinel Event Reporting	Quality Improvement and Information Technology	FY 2021-2022	Improve and increase the number of reportable outcomes (CI),(SE),(UD),(RE) by conducting competency based provider trainings. Target goal is to increase trainings by 10%.	Previous issues identified is not meeting the MDHHS (CE/SE) reporting requirements.		Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.

QAPIP Workplan
FY 2021-2022

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives	Responsible Department	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V.6	Behavior Treatment Plan Monitoring	Quality Improvement and Medical Director	FY 2021-2022	Meet performance on required MDHHS BTPRCs requirements. Target goal is 95% for review of randomly selected cases through the performance monitoring process for compliance.	Previous issues identified is not meeting the MDHHS (BTPRC) reporting requirements.		Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
	Quality Improvement Projects (QIP's)						
V.7a	Improving the availability of a follow up appointment with a Mental Health Professional with-in 7 days after Hospitalization for Mental Illness.	Integrated Health Care and Quality Improvement	FY 2021-2022	Target goal is 45% or higher. This measure has the potential to improve the health of members with mental illness and reduce readmissions through increasing appropriate follow up care.	Previous issues identified as not meeting the targeted goal of 45% or higher; rate was 29.57% for FY2021.		Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.
V.7b	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Integrated Health Care and Quality Improvement	FY 2021-2022	Target goal is 45% or higher. This measure will improve members with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.	No previous issues identified during FY2021.		Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.

QAPIP Workplan
FY 2021-2022

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives	Responsible Department	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V.7c	Antidepressant Medication Management for People with a New Episode of Major Depression	Integrated Health Care and Quality Improvement	FY 2021-2022	Target goal 51% is to improve measurement-medication Compliance for Members 18 years or Older with a Diagnosis of Major Depression on Antidepressant Medication for at least 84 Days (12 weeks).	Previous issues identified failed to meet the goal for FY 2021 (46.42%)		Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.
V.7d	Improving Diabetes Monitoring for People with Schizophrenia and Bipolar Disorder	Integrated Health Care and Quality Improvement	FY 2021-2022	Target goal is 83.2%. This measure is to increase Diabetes Screening for people with Schizophrenia and/or Bipolar Disorder measures for percentage of patients 18-64 years of age.	Previous issues identified failed to meet the goal for FY 2021 (64.86%)		Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.

QAPIP Workplan
FY 2021-2022

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives	Responsible Department	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V.7e	Coordination of Care	Integrated Health Care, Utilization Management and Quality Improvement	FY 2021-2022	Collect and analyze data to identify opportunities for improvement of coordination between behavioral healthcare in the following areas: Exchange of information; Appropriate diagnosis, treatment and referral of behavioral disorders commonly seen in Primary Care. Target goal is 95% or higher for review of randomly selected cases through the performance monitoring process for compliance.	Previous issues identified failed to meet the goal for FY 2021 (82%).		Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.
V.7f	Case Finding for Opiate Treatment	Substance Use Disorder	FY 2021-2022	Increase the Number of Persons Revived with provided Naloxone Kits in Wayne County MI (Naloxone Project). Distribution of Naloxone kits to promote the use of overdose-reversing drugs. Target Goal is 79% or higher.	Previous issues identified failed to meet the goal for FY 2020 (49.0%)		Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.

QAPIP Workplan
FY 2021-2022

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives	Responsible Department	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V.7h	PHQ-9 Implementation	Clinical Practice Improvement	FY 2021-2022	Reduce the suicide rate for enrolled members which includes determining if the PHQ-9 could be a value added screener for its service population, DWIHN reviewed its population data/Agency Profile to determine the prevalence of depression among the enrolled members within the service delivery system. Target goal is 95% or higher.	Previous issues identified failed to meet the goal for FY 2020 (91.3%)		Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.

QAPIP Workplan
FY 2021-2022

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives	Responsible Department	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V.7i	PHQ-A Implementation	Children's Imitative	FY 2021-2022	Improve the health of the pediatric community through a grant to implement the Integrated Care for Kids Model. The Model outlined a child-centered local service delivery and state payment model that aims to improve the quality of care for children under 21 years of age covered by Medicaid through prevention, early identification, and treatment of behavioral and physical health needs. DWIHN in collaboration with providers and practitioners within the contracted provider network determined that youth members ages 11-17 will be assessed for the symptoms of depression via the PHQ-A screening tool.	Previous issues identified failed to meet the goal for FY 2021 (62.9%) Cases in Compliance with follow-up PHQ-A/Total PHQ-A Greater than 10		Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.

QAPIP Workplan
FY 2021-2022

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives	Responsible Department	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
V.7I	Decreasing Wait for Autism Services	Children's initiative	FY 2021-2022	Achieve greater efficiency in processing denials and appeals. Reducing the number of delegated functions is not only cost effective, but positions DWIHN as a leader in integrated care. Targeted goal set at 95% or higher.	Previous issues identified failed to meet the goal for FY 2021 (90%).		Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.
	Advocacy Pillar						
Goal VI.	**Increase Community Inclusion and Integration**						
VI.1	Home and Community Based Services (HCBS)	Quality Improvement	FY 2021-2022	Ensure full compliance (100%) of the network with the Home and Community Based Settings requirements.	Previous identified issue failed to meet the target goal of 100% compliance for the provider network.		Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
Goal VII	**Assure Compliance with Applicable National Accreditation, Legislative, Federal/State**						

QAPIP Workplan
FY 2021-2022

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives	Responsible Department	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
VII.1	MDHHS Certification	QI, MCO, CS, ORR, Finance, Workforce, Credentialing, IHC and Administration	FY 2021-2022	Achieve 95% compliance for all standards of Annual MDHHS Certification Review.	No previous issues identified during FY2021.		Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
VII.2	NCQA Accreditation	QI, MCO, CS, ORR, Finance, Workforce, Credentialing, IHC and Administration	FY 2021-2022	Achieve full 3-Year Re-accreditation for all standards of NCQA Review. Target goal is 95 points or higher.	Previous identified issue DWIHN scored 92.49 points out of a possible 100 points.		Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
VII.3	Health Services Advisory Group (HSAG)	QI, MCO, CS, ORR, Finance, Workforce, Credentialing and IHC	FY 2021-2022	Achieve full compliance for all three separate reviews as required by MDHHS: Performance Improvement Project (PIP), Performance Measure Validation (PMV) and the Compliance Monitoring review.	Previous identified issue failed to meet PIP goal of 80%. Achieved 64.86% for FY2021; Compliance Review achieved 77.0% with a targeted goal of 100%. No identified issues for PMV review for FY2021.		Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.

QAPIP Workplan
FY 2021-2022

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives	Responsible Department	Time frame for Each Activity's Completion	Monitoring of Previously Identified Issues	Previously Identified Issues Requiring Follow-up	Evaluation of QI Program	Oversight of QI Activities by Committee
VII.4	Annual Needs Assessme	QI, MCO, CS, ORR, Finance, Workforce, Credentialing and IHC	FY 2020-2021	Implement targeted and prioritized planned actions identified in Needs Assessment through meaningful feedback from providers meetings, focus groups and members.	No previous issues identified during FY2021.		Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
End							

Detroit Wayne Integrated Health Network

(DWIHN)

Quality Assurance Performance Improvement Plan
Annual Evaluation Fiscal Year 2021

Submitted by:

April L. Siebert - Director of Quality Improvement

Approved:

Approved by the Quality Improvement Steering Committee (QISC)	2/22/2020
Approved by Program Compliance Committee (PCC)	
Approved by the Full Board of Directors	

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Introduction

The Detroit Wayne Integrated Health Network (DWIHN) is the Pre-Paid Inpatient Health Plan (PIHP) and Community Mental Health Service Provider (CMHSP) for Detroit and Wayne County. DWIHN is the largest community mental health service provider in the State of Michigan. The Quality Assurance Performance Improvement Plan (QAPIP) Evaluation is an annual document that assesses the results, Improvements and outcomes DWIHN has made with respect to the Annual Work Plan for FY2021.

Executive Summary

This QAPIP evaluation provides a description of completed and ongoing quality improvement activities that address timeliness, clinical care and quality of services. The goals and objectives from the 2020 QAPIP Work Plan were evaluated and are included in the QAPIP evaluation for FY21. HEDIS scores were used as one of the measurement tools to identify progress or barriers for the Quality Improvement Projects. The QAPIP evaluation follows a structured format including a description of the activity, quantitative analysis and trending of measures, evaluation of effectiveness, barrier analysis and identified opportunities for improvement. The QAPIP evaluation also includes the six (6) pillars that are identified in DWIHN's Strategic Plan. The Quality Improvement Steering Committee (QISC) is the decision-making body that is responsible for the oversight of DWIHN's QAPIP Description, Evaluation and Work Plan. The Program Compliance Committee (PCC) Board gives the authority for implementation of the plan and all of its components. The QAPIP evaluation was presented to QISC, PCC and the full Board of Directors for review and approval.

Description of Service Area

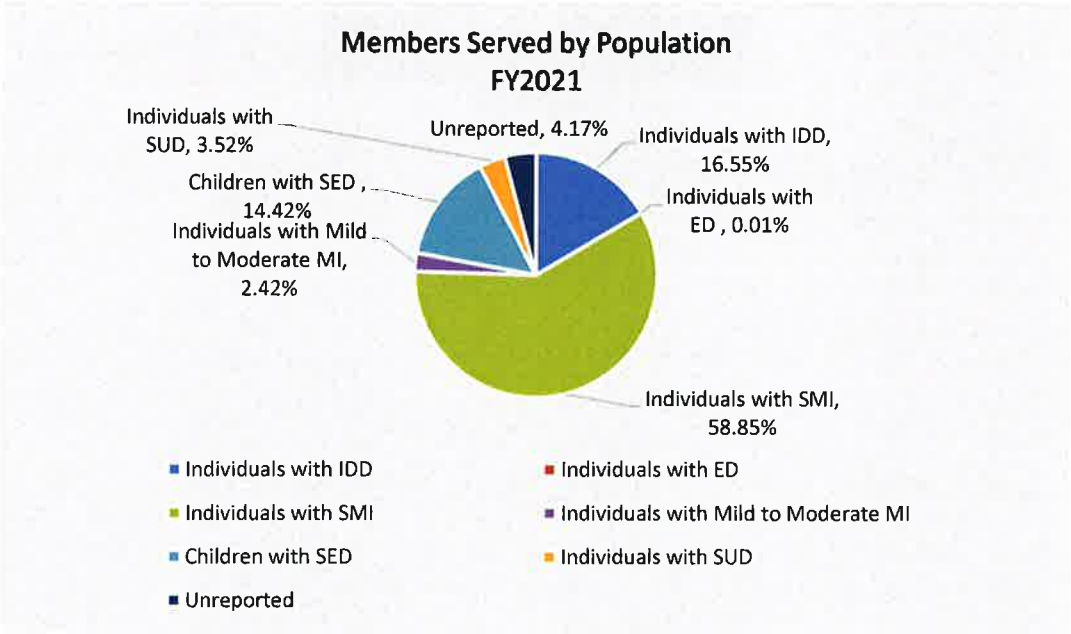
Wayne County is the most populous county in the State of Michigan. As of 2020, the United States Census estimated its population as 1.7 million, and ranked 19th in population in the United States. Wayne County is comprised of 34 cities and 9 townships covering roughly 673 miles. The municipality of Detroit had a 2020 estimated population of 670,031, making it the 23rd-most populous city in the United States. Member populations receiving services through DWIHN are commonly referenced throughout this evaluation using the following abbreviations:

- MI Adults—Adults diagnosed with mental illness
- SMI Adults—Adults diagnosed with serious mental illness
- IDD Adults—Adults with intellectual developmental disability
- IDD Children—Children with intellectual developmental disability
- SUD – Adults diagnosed with substance use disorder
- SED Children—Children diagnosed with serious emotional disturbance
- ASD- Autism Spectrum Disorders
- Youth with serious emotional disturbances

Demographics

DWIHN provided services to an unduplicated count of 73,408 members during FY21, which is an increase of 3,378 (4.8%) from FY20 (70,030). Of those served 46,230 (62.98%) received services through Medicaid funding, 18,147 (24.72%) received services through Healthy Michigan Plan funding, 7,127 (9.71%) received services through General Fund, 6,197 (8.44%) through SUD Block Grant, 5,864 (7.99%) through MI Health Link, 5,864 (7.99%) through State Disability Assistance (SDA), 1,064 (1.45%) through Habilitation Supports Waiver. The percent of adults who reported having a SMI in FY21 43,208 (58.85%), demonstrated an increase of (12.9%) from the previous year. Followed by 10,585 (14.42%) (SED), 12,150 (16.55%) (IDD), 2,586 (3.52%) (SUD), 1,774 (2.42%) (MI), 5,444 (7.42%) Co-Occurring, and 3,053 (4.17%) unreported. Of those served 40,338 (54.95%) were of African American decent. This reflect an increase of 1,728 (4.4%) from FY20. The Caucasian count was 23,175 (31.57%). The remaining (13.47%) were identified as other, two or more races, unreported, Asian, American Indian, Native Hawaiian and Alaskan.

The largest group of individuals served are in the age group of 22-50 years-old 33,095 (45.08%), demonstrating an increase of 2,443 (7.9%) from FY20. Followed by the age group of 0-17 years-old,15,430 (21.02%) and the age group of 51-64 years-old, 15,365 (20.93%). The growth of persons served 65 and over continues to increase by (3.5%) from the previous year. *Data was extracted for this report on February 1, 2022.



Customer Pillar

Member Experience

Activity Description

DWIHN conducted the Experience of Care and Health Outcomes (ECHO) survey to receive feedback from members who accessed behavioral health services in the past 12 months. DWIHN annually reviews the data and develops improvement activities and interventions to impact ECHO scores. DWIHN combines the ECHO data with other data sources throughout the organization to have a comprehensive view of member satisfaction with DWIHN services. Data sources include appeals and grievances, focus groups, internal member surveys, post-survey and member feedback received directly from customer service.

Quantitative Analysis and Trending of Measures

The analysis shows that the initiatives and interventions that were implemented in FY2020 were generally effective in improving service goals. A significant positive trend appeared in the question that asks respondents to rank their overall services from 0 to 10, where 10 is the best. When responding to the question, about getting treatment quickly overall satisfaction rate for FY 21 was 46%, which is a 3% increase when compared to the last fiscal year (43%). There were two measures with scores of higher than (50%): Treatment after benefits used up (56%) and Counseling and Treatment (51%). The score for Perceived Improvement has remained stagnant in the low 30's since 2017. More information about member rights was given in 2021. In 2021, members rated that they were helped more by their services, and their overall mental health was better. Overall, scores were slightly higher in FY 21 than during the subsequent measurement periods as displayed in the table below.

ECHO Reporting Measures, Comparison Across Years

Composite Measures and Global Rating	2021	2020	2017
Treatment after benefits are used up	56%	55%	48%
Counseling and treatment	51%	51%	46%
Getting treatment quickly	46%	43%	37%
Office Wait	44%	36%	33%
Perceived improvement	29%	31%	29%

Evaluation of Effectiveness

In FY21, in collaboration with Wayne State University, exceeded the goal to collect 600 surveys for adult and children's Annual ECHO Surveys. DWIHN scored well on several of measures, notably parents/guardians reporting receiving information on patient rights (95%), confidence in the privacy of their information (93%), and completely discussing the goals of their child's treatment (93%). However, there were four measures with scores of less than (50%): Perceived improvement (25%); Getting treatment quickly (42%); Counseling and treatment (49%); and Amount helped (49%). The chart below illustrates the composite scores in the ECHO Child reporting measures compared to Adult reporting measures for FY21. There was variation in the overall rating for "Perceived improvement" (28% compared to 29%); How Well Clinicians Communicate" (73% compared to 68%); and rating of counseling and treatment (54% compared to 51%).

ECHO Reporting measures, Child Comparison to Adult Results FY21

Composite Measures and Global Rating	Children	Adult
Getting treatment quickly	46%	46%
How well clinicians communicate	73%	68%
Getting treatment and information from the plan or MBHO	51%	51%
Perceived Improvement	28%	29%
Counseling and Treatment	54%	51%

Barrier Analysis

The causal analysis of barriers to improving member satisfaction and experience continues to remain relatively the same from one year to the next. It is apropos to mention that these surveys were conducted during a major pandemic and thinking about Perceived Improvement most members will not consider themselves better off during that timeframe. Also, DWIHN continues to receive low response rates on getting members to complete the ECHO survey. The data that is gathered is not entirely representative of all DWIHN members that access behavioral health services. The survey is a sample of member scores and is a barrier to representative data for the populations served and who received behavioral health services. Members may not always be aware of how to access behavioral health materials from the service provider and are not aware of behavioral health services offered.

There was a statistically significant difference in subgroups. Respondents 18 to 24 had lower scores than the other age groups on several measures. Overall, (43%) of the respondents reported always seeing someone as soon as they wanted, 21% of respondents were 18 to 24. A lower percentage of people with guardians (50%) reported clinicians always listened carefully to them, compared to 66% overall. Respondents with substance use disorders were more likely to report that they always felt safe with people they went to for counseling or treatment (96% compared to 78% overall).

Another major barrier is understanding available treatment options and services included in their benefits. Also, members may require continued access to behavioral health care services and treatment options before they begin to see improvement. Social factors are another aspect that can affect individuals with a mental health diagnosis. Individuals may experience lack of education or health literacy, economic instability, lack of social connections, poor infrastructure of neighborhoods and communities, and access to health care including mental health services. Social factors and mental health often correlate with health equity. Individuals who have a mental health diagnosis and experience any type of social factor may find it difficult to know and understand types of services they qualify for to address the condition, as well as accessing the appropriate level of care to address their needs.

DWIHN will continue to address questions about treatment and access to behavioral health services. DWIHN's behavioral health case management/supports coordination team will work directly with parents/guardians of its minor-aged members with a behavioral health condition and encourages medication adherence. Case managers/supports coordinators will review medications with members and talk about the importance of timely medication refills, provide education about timely follow-up and assist members with scheduling appointments. Each provider was shared personal measure data to be incorporated into their annual workplan and to address areas of concern.

Interventions and Actions

DWIHN will continue to focus on access to care for behavioral health services based on the 2021 survey results. Each intervention is designed to address an identified barrier in the treatment related factors:

- Analyze outcomes and work with providers to improve outcomes.
- Service providers to identify barriers to, and potential improvements that would support, members being seen within 15 minutes of appointment time.
- Service providers and members to identify barriers to members being able to get treatment quickly, particularly as it pertains to getting help over the telephone.
- Service providers to ensure all members, including those with DD or SUD, are confident in the privacy of their information and that those with guardians feel clinicians listen carefully to them.
- Review the provider network for access to behavioral health services, especially in more urban counties and reducing the amount of services that require a prior authorization, increasing behavioral health staff, and expanding to telehealth services.
- Service providers and members to explore the reasons why more families do not perceive improvements in their children, particularly with regard to social situations, and whether their self-assessments reflect clinicians' assessments.
- Service providers and families to identify barriers to members being able to get treatment quickly, particularly as it pertains to getting help over the telephone.
- Service providers to help them to understand the feedback their clients offered via the ECHO survey, particularly for those providers given lower scores on members' experience.

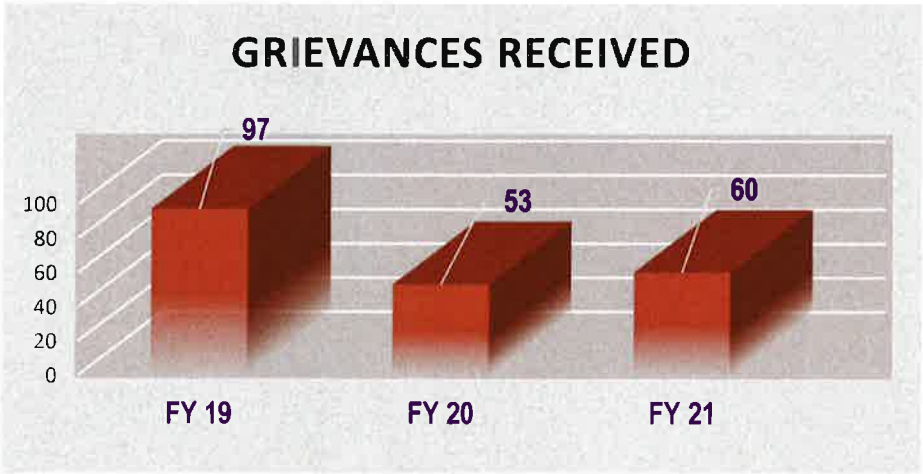
Member Grievances

Activity Description

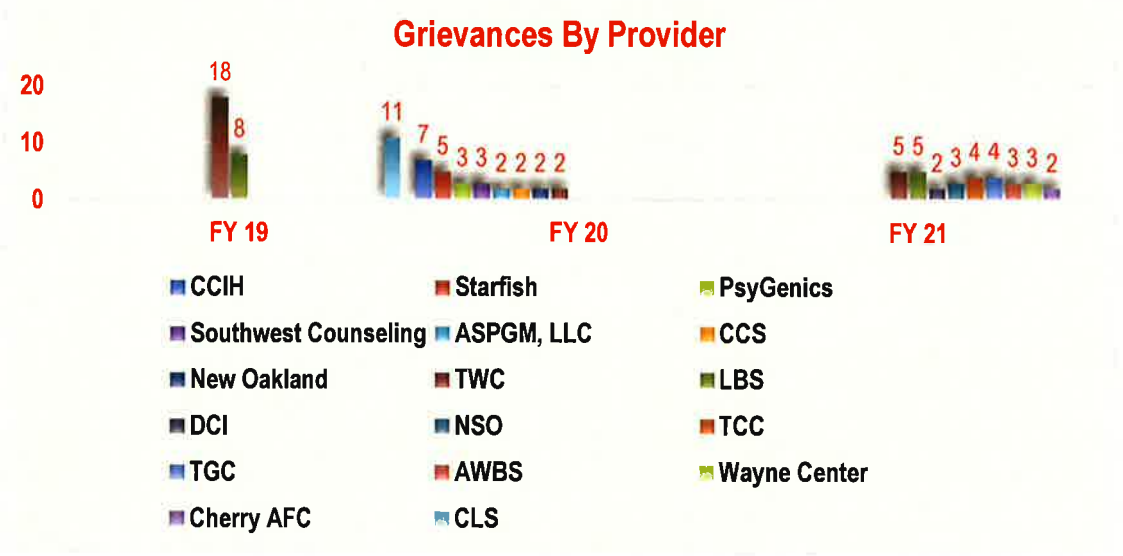
DWIHN's Customer Service completes an analysis of member experience trends and occurrences through review of Grievances, Appeals, Recipient Rights and Sentinel Events data. DWIHN uses this data and other initiatives to determine priority actions and improvements to better engage members and stakeholders. Outcomes of the analysis helps to forecast the direction and future of DWIHN's public behavioral health system by enhancing and developing policy, initiating process improvement plans, funding new programs and services to enhance our system of care. It also serves as a source to identify opportunities for improvement in the quality and delivery of behavioral health service within the DWIHN system. It is DWIHN's goal to educate members as well as providers on the importance of promoting expressions of member dissatisfaction as a means of identifying continuous quality improvements in our delivery of behavioral health care services. It promotes members access to medically necessary, high quality, consumer-centered behavioral health services by responding to member concerns in a sensitive and timely manner. This process supports recovery and assures that people are heard. It empowers individuals receiving services to become self-advocates and provides input for making the system better for everyone. Monitoring metrics include the annual Provider Satisfaction Survey, member complaint and appeal data.

Quantitative Analysis and Trending of Measures

The results described below include responses from members who received services in fiscal year 2021. There was a total of 210 grievances reported within the last three fiscal years. Grievances originated with either the Service Provider or DWIHN. As the graph below indicates the most grievances were reported in FY '19. with a decrease by 35% in FY '20, and 29% decline in FY '21. However, there was a slight increase by 4% in the number of grievances reported in FY '21 compared to FY '20. It is believed that the number of member grievances has declined over the past two years due to the COVID 19 pandemic and most services have been provided via telehealth.



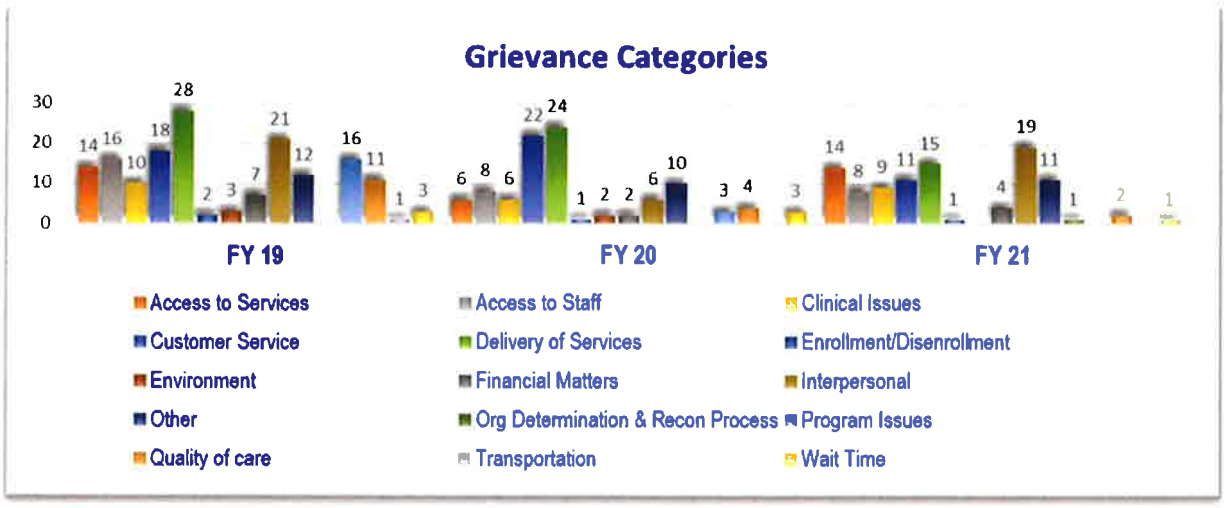
DWIHN has network of approximately 120 providers. However, grievances were not reported against every provider. Although grievances were filed against several providers. For the purpose of this report, recipients filed the most grievances against the providers as identified in the graph below.



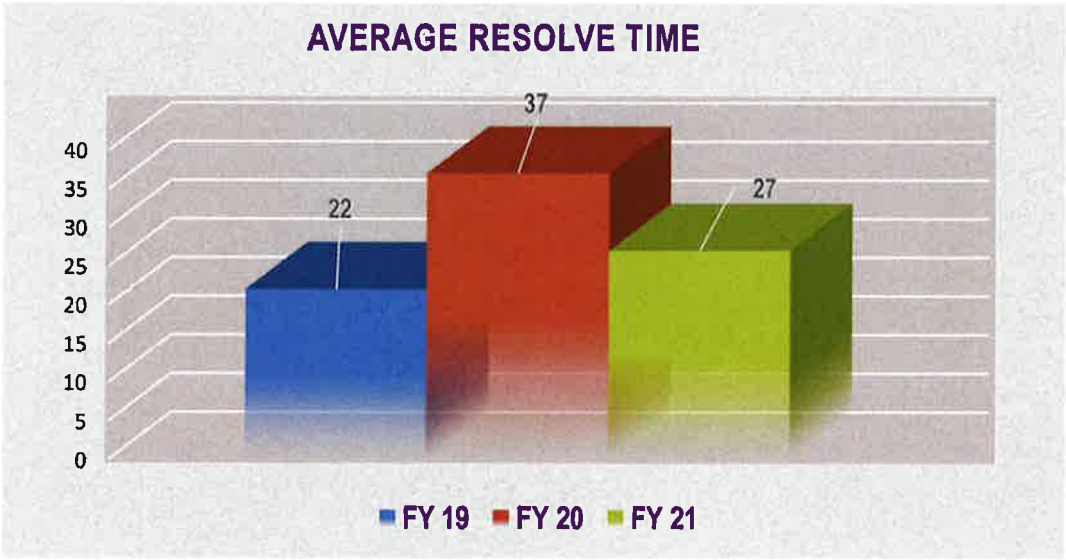
Team Wellness Center (TWC) had the highest volume of grievances, total of 25, reported over the past three years. It is important to note there was a decrease by 92% in FY '20 and 80% decrease in FY '21 compared to the number of grievances reported in FY '19 LBS had the second highest number of grievances reported against them over the past three years. There were eight grievances reported in FY ;19 and five in FY '21 which equates to a total of 13 grievances with none in FY '20. FY '19. CLS had the third highest number of grievances, total 11 which were noted in FY '19 and none reported in FY '20 or 21. Seven grievances were reported against CCIH in FY '20.

Evaluation of Effectiveness

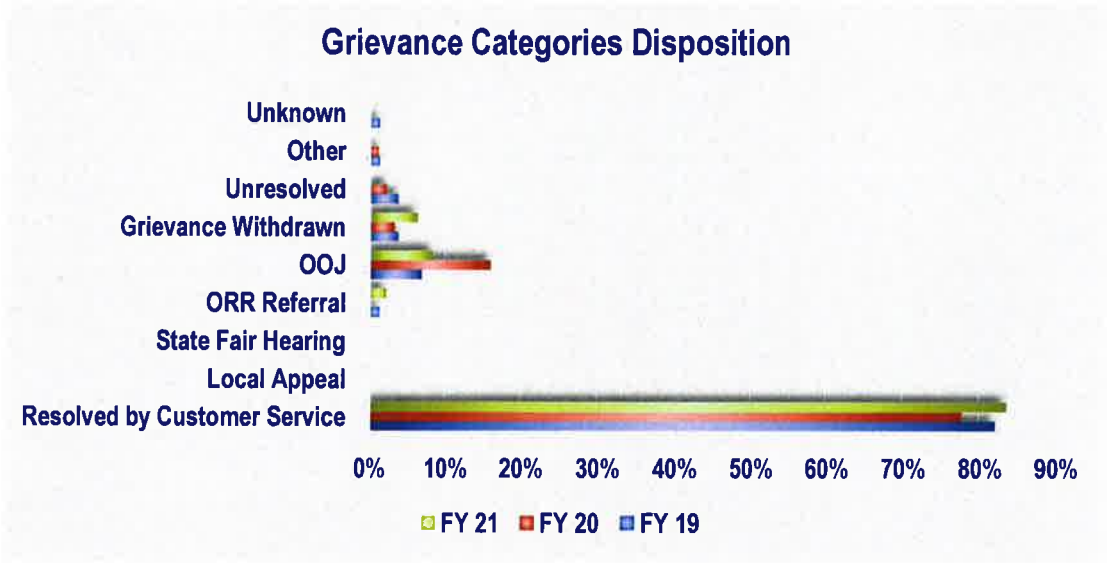
The number of categories identified within a grievance can be significantly greater than the number of grievances received. However, a grievance is not considered resolved until all the categories within a grievance have been thoroughly investigated and considered appropriate for closure. DWIHN identifies grievance categories in alignment with MDHHS requirements as illustrated in the graph below. During FY '19 there were 97 grievances reported in which 162 issues were identified. In FY '20, there were 97 issues identified within the 53 grievances reported. During FY '21, there were 60 grievances reported in which there were 96 issues identified. Delivery of Service and Customer Services were consistently high over each of the three years. Interpersonal relations came in third with a total of 46 complaints. There had been a decline in this area in FY '20 by 87% compared to FY '19. However, there was an increase by 76% in FY /21. There was a consistent decline in the number of grievances in the following categories over the past three years: 1.) Quality of Care; 2.) Program Issues and 3.) Environmental.



A total of 11 grievances were reported for the five ICOs over the last three fiscal years. Molina has consistently had the highest number of grievances reported. Six grievances were received in FY '21, four in FY '20 and one in FY'19 and. Those eleven (11) grievances are included in the total number of grievances reported for each year and same for the grievance categories. Medicaid and MI Health Link grievances are required to be resolved within ninety (90) calendar days, whereas Non-Medicaid grievances must be resolved within sixty (60) calendar days. Grievances were resolved within the average number of 22 days during FY '19. The average timeframe for resolution of a grievance was 37 days in FY '20 and 27 days in FY '21.



Of the 355 grievance categories reported over the last three fiscal years, 287 or 81% were resolved within the Customer Service unit at either the Service Provider or DWIHN. Those grievances were usually coordinated with other departments for resolution. Nineteen (19) or 4.3% of the grievance categories were suspected recipient rights violations and therefore, referred to ORR for further follow-up and investigation. There were 34 (9.5%) grievances received during the same time frames that were determined not to be in DWIHN jurisdiction and therefore referred to outside entities for further assistance and follow-up. 3% or 13 of the grievances reported were later withdrawn by the grievant. The remaining 7% of the grievance categories were either not resolved or disposition is unknown. Typically, in such a case as this, the member cannot be reached to determine satisfaction



There were 236 grievances reported over the last three fiscal years (FY '18, FY '19 and FY '20). 163 or 69% of those grievances were resolved to the satisfaction of the grievant. 19% were not satisfied with the resolution of his/her grievance. Unable to determine the satisfaction disposition for 8% of the members due to inability to speak with the member. The remaining 5% of the member satisfaction fell in the other category as those grievances were not resolved.

Barrier Analysis

Overall, member ratings of quality, satisfaction, appropriateness, and outcomes were positive. Measures of outcomes tended to be lower than other scales. This may be due to the fact that consumers are still in services and their ultimate goals have not been attained. Majority of the open-ended comments were positive. Members made request for more flexibility with scheduling including requests for weekend appointments and more reliable transportation. Members also made requests to get back to face to face contact due to the COVID 19 pandemic.

Opportunities of Improvement

DWIHN continues to expand our collaboration with community partners to further support our most vulnerable population and improve the health and safety of members through innovative services and partnerships.

- Providing relevant training on cultural competence and cross-cultural issues to health professionals and creating policies that reduce administrative and linguistic barriers to member care.
- Continue to work with our Member Engagement division to provide outreach, education, advocacy, peer development, and surveying member experiences.
- Continue the Constituents' Voice Advisory Committee which addresses consumer legislative issues including the delivery of service, interpersonal relations and customer service.
- Review and discuss grievance data with the Member Engagement Division which will allow for an additional avenue for evaluating member experiences.
- Continue to identify continuous quality improvement opportunities through use of patterns and trends of grievances reported.
- Continue to support members by resolving issues of dissatisfaction with DWIHN.
- Offer continuous training and education on customer service and the delivery of services.
- Continue to offer education and training for the provider network and enrollees on grievances and other due process rights.
- Review and discuss grievance data with the Member Engagement Division which will allow for an additional avenue for evaluating member experiences.

Provider/Practitioner Survey

Quantitative Analysis and Trending of Measures

DWIHN administered the Provider and Practitioner Surveys for FY21 during the month of September related to service access, service provision, treatment experiences and outcomes. The surveys were distributed to approximately 400 organizations in which there was a 35% increase in responses which is 13% higher than FY20. The Practitioner Survey was distributed in late September, resulting in 280 responses, a 17% increase from last year's responses of 232. Both surveys are comprised of 76 questions and covered all areas of DWIHN's operations.

Evaluation of Effectiveness

The total number of actual respondents for FY 21 from provider organizations was 140 out of 529. The total number of actual respondents for FY 21 from individual practitioners was 280 respondents out of 1243 individual practitioners. Percentage wise the provider and individual practitioner's response rates were 26% and 23%, respectively. In total, 420 surveys were returned out of 1772 surveys with an overall percentage response rate of about 24%. *"Note DWIHN's targeted response rate is 50-60% a response rate".*

Intervention and Action Taken

In FY 20-21, DWHIN instituted the following improvements to close the gap between the actual response rates and DWIHN's targeted response rates of 50%-60%:

- Provider Survey Ad-Hoc Task Force reviewed the survey instruments to assess and identify opportunities for improvement aimed at increasing the response rate, inclusive of shortening questionnaire and time to complete the survey.
- Alerts sent to Providers and Practitioners of the issuance of the survey prior to release.
- Notifications were posted in MHWIN prompting providers and practitioners to complete the survey.
- Provider Network Managers prompted and reminded providers and practitioners via email and phone to complete the survey.

Barrier Analysis

The most critical barrier to the response rates not increasing was the Covid 19 Global Pandemic. The Covid 19 Global Pandemic adversely impacted providers' and practitioners' ability to provide services inclusive of closures, staffing shortages and getting acclimated to operating remotely. The survey results also revealed that reducing the number of questions which will shorten the time to complete survey will likely increase the number of completed surveys returned.

Opportunities for Improvement

As was identified in FY 19-20, the length of the surveys (76 questions) may dissuade provider organizations and practitioners to complete the survey. A Task Force, Provider Survey Task Force, was established prior to the release of the Provider Surveys to determine if the survey instruments should be revised, inclusive of shortening questions, in an effort to increase the response rate. The decision was made not to revise the study because changing the survey tools could adversely impact comparisons with previous years' surveys. The Provider Survey Ad-Hoc Task Force will reconvene and revisit the revision of the FY 21-22 Annual Provider Surveys to include decreasing the number of questions and shortening the amount of time it takes to complete the survey in an effort to achieve DWIHN's targeted response rate. In addition, DWIHN will continue the following actions implemented in FY 20-21.

- Alert Providers and Practitioners of the issuance of the survey prior to release.
- Post notifications in MHWIN prompting providers and practitioners to complete the survey.
- Increase the number of reminders to complete the survey per the providers assigned Provider Network Manager.

National Core Indicators Survey (NCI)

Another measure to assess the satisfaction of services and to improve satisfaction of persons served and quality of care, is the National Core Indicators Survey (NCI), which surveys adults with intellectual developmental disabilities. The NCI survey is conducted by MDHHS annually. Ongoing COVID-19 issues has delayed the operation of the survey. This activity will continue as a quality improvement project for FY22 to improve access to service and quality of care. DWIHN will use the results of the NCI Survey to identify and investigate areas of dissatisfaction and implement interventions for improvement.

Complex Case Management (CCM)

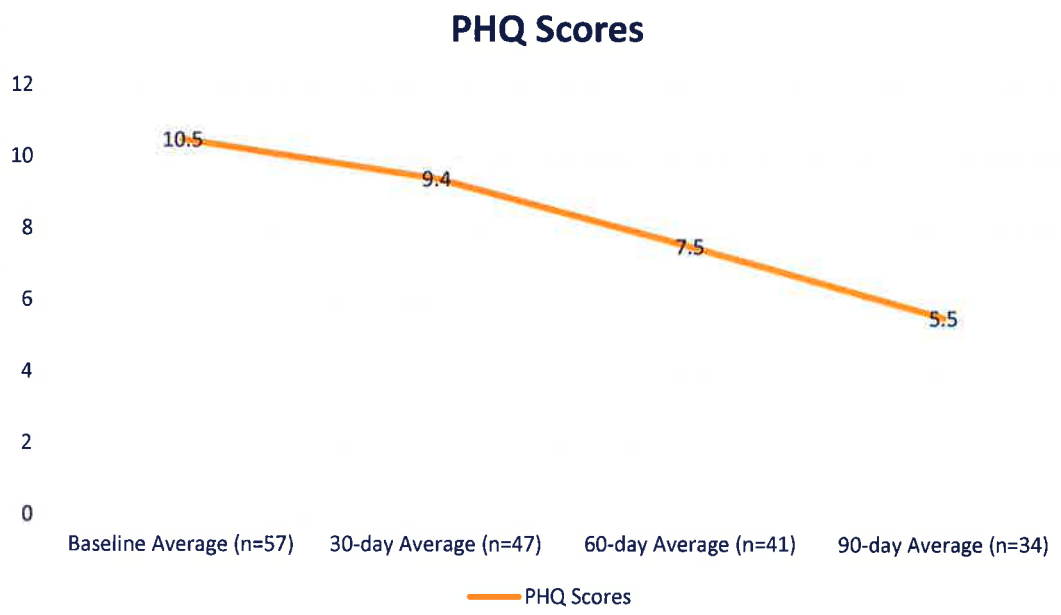
DWIHN's CCM program has innovative methods to identify and proactively reach out to members who are at high risk for psychiatric hospitalization, to help them understand their behavioral health clinical condition, adhere more closely to outpatient treatment recommendations and gain condition self-management skills.

Quantitative Analysis and Trending Measure

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

Evaluation of Effectiveness

Sixty (60) members were enrolled in CCM services during FY21. Forty-seven (47) members were enrolled in CCM for at least 60 days during FY21. During FY2021, information was gathered to identify member rates of symptoms of depression. Depression symptoms were measured using the Patient Health Questionnaire (PHQ-9) for adults (18 and older) and Patient Health Questionnaire – Adolescent (PHQ-A) for children (under 18). The PHQ assessments are embedded in the CCM assessments for adults and children and are completed when the assessment is completed at the start of CCM services and every 30 days thereafter until CCM services end. The higher the score on the PHQ-9/PHQ-A, the greater the symptoms of depression are present. A decrease in PHQ score indicates an improvement in symptoms of depression. PHQ scores were gathered from the CCM assessments that were completed at the start of CCM services and at 30, 60 and 90 days after starting CCM services. Members PHQ baseline scores ranged from 2 to 22, with an average score of 10.5. Members participating in CCM services demonstrated overall improvement in their PHQ scores, and the improvement increased the longer that the members participated in CCM services. As displayed in the table below, average PHQ scores improved 10% from baseline at 30 days, 20% at 60 days and 27% at 90 days of receiving CCM services.



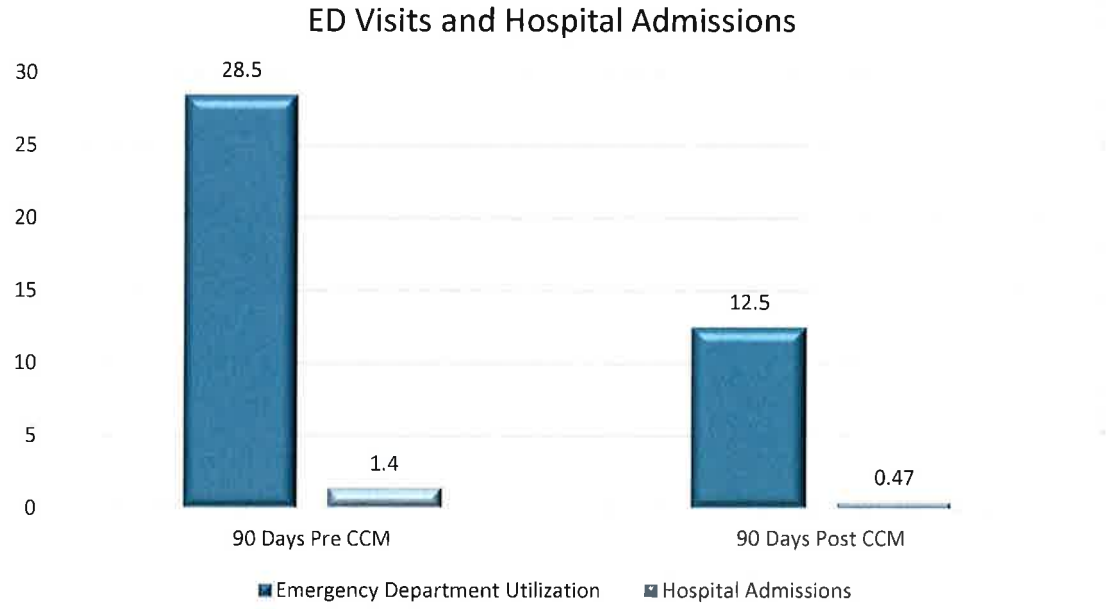
57 out of 60 members were included in the denominator for the initial PHQ scores. 3 of the members were not included in the denominator due to being unable to reach for assessment completion. 47 out of 60 members were included in the denominator for the 30-day PHQ scores. 13 of the members were not included in the denominator, in which 3 were unable to reach for assessment completion, 2 members CCM cases closed prior to completion of 30-day PHQ assessment and 8-member assessments were completed after the end of the FY date (after 9/30/2021). 41 out of 60 members were included in the denominator for the 60-day PHQ scores. 19 of the members were not included in the denominator, in which 5 were unable to reach for assessment completion, 4 members CCM case closed prior to completion of 60-day PHQ assessment and 10-member assessments were completed after the end of the FY date (after 9/30/2021). 34 out of 60 members were included in the denominator for the 90-day PHQ scores. 26 of the members were not included in the denominator, in which 5 were unable to reach for assessment completion, 9 members CCM case closed prior to completion of 90-day PHQ assessment, and 12-member assessments were completed after the end of the FY date (after 9/30/2021). 47 out of 60 members were included in the denominator for overall PHQ scores, in which 2 members were excluded due to only having one PHQ assessment completed. 8 members were excluded due to assessments being completed after the end of the FY date (after 9/30/2021) and 3 members excluded due to being unable to reach and having no PHQ assessments completed. 41/47 members (87%) met the goal of having a 10% improvement in PHQ scores from the start of CCM services to closure of CCM services.

Causal Analysis

Three members did not show an improvement in PHQ scores from baseline to the time that CCM services were ended. Three members PHQ scores increased while in CCM services, in which 2 of those members had continued high hospital admission utilization rates and 1 of those members went to a detention center and residential treatment while participating in CCM services. Two members showed an increase in PHQ scores but the improvement did not meet the 10% threshold. In order to continue to promote an improvement in PHQ scores, CCM will review and update Crisis Plans with members and existing care team after hospitalization. CCM will also encourage a connection with Members and Peer Support Specialists as an added support.

During FY21, information was gathered to assess member quality of life using the World Health Organization's Disability Assessment Schedule (WHO-DAS). Members WHO-DAS baseline scores ranged from 7 to 48, with an average score of 16. Members participating in CCM services demonstrated overall improvement in their WHO-DAS scores, and the improvement increased the longer that the members participated in CCM services. Average WHO-DAS scores showed improvement from baseline to 30 days of receiving CCM services. Average WHO-DAS scores improved 8.8% from baseline at 30 days, 17% at 60 days and 22% at 90 days of participating in CCM services. Overall, 38/47 members (80%) met the goal of having a 10% improvement in WHO-DAS scores from the start of CCM services to closure of CCM services.

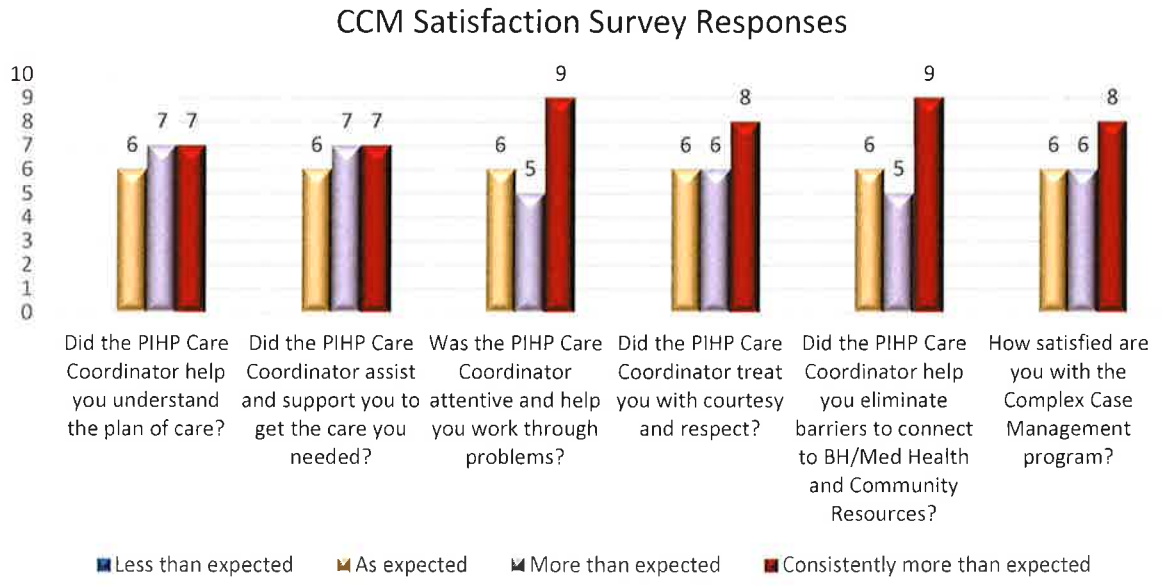
DWIHN analyzed member Admission, Discharge and Transfer (ADT) alerts and DWIHN claims data to measure utilization of Emergency Department and Hospital Admissions 90 days prior to participating in CCM services and 90 days after starting CCM services. Members participating in CCM services showed an average 48% reduction in Emergency Department utilization and average 74% reduction in Hospital Admissions from 90 days prior to 90 days after starting CCM services. Members had an average of 28.5 Emergency Department visits and 1.47 Hospital admissions during the 90 days prior to receiving CCM services and had an average of 12.5 Emergency Department visits and 0.47 Hospital admissions during the 90 days after starting CCM services.



DWIHN also measured the number of members who attended two out-patient behavioral health services within 60 days of starting CCM services. Out of 41 members that were available to participate in 2 out-patient services after starting CCM services, 36 members (87%) attended two out-patient behavioral health services within 60 days of starting CCM services. Fourteen members were not included in this measure due to not being enrolled in CCM services for 60 days at the time of the report. Five members were not included due to not being open for longer than 90 days. For FY21 as an area of improvement, DWIHN measured the number of members who attended two out-patient behavioral health services within 60 days of the closure CCM services. Out of 38 members that were available to participate in 2 out-patient services after CCM case closure, 16 members (42%) attended two out-patient behavioral health services within 60 days of CCM case closure. Seventeen members were not included in this measure due to not being enrolled in CCM services for 60 days at the time of the report. Five members were not included due to not being open for longer than 90 days.

Satisfaction surveys were offered to all members upon closure of Complex Case Management services. Members were informed that completion of the Survey was not mandatory, but that they were encouraged to complete the Survey to provide feedback regarding their experience receiving CCM services. Of the 60 CCM cases opened during FY21, 42 members had Complex Case Management services closed during FY21. 20 (48%) Satisfaction Surveys were completed and returned. The Satisfaction Survey consisted of 6 questions with Likert Scale response options of *Less than expected, As expected, More than expected, and Consistently more than expected*. There was also a section for members to write in comments if they chose. A response of 'Less than expected' is considered a report of dissatisfaction. A response of 'As expected' is considered a neutral response. Responses of 'More than expected' and 'Consistently more than expected' are considered reports of satisfaction.

No members reported responses of 'Less than expected' to the Survey questions. Six members provided a response of 'As expected' to the first question. All other members provided responses of 'More than expected' and 'Consistently more than expected'. The first question had a 70% of the questions were 'More Than Expected' and were 'Consistently more than expected'. 30% of the responses were 'As expected', as indicated in Table below satisfaction surveys were offered to all members upon closure of CCM services. Members were informed that completion of the Survey was not mandatory, but that they were encouraged to complete the Survey to provide feedback regarding their experience receiving CCM services. Of the 60 CCM cases opened during FY21, 42 members had CCM services closed during FY21. Forty-eight (48%) Satisfaction Surveys were completed and returned. The Satisfaction Survey consisted of 6 questions with Likert Scale response options of *Less than expected*, *As expected*, *More than expected*, and *Consistently more than expected*. There was also a section for members to write in comments if they chose. No members reported responses of 'Less than expected' to the Survey questions. The results of the survey are reported below.



The results of the FY21 analysis of CCM services can be compared to the results of analysis completed for FY20 and FY19. Comparisons can be made in the areas of PHQ scores, WHO-DAS scores, hospital admissions, behavioral health engagement, and Satisfaction Survey results. PHQ and WHO-DAS scores were lower than PHQ and WHO-DAS scores at baseline, 30 days and 60 days after starting CCM services in FY21 compared to FY20. PHQ and WHO-DAS scores were lowest in FY19, this could be an issue of interrater reliability as a result of staff changes that occurred during FY19. The two staff that provided CCM services during FY19 timeframes transferred to other positions within the organization during FY19. The number of members who met the goal of a 10% reduction in their PHQ scores at time of closure from CCM services remained the same in FY21 compared to FY20 and decreased from FY19. While the number of members who met the goal of a 10% reduction in their WHO-DAS scores at time of closure from CCM services increased in FY21 compared to FY20 and FY19.

Barrier Analysis

The causal analysis of barriers to improving member satisfaction and the experience continues to remain relatively the same from one year to the next (FY21 to FY20 48%). DWIHN would like to increase the return rate to 55% in FY22. DWIHN will continue offer a $10 Walmart Gift Card to all members who complete and return a CCM Satisfaction Survey. In addition, the Clinical Specialist of Complex Case Management will continue to contact any members who have not returned their satisfaction survey within 30 days of the satisfaction survey being mailed to encourage them to complete by telephone. Also, in effort to increase member sustainability and engagement in out-patient behavioral health services after they are no longer receiving CCM services, the percentage of members who engage in at least two out-patient behavioral health services within 60 days of closure of CCM services will continue to be measured. Care Coordinators will mail out educational material to members about the benefits of attending Behavioral Health Outpatient appointments within 2-3 weeks after case closure. Care Coordinators will contact members around 30 days post case closure for follow up. Care Coordinators will also contact members CRSP to speak with the assigned Case Manager or Supports Coordinator to ensure members barriers are being addressed and care team is working with member to increase outpatient visit participation.

Opportunities of Improvement

An area identified as an opportunity for improvement during FY20 was reduction in Emergency Department utilization. During FY21, Care Coordinators emphasized the importance of familiarization with crisis plans, and becoming more knowledgeable of managing conditions. Care Coordinators also emphasized the importance of member attendance and participation at outpatient behavioral health appointments. Care Coordinators also worked with members to address barriers of attending appointments, including arranging transportation, rescheduling appointments to accommodate member schedules, and connecting members to service providers of members preference. Care Coordinators completed transition of care calls to members to encourage FUH appointment attendance and ensure needs were met. Care Coordinators also contacted members assigned Clinically Responsible Service Provider (CRSP) for increased coordination to improve member attendance for aftercare appointments. As a result of these efforts, 95% of members who received CCM services met the goal of a 10% reduction in Emergency Department Utilization.

DWIHN will continue to place greater emphasis on developing, reviewing and updating crisis plans with members in an effort to reduce utilization of Emergency Department services. Teach back methods will be used once the crisis plans are developed to ensure that members can articulate back their crisis plans and know what actions to take when symptoms start to occur. DWIHN will also continue working with current care team to increase members participation in Follow up after Hospitalization appointments as well as attendance for regular outpatient appointments. This goal will be continued through fiscal year 21/22.

Cultural and Linguistic Needs

Quantitative Analysis and Trending of Measures

How well providers communicate impacts members' overall satisfaction and has remained consistent over the three-year period from 2019 to 2022with slight upward movement. The Cultural and Linguistic needs data reports that literacy; language and cultural barriers are inherent in the DWIHN's populations and cause frustration often resulting in member dissatisfaction surrounding access to care and/or the customer service they receive from their provider. Focus studies show that members with complex medical needs are frustrated with their experiences and believe they are receiving low-quality medical coverage. Members have reported frustration and suggest that office staff receive training on how to treat and communicate with people of different cultures and ethnicities. Members report that they are unaware of free interpreting services although this is highly promoted to DWIHN members.

As a proxy, DWIHN reviewed the languages spoken at provider locations. Providers had identified the languages spoken by their staff at their various locations. These are languages (other than English) spoken at 242 provider locations in the DWIHN service network. The most frequently requested languages for interpretation were Arabic and Spanish. The least frequent requested languages for interpretation were Filipino, Chinese, Tagalog, Chaldean and Polish. In addition, DWIHN has adopted the Culturally and Linguistically Appropriate Services (CLAS) standards to advance health equity, improve quality, and help eliminate healthcare disparities. These standards provide a blueprint for individuals and healthcare organizations to implement culturally and linguistically appropriate services.

Evaluation of Effectiveness

As the nation continued to grapple with the realization of racism and the impacts of oppression on health outcomes, the development of professionals that are able to recognize and respond to their implicit biases is critical and has been a primary objective for the development and retention of providers. Trauma-informed approaches to care includes addressing minority stress and race-based trauma. During FY21, staff supported 6,005 callers. Using the least restrictive methods to access services, callers that live, work, play, worship, and learn in Wayne County are able to access behavioral health support that is consistent with their current stage of change. As callers are often pre-contemplative, staff provided support and encouragement without requiring identifying information to receive services. The focus on engagement has led to a majority of individuals reporting an increased level of comfort in accessing services that positively affect their behavioral health. When callers demonstrate an ongoing need for services, staff provided a direct referral with a community mental health provider.

Barrier Analysis

It is recommended that partner organizations create a trauma-informed culture, safe work environment that includes physical and work place policies that prevent harassment, stalking, and violence. Promote respectful interactions amongst staff members at all levels. In addition, implement regular and consistent clinical supervision for all clinical staff members and provide ongoing training related to trauma-informed care and evidence-based interventions. Develop consistent hiring practices to ensure the best candidate for the role, be clear and concise about role expectations, and offer training that will build staff competencies. Lastly, utilize general approaches and techniques of building a rapport, providing a safe and comfortable environment to increase consumer participation.

Opportunities for Improvement

Through discussion and feedback, the following have been identified as opportunities for improvement:

- Continue to advance health equity, improve quality and help eliminate health care disparities by implementing culturally and linguistically appropriate services.
- Address barriers to accessing interpreters and language services.
- Increase data collection to document cultural linguistic competency need, include cultural linguistic competency in staff evaluations and creating recruitment strategies for bilingual and diverse staff.
- Place greater emphasis on policy change related to sexual orientation and gender identity and expression.
- Continue to utilize the data so the Implementation team and participating agencies and organizations can develop best practices that promote cultural linguistic competency and enrich workforce development on cultural linguistic competency specific needs.
- Continue efforts toward the recruitment and retention of providers and practitioners with cultural, linguistic, or special needs expertise.
- Continue Cultural Competency training to staff and network providers as required.
- Continue to meet the cultural, ethnic and linguistic needs of members by assuring a diverse provider network.

Credentialing

Activity Description

Detroit Wayne Integrated Health Network credentials practitioners and providers that provide Behavioral Health and Substance Use Disorders services. The credentialing standards comply with 42 CFR 422.204, NCQA, and Michigan Department of Health and Human Services. Medversant Technologies LLC, a National Committee for Quality Assurance (NCQA) Credentialing Verification Organization, primary source verifies the electronic applications and supporting documentation for practitioners and providers. Once that occurs the information is submitted to the DWIHN Credentialing Committee. This committee is composed of DWIHN's the Chief Medical Officer or their physician designee, the Credentialing Administrator, DWIHN staff and various quality members from Core Provider Agencies. The committee reviews and votes on moving the files to the CMO's que for approval. The committee also discuss disposition for files that do not meet the credentialing threshold. The CVO sends letters to the practitioners or providers of the credentialing decision. The Credentialing Committee also monitors the following databases monthly to determine if practitioners or providers have been excluded or sanctioned:

- Michigan Department of Health and Human Services Sanctions
- System for Award Management
- Office of Inspector General
- Medicare Opt Out
- Preclusion

Quantitative Analysis and Trending of Measures

DWIHN analyzed trends in service delivery and health outcomes over time, including whether there have been improvements and barriers impacting in the quality of health care services for members as a result of the activities. On a monthly basis, DWIHN credential and re-credential licensed practitioners who need to complete this process upon hire and every two years thereafter for participation in the DWIHN provider network. In FY21, DWIHN completed verification for 1074 practitioner files for credentialing and 73 providers, which is a slight increase compared to last fiscal year. All files were clean, had appropriate checks done, and had no issues or concerns.

Barrier Analysis

No barriers identified

Office of Recipient Rights

Activity Description

The Office of Recipient Rights' mission is to ensure that recipients of mental health services throughout the DWIHN system of care receive individualized treatment services suited to their condition as identified in their individualized Plan of Service (IPOS). The IPOS is developed by using the Person-Centered Planning (PCP) process and maps out how to receive service in a safe, sanitary, and humane environment where people are treated with dignity and respect, free from abuse and neglect.

Quantitative Analysis and Trending of Measures

During FY21, the Office of Recipient Rights (ORR) received 1,111 allegations, investigated 889 cases, and substantiated 251 investigations. The ORR received allegations from 474 recipients and 376 employees which represents the highest number of individuals that filed complaints. There was a significant decline in the number of allegations reported in FY20 1,383 (17%) compared to 1,631 reported allegations in FY19. The difference in the four years represents a (5%) decrease in complaint allegations since 2017; (3%) increase in complaint investigations since 2017; and (1%) increase in substantiated complaint allegations since 2017.

ORR also oversees the training for all DWIHN and provider employees, for the FY 20-21, the Recipient Rights Trainers registered 5,159 participants, 2,590 attended and passed the virtual class, and there were 2,569 no shows. This is significant and supports the fact that recipients and employees are one of our greater resources in protecting the rights of the ones we serve.

Evaluation of Effectiveness

The role of ORR plays a vital role in the monitoring of member safety through investigations, identification of potential quality of care issues and identification of potential trends in retaliation, harassment or discrimination. This critical component of the rights protection system aims to reduce risk factors for rights violations and increase proactive influences which prevent violations. Complaint Resolution through the recipient review and investigation of suspected or alleged rights violations. If it is determined that violations have occurred DWIHN ORR recommends appropriate remedial action and will assists recipients and /or complaints or to fulfill its monitoring function.

Barrier Analysis

Abuse and Neglect are the most serious violations in the rights system and account for much of the time spent in investigations by rights staff. The data that is gathered is not entirely indicative of all DWIHN members that access behavioral health services, as the violations is a sample of member scores and is a barrier to representative data for the populations served and who received behavioral health services. A review of the data as it relates to access to behavioral care services deserve high priority as the ECHO survey results in 2020 indicated (36%) of respondents see it as a critical issue and see transportation or the lack thereof being a critical part of the correlation of access due to prohibitive mobility.

Opportunities for Improvement

DWIHN has identified the following as opportunities for improvement:

- Continue to education and trained the provider network to assist in the Code mandated provision
- Continue to monitor recipient rights compliance through the review of incident and death reports, behavior plans, contracts and service provider locations.
- Ensure uniformly high standard of recipient rights protection across all service providers
- Continue resolution through the recipient review and investigation of suspected or alleged rights violations.

Access Pillar

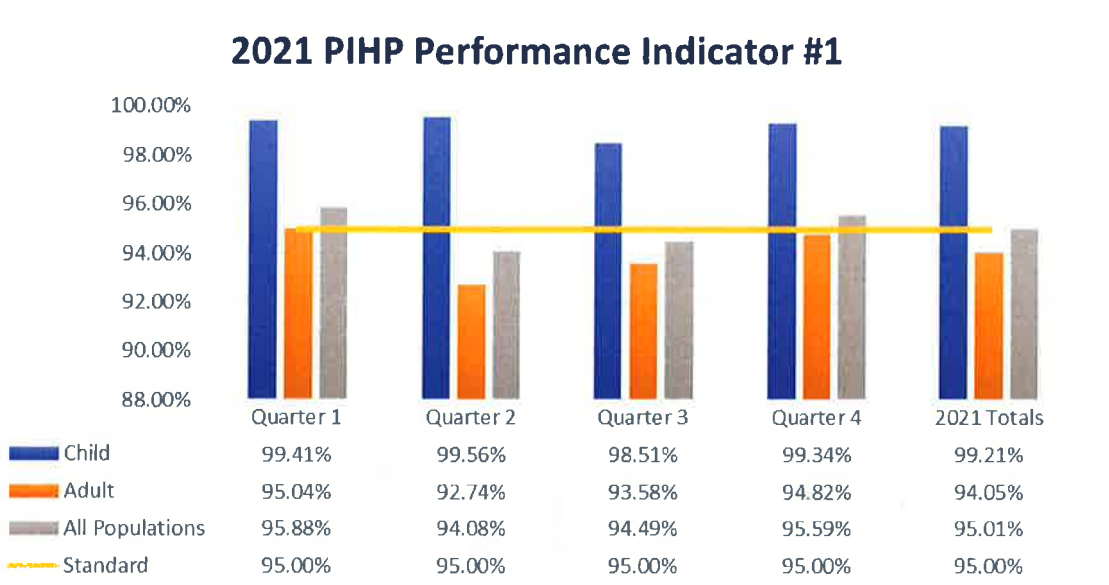
Michigan Mission Based Performance Indicators (MMBPI)

Activity Description

The Michigan Mission Based Performance Indicators data are a way of measuring how well we are helping the people we serve by meeting standards of care like timeliness; by reducing problems like hospitalization; or by helping people improve their lives in other ways. There are five (5) indicators that have been established by Michigan Department of Health and Human Services (MDHHS) that are the responsibility of the PIHP to collect data and submit on a quarterly basis. The established standards for indicators #1 and #4 are (95% or above) and the standard for indicator #10 is (15% or less). Indicators #2 (The percentage of new persons during the period receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service) and Indicator #3 (The percentage of new persons during the period starting any medically necessary on-going service within 14 days of completing a non-emergent biopsychosocial assessment) are new indicators in which there are no established standard/benchmark set by MDHHS.

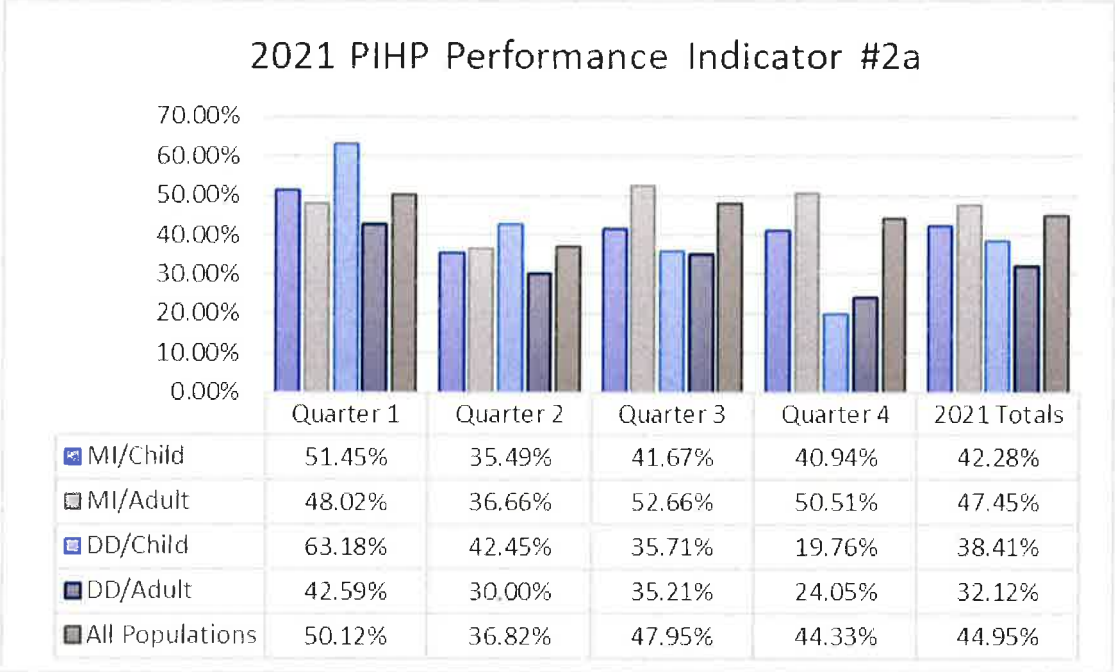
Quantitative Analysis and Trending of Measures

The percentage of persons during 2021 receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. **Goal**: The goal is to attain and maintain performance standards as set by the MDHHS contract. Standard 95% or above. **Results:** FY21 standard met for all populations with the exception of Q2 Adult (92.74%), Q3 Adult (93.58%) and Q4 Adult (94.82). Total population rate (95.01%).



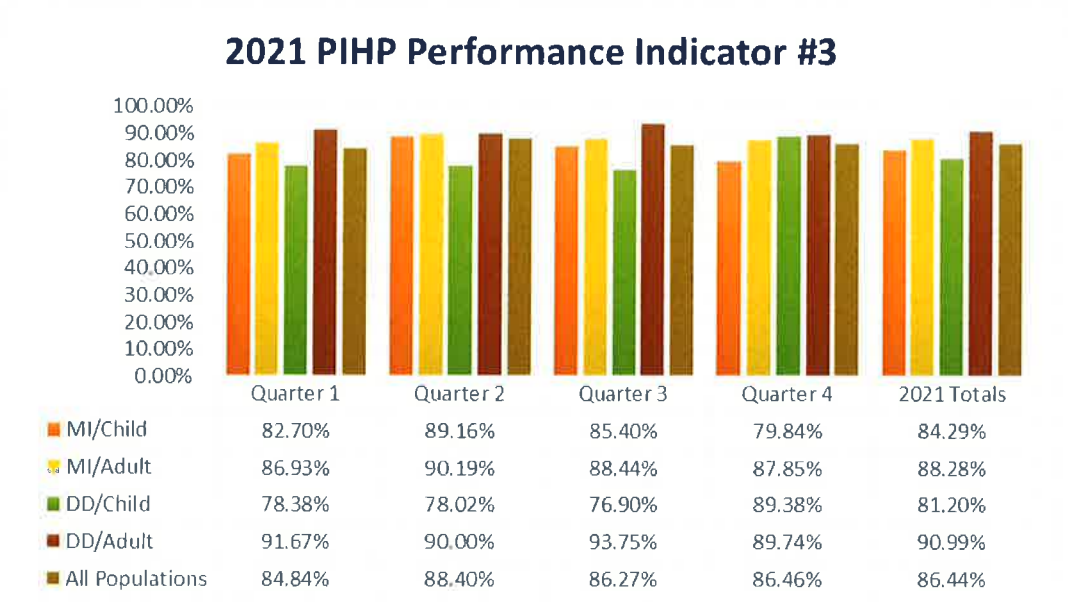
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2021 Totals
Child	99.41%	99.56%	98.51%	99.34%	99.21%
Adult	95.04%	92.74%	93.58%	94.82%	94.05%
All Populations	95.88%	94.08%	94.49%	95.59%	95.01%
Standard	95.00%	95.00%	95.00%	95.00%	95.00%

The percentage of persons during FY 2021 receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service. No standard/benchmark has been set by MDHHS. This measure allows for no exceptions. **Results**: Q1(50.12%), Q2 (36.82%), Q3 (47.95%) and Q4 (44.33%). Total population rate (44.95%).



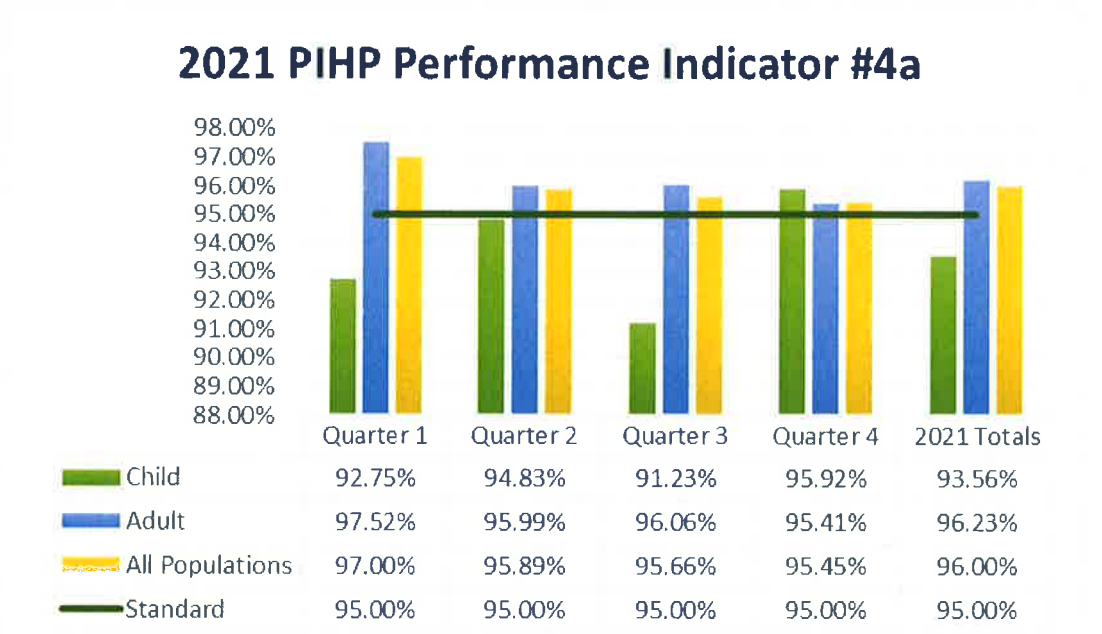
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2021 Totals
MI/Child	51.45%	35.49%	41.67%	40.94%	42.28%
MI/Adult	48.02%	36.66%	52.66%	50.51%	47.45%
DD/Child	63.18%	42.45%	35.71%	19.76%	38.41%
DD/Adult	42.59%	30.00%	35.21%	24.05%	32.12%
All Populations	50.12%	36.82%	47.95%	44.33%	44.95%

The percentage of persons during FY 2021 needed on-going service within 14 days of a non-emergency request for service. No standard/benchmark has been set by MDHHS. This measure allows for no exceptions. **Results:** Q1(84.84%), Q2 (88.40%), Q3 (86.27%) and Q4 (86.46%). Total population rate (86.44%).



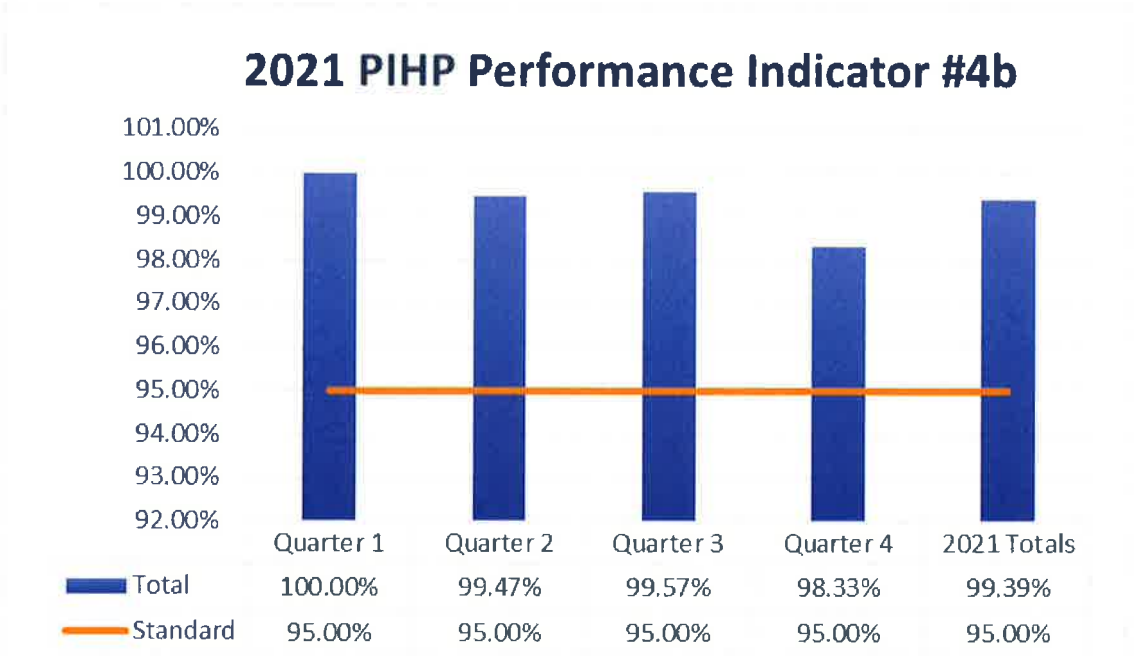
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2021 Totals
MI/Child	82.70%	89.16%	85.40%	79.84%	84.29%
MI/Adult	86.93%	90.19%	88.44%	87.85%	88.28%
DD/Child	78.38%	78.02%	76.90%	89.38%	81.20%
DD/Adult	91.67%	90.00%	93.75%	89.74%	90.99%
All Populations	84.84%	88.40%	86.27%	86.46%	86.44%

The percentage of discharges from a psychiatric inpatient unit during FY2021 who are seen for follow-up care within seven days. **Goal**: The goal is to attain and maintain performance standards as set by the MDHHS contract. Standard 95% or above. **Results**: FY21 standard met for all populations with the exception of Q1 Child (92.75%), Q2 Child (94.83%) and Q3 Child (91.23%). Total population rate (96.00%).

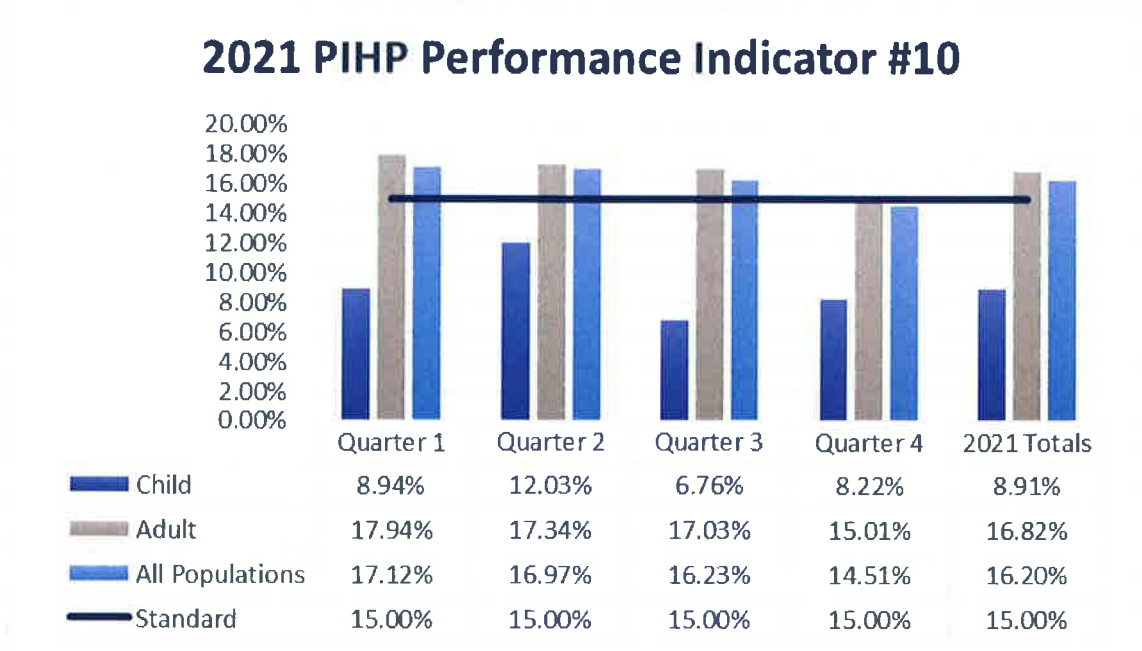


	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2021 Totals
Child	92.75%	94.83%	91.23%	95.92%	93.56%
Adult	97.52%	95.99%	96.06%	95.41%	96.23%
All Populations	97.00%	95.89%	95.66%	95.45%	96.00%
Standard	95.00%	95.00%	95.00%	95.00%	95.00%

The percentage of discharges during FY 2021 from a Substance Abuse Detox Unit who are seen for follow- up care within 7 days. **Goal**: To achieve MDHHS established benchmark of (95% or above) for (4) quarters during FY21. Standard 95% or above. **Results**: FY21 standard met for all 4 quarters. Total rate (99.39%).



The percentage of readmissions of children and adults during FY 2021 to an inpatient psychiatric unit within 30 calendar days of discharge from a psychiatric inpatient unit. **Goal**: The goal is to attain and maintain performance standards as set by the MDHHS contract. Standard 95% or above. **Results:** FY21 standard met for the children population. Standard not met for the adult population for all quarters Q1 (17.94%), Q2 (17.34%), Q3 (17.03%), Q4 (15.01). Total population rate (16.20%).



	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2021 Totals
Child	8.94%	12.03%	6.76%	8.22%	8.91%
Adult	17.94%	17.34%	17.03%	15.01%	16.82%
All Populations	17.12%	16.97%	16.23%	14.51%	16.20%
Standard	15.00%	15.00%	15.00%	15.00%	15.00%

Evaluation of Effectiveness

The results below show that the initiatives and interventions that were implemented in FY2020 were generally effective in reducing recidivism rates. In FY21, as a result of 447 conversations, DWIHN has been able to divert 64% of those members considered to be familiar faces to the least restrictive environment. Also, as displayed in the table below, DWIHN's Recidivism Workgroups which includes our Clinically Responsible Service Providers (CRSP) (led by DWIHN Crisis/Access team) initiatives have led to a decrease with the adult recidivism rate from 22% during Quarter 2 in FY20 to 15.01% for Quarter 4 for FY21, with a total population rate of 14.51%, which is the second lowest rate in the last 2 years. The threshold for PI# 10 is 15% or less.

	Population	FY20Q1	FY20Q2	FY20Q3	FY20Q4	FY21Q1	FY21Q2	FY21Q3	FY21Q4
Indicator 10a: Percentage who had a Re-Admission to Psychiatric Unit within 30 Days (<15% Standard)	Children	10.91%	9.09%	8.09%	11.11%	8.94%	12.03%	6.76%	8.22%
	Adults	20.41%	22.00%	20.83%	16.60%	17.94%	17.34%	17.03%	15.01%
	Total								14.51%

DWIHN continued to meet the standards for PI#1 (Children), PI#4a (Adult), 4b (SUD) and PI#10 (Children) for all quarters during FY21. DWIHN provided access to treatment/services for 95% or more members receiving a pre-admission screening for psychiatric inpatient care within 3 hours of a request for service with 95% or more receiving follow-up care within 7 days of an assessment. DWIHN provided access to treatment/services for 95% or more members discharge from a Substance Abuse Unit who are seen for follow-up care within 7 days. DWIHN demonstrated an 8.9% performance rate for Children who were re-admitted within 30 days of being discharged from a psychiatric hospitalization. This was a significant improvement in performance from the previous reporting period.

For Q2 (92.74%), Q3 (93.58%) and Q4 (94.82%), PI #1 the percentage of persons of adults during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours did not meet the 95% compliance standard. Efforts for PI#1 (Adults) include DWIHN's Access/Crisis team monitoring Community Outreach for Psychiatric Services (COPE) documentation in MH-WIN for cases that are not meeting the three (3) hour threshold. There was a slight increase of .84 percentage points from Q2 to Q3. For Q1(92.75%), Q2 (94.83%) and Q3 (91.23%) #4a the percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days" (Children) did not meet the 95% standard. Root Cause Analysis (RCA) revealed that three (3) follow-up appointments were scheduled in error with a provider not accepting new members. One (1) IDD provider reported that a member should have been scheduled with a SED provider. The last event was scheduled outside of the 7-day period but with no explanation. Performance Improvement Plans (PIP) and discussions with DWIHN's Access Center will be completed as a result of these out of compliance events. Ongoing efforts to include review of potential barriers for members that are not following through with their 7-day follow up appointments.

Data Analysis

- PI#1 - The adult rate was 94.82% for Q4 (95% standard), an increase of 2.4 percentage points from Q1(95.04%).
- PI#1's - Overall rate was 95.59% (95% standard), up 0.81 percentage points from Q1 (95.88%).
- PI#10 - The adult rate was 15.01% for Q4 (15% standard), a decrease of 16.33 percentage point from Q1 (17.94).
- PI#10's - Overall rate was 14.95% (15% standard), a decrease of 15.24 percentage points from Q1(17.12%).

Beginning Q3 of FY 2020, separate indicators were developed for PI#2a new persons receiving a completed Biopsychosocial Assessment within 14 calendar days of a non-emergency request for service, PI#2b SUD Services and indicator #3 new persons starting any medically necessary on-going covered service within 14 days of completing a non-emergent Biopsychosocial Assessment. There is no established standard for these indicators until one year of baseline data has been collected. The indicators are for persons with mental illness, developmental disabilities and substance use disorder. During FY21, the total compliance rates ranged from 36.02% - 50.12% for 2a, 86.10% - 89.81% for 2b and 84.84% -88.4% for #3.

Barrier Analysis

DWIHN developed dashboards to measure and track the outcomes for evidence-based practices, which are tied to DWIHN value-based service models. These dashboards will track incentives related to outcomes on four the performance indicators (2a, 3a, 4a and 10). For Q2 and Q3 DWIHN has failed to meet the threshold (95%) for PI# 1. DWIHN's Access/Crisis team has been working with COPE to review and request Corrective Action Plans (CAP) and Root Cause Analysis (RCA) as required. During the COVID-19 pandemic, COPE has expressed issues with being understaffed, which has attributed to the lower compliance scores. Several meetings have occurred with COPE and DWIHN and there was a slight increase from Q2 to Q3. DWIHN is optimistic with the interventions and initiatives that have been implemented that Q4 reporting data will improve to meet the threshold of 95% as required. PI#2a continues to demonstrate low scores. Providers are reporting a staffing shortage of intake workers due to the pandemic. Appointment meetings with DWIHN's clinical team, the Access Center, Quality and providers' executive leadership have been occurring in the last month to discuss solutions.

Those areas that perform below the standard DWIHN has developed a workplan to address areas of deficiency to increase the reported scores. Providers are reporting a staffing shortage of intake workers due to the pandemic. Appointment meetings with DWIHN's clinical team, the Access Call Center, Quality and providers' executive leadership have been occurring in the last month to discuss solutions. However, DWIHN is optimistic with the interventions and initiatives that have been implemented that Q4 reporting data will improve to meet the threshold of 95% as required. Efforts will continue to include working with DWIHN's Access Center unit, IT and PCE to review and identify barriers from scheduling the first appointment to completing the biopsychosocial assessment within 14 calendars.

Efforts to decrease hospital admissions and readmissions have continued to be a challenge. DWIHN seeks to reduce psychiatric inpatient admissions and provide safe, timely, appropriate and high-quality treatment alternatives while still ensuring members receive the appropriate required care. DWIHN continues its efforts to expand the comprehensive continuum of crisis services, supports, and improve care delivery. Rates continue to decrease slightly from quarter to quarter. Q3 2021 overall rate of 16.23% is the second lowest rate in the last 2 years.

Those areas that perform below the standard DWIHN has developed a workplan to address areas of deficiency to increase the reported scores. Providers are reporting a staffing shortage of intake workers due to the pandemic. Appointment meetings with DWIHN's clinical team, the Access Call Center, Quality and providers' executive leadership have been occurring in the last month to discuss solutions. DWIHN remains optimistic with the interventions and initiatives that have been implemented to meet the threshold of 95% as required. Efforts will continue to include working with DWIHN's Access Center unit, IT and PCE to review and identify barriers from scheduling the first appointment to completing the biopsychosocial assessment within 14 calendars.

Opportunities of Improvement

DWIHN will continue to focus on utilizing a system for formal tracking in order to identify trends where systemic change may be helpful:

- For Indicators 2 and 3 baseline data collection, improvements will be focused on ensuring valid, reliable, and actionable data is being collected.
- Continue to work with DWIHN's Crisis Team to identify potential delays in care.
- Working on expansion of "Med Drop" Program to improve outpatient compliance with goals to decrease need for higher level of care inpatient hospitalizations.
- Continue engagement and collaboration with members' outpatient (CRSP) providers to ensure continuity of care and when members present to the ED in crisis but may not require hospitalization.
- Continue efforts to chart alerts which notify the screening entities and the Clinically Responsible Service Provider (CRSP) of members who frequently present to the ED.
- Properly navigated and diverted members to the appropriate type of service and level of care.
- Provide referrals to Complex Case Management (CCM) for members with high behavioral needs.
- Continue coordination and collaboration with crisis screeners on measures to decrease inpatient admissions.

Improving Access and Crisis Services

Activity Description

In Fiscal Year 2021, DWIHN brought its Access Call Center in-house as a newly hired team began to champion the mission of providing the community we serve prompt and efficient service while ensuring that all members are treated with dignity and respect. The intent of this goal was to improve access to services. Implementing "First Call Resolution" empowers the Access Call Center staff to be sensitive to members' needs including those that need special accommodations and to accommodate specific needs so that appropriate services are always provided upon the first request. This service principle allows for calls to be managed with efficiency and care.

Quantitative Analysis and Trending of Measures

The data collected by the call center phone system software in FY21 indicates that performance exceeded the National Standards for Call Centers:

- Abandonment Percentage: from 1.2% to 4.9% less than standard.
- Average Speed to Answer: from 13 seconds to 17 seconds less than standard Percent of Calls
- Answered: from 16.2 to19.2 % greater than standard
- Service Level Percent: from 8.2% to 17.4% greater than standard

Requests for service (RFS) data shows a decreased for the 2nd year in a row, though the decrease is slight FY 20/21. Diversion rates improved for children, though decreased slightly, by 1% for adults. The Crisis Services unit has been working diligently, with increased face to face assessments, to improve outcomes of members in crisis, and has continued efforts to improve recidivism rates despite increasing staff shortages in several areas of care within the provider network. Crisis Services staff have continued efforts to improve communication with CRSP providers and community contacts to alleviate re-admissions to an inpatient level of care, and have been assisting in appropriate discharges of members into the least restrictive environments. Outreach efforts continue with a newly added mobile outreach clinician, providing education and access to DWIHN services, and this is occurring in the communities for those in need in the partnership with Wayne Health.

Evaluation of Effectiveness

The Request for Service (RFS) is slightly lower (0.75%) than FY 19/20. Diversion rates increased by 4% as compared to last year. The increase in diversion rates seem to have been impacted with crisis screeners resuming face to face screening and an increase in crisis stabilization services. The number of RFS decreased in FY 20/21 by 5%, however the overall percentage admitted slightly increased (1%) and diversions slightly decreased (1%). Inpatient due to no Crisis Residential Unit (CRU) bed available decreased by 68% from last year, though CRU capacity has deceased during COVID. Inpatient admits are due to higher acuity cases. There was 2.2% increase in (CRU) admissions in comparison to last FY. CRU capacity increased from 14 to 16 beds. As CDC guidelines allow, more beds will open gradually. COPE (DWIHN's Crisis Stabilization Unit) services increased by 5.3 as compared to the last FY. Team Wellness CSU number served increased by 732 cases from last year (last year numbers were for a period of 5 months)

FY	# Incoming Calls	# Calls Answered	% answer w/in 30 secs	Avg. Speed of answer	Abandonment rate
19/20	15,450	14,721	85% (avg)	22 secs	3.35
20/21	11,291	10,591	77.25	31.5	4

The call volume for the year decreased by 27%, however, the performance outcomes are out of compliance, with the exception of the abandonment rate. ProtoCall (DWIHN's Crisis Vendor) reports addressing staffing concerns and are working on recruiting and retention. A plan of correction has been requested and will continue to be monitored.

Barriers Analysis

Recidivism to inpatient hospitalization is an opportunity for improvement. The total number of Crisis Alerts received for the year is 447 and the diversion rate for the alerts received was 64% which positively impacted recidivism. The hospital rate of recidivism decreased from 17.12% in Quarter 1 to 14.59% in Quarter 4 and the average length of stay for FY21 was 11 days.

Opportunities of Improvement

The following opportunities were identified:

- Establish contract with Beaumont Hospital Psychiatric Inpatient facility
- Implement next phase of mobile outreach to include mobile crisis services, expand to shelters
- Develop Workplan and RFP for Crisis Care Center
- Apply for RFP for Crisis Stabilization Unit with the state
- Implement recommendations from the Steering Committee to reduce inpatient and recidivism

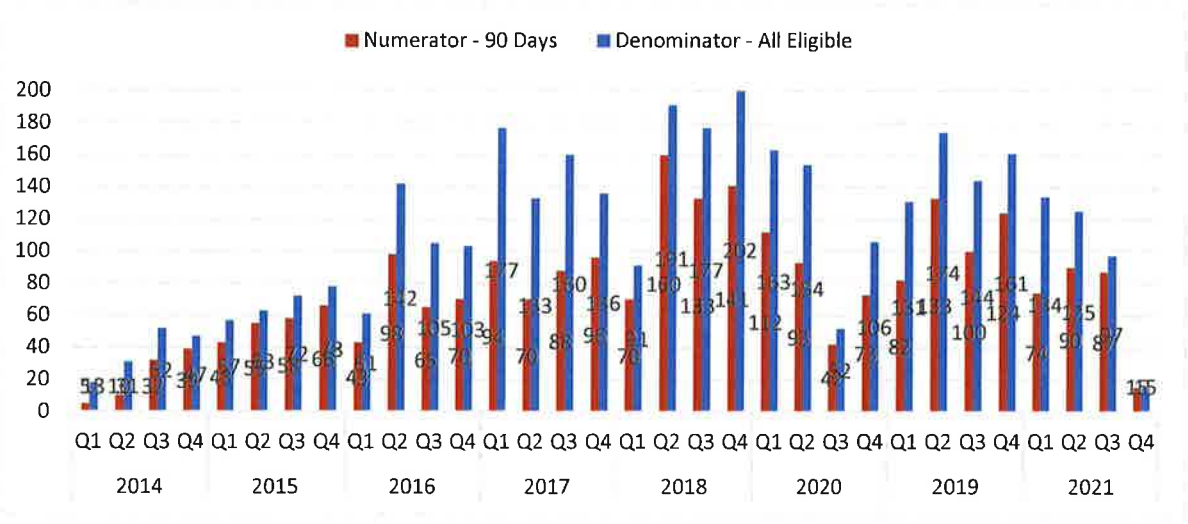
Access to Autism Services

Activity Description

Another significant area in which DWIHN strive to improve is eligible members access to Applied Behavior Analysis (ABA) treatment either on or before 90-days of entering DWIHN's system of care.

Quantitative Analysis and Trending of Measures

In FY21, DWIHN saw an increase in referrals from the previous year by 261 cases. In FY20, referrals reduced by (20%) due to COVID-19. This increase may suggest that members and their families are feeling more comfortable engaging in center and home-based ABA now than they had at the onset of COVID-19. Data below is a visual display of cumulative data across 2014 to present on eligible members access to ABA treatment either on or before 90-days of entering DWIHN's system of care. Data outlined in blue is the denominator which depicts all eligible members enrolled in the ASD Benefit. Data outlined in orange is the numerator which depicts all members that entered services on or before 90-days.



Evaluation of Effectiveness

The DWIHN ASD Benefit continues to grow each quarter. Fiscal year 20/21 4th quarter ended with 2,009 open cases which was an increase of 261 cases from the beginning of the fiscal year. An RFP was issued to meet the growing demands of accessing services in specific demographic areas in Wayne County. The RFP was awarded to 2 new ABA providers increasing member choice to 5 new sites bringing the number of sites to 31 with a total of 15 ABA Providers across Wayne County. DWIHN made a significant change in the ASD Benefit process flow by adding 2 Independent Evaluators through a Request for Proposal (RFP) to improve the timeliness standards and reduce conflict of interest and potential bias of treatment providers providing initial diagnoses of autism to the network. The two Independent Evaluators averaged 123 referrals for diagnostic evaluations across three months.

Barrier Analysis

Expand the ABA provider network to demographic areas with limited access to "brick and mortar" locations in the County. There continues to be an increase in referrals for autism services. DWIHN is currently reviewing applications to add additional locations in identified gap areas within the county. DWIHN also has an increased need for autism evaluation services and is working with an identified provider to provide temporary assistance in this area until a new provider is added. DWIHN continues to struggle to provide services within 90 days of MDHHS approval (15:1 is the requirement set forth by the national guidelines of the Behavior Analysis Certification Board). Another barrier is that Behavior Technicians are unable to provide ABA Direct Services until IPOS and Authorization is input timely and BCBAs are expending time and energy into getting Support Coordinators to update IPOSs and input authorizations timely. DWIHN has a (38) percent denial rate and (62) percent approval rate for meeting ASD benefit enrollment criteria and Medical Necessity criteria for FY21.

Opportunities of Improvement

DWIHN is continuously striving to improve ABA services through focus areas and interventions. DWIHN identified a number of key areas of focus:

- Streamline workflow and timeliness from referral to access to 1:1 ABA therapy for eligible members.
- Expand the ABA provider network to demographic areas with limited access to "brick and mortar" locations in the County.
- Improved reporting integrity on Behavior Assessment Worksheets
- Provide support and training to the ASD Network to improve on accessing the ASD benefit.
- Increase provider meetings to monthly to increase communication, education, and support for providers from DWIHN.
- Encourage providers to increase number of consumers per BCBA to reach 15:1 ratio.
- Begin tracking number of Behavior Technicians in DWIHN's network.
- Continued training and technical assistance for supports coordinators submitting authorizations.
- Hosted Supports Coordinator Roundtable.

Access to Substance Use Disorder (SUD) Services

Activity Description

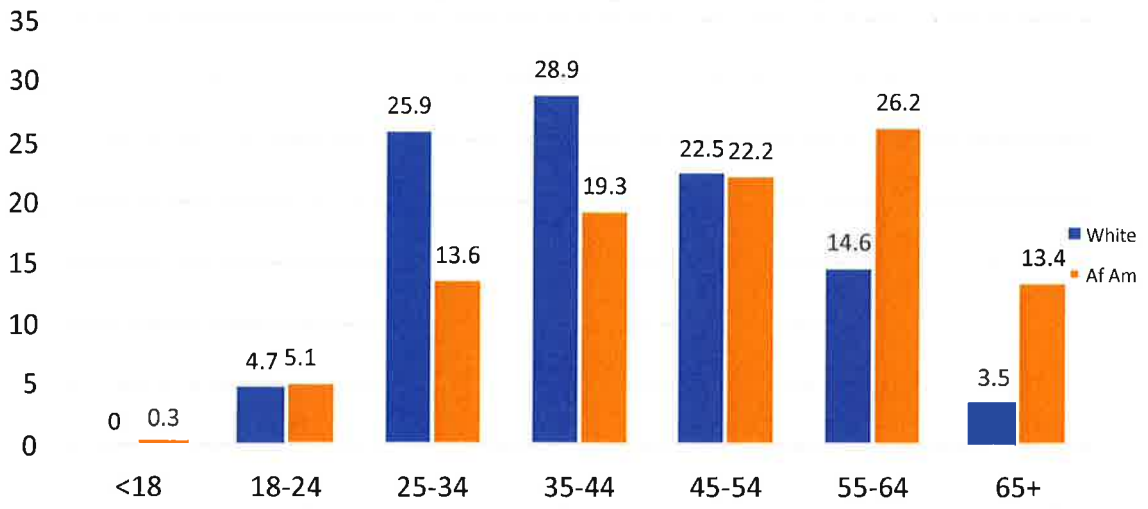
In FY21, the Substance Use Division focused on improving treatment services for individuals with opioid use disorder. The goal of this improvement was to develop and implement an Opioid Health Home (OHH) model of care. An Opioid Health Home is a model of care that provides comprehensive care management and coordination services to Medicaid beneficiaries with opioid use disorder. The model takes a holistic approach to health care and provides one "home" base for coordinating recovery and health needs while functioning as the central point of contact for directing patient-centered care across the broader health care system. The Substance Use Division successfully recruited and contracted with two new Office Based Opioid Treatment providers and expanded this service with three 17 additional contracted Opioid Treatment Providers. Procedures were developed to identify and enroll individuals into the OHH program, training on the procedures, MDHHS data base, and OHH requirements was provided to all participating programs. A data tracking system has been developed to manage enrollment and disenrollment within the system.

Quantitative Analysis and Trending of Measures

The Substance abuse treatment admissions data is an indicator of how many individuals received treatment for their substance abuse. There were 6,197 individuals that received SUD services for FY21, a 15.74% decrease from FY 21. This decrease can be attributed to COVID-19 which greatly reduced the capacity of many providers to serve members in both residential and outpatient settings. The age distribution metric has remained relatively constant over the last several years. During FY20, (68%) percent of individuals admitted were between 25-54 years of age. Twenty-eight (28%) of individuals admitted were for 55+ years of age. Four (4%) were for individuals age 18-24, and less than (1%) were admissions individuals between 0-17. DWIHN demonstrated a 99.39% performance rate for individuals who were seen for follow-up care within 7 days of discharge from a detox unit. This is an increase of 2.56% from FY20 (96.90%).

Evaluation of Effectiveness

In FY21, DWIHN met the standards for all 4 quarters for indicator 4b (timeliness of Substance Abuse Detox) follow-up care within 7 days) Q1(100%), Q2(99.47%), Q3(99.57%), Q4(98.33%). DWIHN continues to train first responders, its providers, drug court staff, inmates/jail staff and the community on how to reverse an opioid overdose. DWIHN is increasing the number of providers that can train and distribute Naloxone in the community. The medical examiners provisional data suggest that drug overdose deaths declined by 9.3% since April 2020 to April 2021 in Wayne County. We saw the following: Slight decrease in whites by 1% and a slight increase in African American by 1%.



Evaluation of Effectiveness

In FY21, DWIHN conducted 56 Narcan trainings and distributed 3,103 Narcan kits during FY'21. Community outreach and engagement remain a top priority within the SUD department. Staff offers free lifesaving Naloxone (Narcan) training to various local businesses, law enforcement, companies, and organizations throughout Wayne County. During the training, information and resources are shared and attendees receive a free Narcan kit. One component of this program includes outreach to local Detroit barbershops as DWIHN providers work with customers on educating them about substance use disorder and mental health matters. This is especially important because many times men do not want to discuss mental health and this is a safe environment in their community where they can share information with professionals who can offer resources to them and their families. So far, 38 barbershops have participated in this program and almost 90 men have been given mental health and SUD resources.

Barrier Analysis

Fentanyl remains the driving force in the drug overdose deaths. The COVID-19 pandemic continues to impact service delivery throughout the provider network by workforce shortages across disciplines, adjusting to the use of telehealth for the delivery of behavioral health services and limited resources. DWIHN continue to work with our provider network to ensure that services are not interrupted for those we serve but also recognizing that we must increase our level of communication and outreach.

Opportunities for Improvement

DWIHN will continue to educate and improve understanding about substance use disorder, increase access to effective treatment and support recovery through working across the criminal justice systems, hospital settings, and other systems within Wayne County.

Quality Pillar

Performance Monitoring

Activity Description

Each year the performance monitoring staff conducts reviews of provider services and programs to ensure the safety and wellness of all persons served.

Quantitative Analysis and Trending of Measures

In FY21, DWIHN saw an increase in audits performed compared to FY20 through virtual monitoring. The reviews include the Clinically Responsible Service Provider (CRSP), Autism, SUD, MI Health Link and Residential Treatment Providers. The average scores of these reviews ranged from 77% being the lowest and 96% being the highest. 274 staff records were reviewed this fiscal year with an average score of 93%. Those providers who scored below 95% were placed on a corrective action plan.

The CRSP Providers were found to have good, thorough assessments and implementation of person-centered planning process when changes or amendments were needed to the plan. Progress notes were detailed and provided a snapshot of the person being served. However, reviewers found that members' Individual Plans of Service did not include "SMART" goals, goals in the members' own words, and/or had a lack of specific amount, scope, frequency, & duration of supports and services. There was also a lack of evidence members received a copy of their IPOS within 15 business days. Reviewers also found that documentation frequently lacked evidence of members' signature. Coordination of care was also noted as a challenge this fiscal year as many providers lacked evidence of this occurring.

An additional challenge that was identified was following the BTPRC requirements for intrusive / restrictive interventions and for medications prescribed to manage behaviors. There were also some discrepancies in agency policies reflecting the most updated DWIHN policies. Providers reportedly experienced many barriers related to the COVID-19 pandemic, including but not limited to, staff turnover, adjusting to tele-health services, etc. It was noted that providers displayed a vast amount of adaptability and flexibility to ensure members received appropriate, high quality services throughout the pandemic. Many providers developed their own comprehensive tele-health consents during this time.

DWIHN will continue to evaluate applicable policies and procedures to more effectively support the evaluation and improvement of access and availability to the provider network. The goal will be to streamline data collection and evaluation efforts to enhance quality reporting. This will include exploring additional or new quantitative and qualitative assessment tools and metrics regarding accessibility.

Evaluation of Effectiveness

DWIHN continues to present trends of quality concerns to the Quality Improvement Steering Committee quarterly. The collaborative effort continues to identify that education is an important factor to informing providers, members, and community stakeholders about compliance. DWIHN has several forums to educate providers on performance measures, as well as provide the right tools and resources that providers can leverage. DWIHN maintains an adequate network of providers available to meet the needs of persons serve. DWIHN contract with all available providers in our service area if they meet our credentialing standards, are in good legal standing, and provide additional value to our network. DWIHN geographic adequacy analysis helped identify that DWIHN currently meets adequacy in the network. DWIHN also have been pioneering Telehealth services as ways to further expand accessibility for members.

Barrier Analysis

The COVID-19 pandemic continues to impact service delivery throughout the provider network by workforce shortages across disciplines, adjusting to the use of telehealth for the delivery of behavioral health services and limited resources. Providers reportedly experienced many barriers related to the COVID-19 pandemic, including but not limited to, staff turnover, adjusting to tele-health services, etc. It was noted that providers displayed a vast amount of adaptability and flexibility to ensure members received appropriate, high quality services throughout the pandemic. Many providers developed their own comprehensive tele-health consents during this time.

DWIHN will continue to monitor the network to determine if additional contracts need to be executed to provide more access to services. DWIHN will also engage with providers to expand the behavioral health providers including diverse ethnic and cultural service. Further identification of these providers will provide a more personalized member experience. DWIHN will continue to evaluate applicable policies and procedures to more effectively support the evaluation and improvement of access and availability to the provider network. The goal will be to streamline data collection and evaluation efforts to enhance quality reporting. This will include exploring additional or new quantitative and qualitative assessment tools and metrics regarding accessibility. This will include continuing quarterly forums with member-facing staff to discuss the barriers and challenges members are experiencing while accessing care across our service provider network, especially ancillary providers.

Opportunities of Improvement

- Increase monitoring of the providers corrective active plans.
- Provide technical assistance as needed.
- Ensure providers are self-monitoring through quarterly reviews.
- Monitor the information in the Autism Dashboard to provide continuous feedback to the providers.
- Continue to conduct procedure trainings to educate SUD providers on proper credentialing for billing.
- Continue to educate and train the provider system for areas in which compliance

Critical Incident (CI), Sentinel Events (SE), Unexpected Deaths (UD) and Risk Event (RE) Reporting

Activity Description

The following data represents fiscal years 2018 through 2021 system reports of Critical/Sentinel events gathered from the Clinically Responsible Service Provider (CRSP) reports into the Mental Health Wellness Information Network (MH-WIN). The reporting represents only those events entered into the system; however, of important note is the underreporting throughout the system based on the monitoring and review of Quality Performance Improvement findings.

Each contracted clinically responsible service provider (CRSP) is responsible to enter the Critical Event, Critical Incident, Sentinel Event, and Risk thereof events into the Critical/Sentinel Event Module in MH-WIN for members actively receiving services assigned to their organization. These events include CI's that occur at residential treatment provider settings.

Quantitative Analysis and Trending of Measures

DWIHN prior year's performance goal was met. In FY21, the Quality Performance Improvement Team processed 3158 Critical/Sentinel Events, which is a decrease of (29.19%) in FY20. Of those incidents, the SERC reviewed and analyzed over eight-hundred and thirty (830) critical incidents. Critical Incidents include arrests, deaths, emergency medical treatment due to injuries or medication errors, and hospitalizations due to injuries or medication errors. If a CI is determined to be a Sentinel Event, DWIHN requests that a Root Cause Analysis (RCA) be conducted by the Provider. The SERC reviews and approves the RCAs. In FY21, the highest category being reported Physical Illness Requiring Emergency Room (975); the next top category is Serious Challenging Behavior (609); and the lowest number of critical incidents is Medication Error (16).

Based on various audits, this report has been expanded to include data for each CRSP and the Sentinel Event Committee/Peer Review Committee (SEC/PRC) Trends and Patterns with recommendations. SEC/PRC is represented by clinicians and administrative staff members of DWIHN. Committee membership is represented by psychiatry, nursing, social work, psychology, counseling, law, and business.

Annual Summary by Category	FY 2020/2021	FY 2019/2020	FY 2018/2019
ARREST	71	83	161
Behavior Treatment NEW- FY 20/21	61	0	0
DEATHS	551	731	480
ENVIRONMENTAL EMERGENCIES	79	38	65
Injuries Requiring ER	227	259	498
Injuries Requiring Hospitalization	47	70	88
Medication Errors	16	27	123
Physical Illness Requiring ER	975	634	1039
Physical Illness Requiring Hospitalization	445	400	763
Serious Challenging Behavior	609	815	1322
Other/Administrative	77	166	409
TOTAL	**3158**	**3223**	**4948**

Evaluation of Effectiveness

Common Issues #1—Death: DWIHN analysis considered all Unexpected Deaths (UD) (those that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect), including aggregated mortality data over time to identify possible trends. Though death is unavoidable, some issues leading to death can be prevented or highly mitigated. Congestive Heart Failure/Coronary Artery Disease, COVID-19, Pneumonia, and Substance Use Toxicity (Overdose) were the leaders in our deaths within the FY 2020/2021. All of these issues can be prevented though education, access to health care preventative modalities, and frequent monitoring our of members. Oftentimes, we find that providers are reporting death months after a member has died. Things to be considered:

- ✓ How much emphasis are we putting on medical health?
- ✓ Are we routinely making sure that members have a PCP and are attending their appointments?
- ✓ What does our physical health education look like and are we placing emphasis on holistic health care or JUST mental health?
- ✓ How often between appointments/visits are we checking in and monitoring our SUD clients?
- ✓ Could our monitoring processes be revised?
- ✓ What are other barriers that need to be addressed in our SUD population that would lower or mitigate substance use toxicity (perhaps different treatment modalities)?

Common Issue #2—Serious Challenging Behavior: Many providers report hundreds of events in this category, as it is the second widely used category behind physical illnesses. Oftentimes providers are reporting at the *FIRST* instance of serious challenging behavior rather than after *three instances in a 30-day period* as noted in the Guidance Manual, which causes an influx of unnecessary reporting. Many times, we don't have access to the IPOS. When the case is "closed", rarely do we see changes being made to the IPOS to address this behavior and reporting continues. Also, there is underreporting in this area because we often find multiple inpatient psychiatric discharge summaries uploaded into the member's chart with no CE reported. Things to be considered:

- ✓ How many of these members are candidates for a Behavior Treatment Plan and are these discussions being had at the provider level when a member has an increase of events?
- ✓ How can we emphasize/restructure in training or in MH-WIN the fact that serious challenging behavior is more than THREE instances in a 30-day period?
- ✓ How often are medication reviews being done?
- ✓ How often are providers ensuring information for crisis lines, suicide information, and resources for crisis is explained and provided?
- ✓ How often are providers utilizing other treatment modalities rather than talk therapy and medication such as yoga, psychotherapy (EMDR), skill building, etc.?

Common Issue #3— Physical Illness: This issue is multifaceted, as the issues in which people are hospitalized vary greatly, are caused by different precipitating factors, and are managed differently based on member setting. On a general note, we often have issues getting hospital discharge documents in this category as opposed to inpatient psychiatric hospitalizations where documentation is usually uploaded shortly after discharge. Many providers simply do not ask for hospital documentation nor show evidence of follow up after a member is released from the hospital. Many CEs in this category are vague, and providers often don't have other information to add, even after more information is requested. Many of these cases are "administratively" closed due to lack of information, documentation, and provider follow up. This leads to re-admissions, and possible increased mobility and mortality. Things to be considered:

- ✓ If Coordination of Care letters are signed, what then is the barrier to receiving hospital discharge documentation?
- ✓ Are providers offering services to help members to get access to care and following up with appointments after hospitalizations?

- ✓ What can we implement in MH-WIN to have easy access to this information without having to go through the provider?
- ✓ (*Tying back into common issue #1*) How can we integrate the member's health care to not just focus on getting services to mental health, but physical health as well?

An appropriate response to a sentinel event includes a thorough and credible Root Cause Analysis, implementation of improvements to reduce risk, and monitoring of the effectiveness of those improvements.

Patterns, Trends, and Recommendations:
Substance Use Disorder

- ✓ Consider distribution of Naloxone kits at MAT provider locations;
- ✓ Look at prevalence of overdose by location (residential providers, outpatient service providers independent member home/community), to develop methods to reduce or eliminate incidents;
- ✓ Identify all providers and determine where there is low to no reporting;
- ✓ Consider Discharge Planning to include distribution of Naloxone kits; and,
- ✓ Fentanyl houses are "popping up" in neighborhoods – some close to clinics (possibility of working with law enforcement if addresses/locations are identified).

Behavioral Health

- ✓ Fall/Risk Protocols and Choking Hazard Protocols training throughout entire DWIHN system based on the number of falls and choking events reported in the past 1 ½ years;
- ✓ Inclusion of Constituents in making recommendations through their committee;
- ✓ Bring MCO into the notification process when CRSP providers are not responding to assist in contract compliance; Add to SEC/PRC Committee representation of Director/Designee from Clinical Practice departments;
- ✓ Updating Policies and Procedures and Contract language details for Critical/Sentinel Events Reporting;
- ✓ Clear and concise guidelines required when there is evidence of regression only face-2-face or telehealth face-2-face should be added to protocols for services;
- ✓ Every member has to have a Crisis Plan and it must be reviewed with the member as a reminder of what to do in times of crisis, loneliness, depression, etc.;
- ✓ Is there adequate funding for chronic conditions – systems have to be designed to address the real issues; and,
- ✓ Residential providers not consistently notifying CRSP timely (or at all) of events involving members not providing hospital documentation or police reports.

Barrier Analysis
Though death is unavoidable, some issues leading to death can be prevented or highly mitigated. Congestive Heart Failure/Coronary Artery Disease, COVID-19, Pneumonia, and Substance Use Toxicity (Overdose) were the leaders in our deaths within the FY 2020/2021. All of these issues can be prevented though education, access to health care preventative modalities, and frequent monitoring our of members.

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- How can we emphasize/restructure in training or in MH-WIN the fact that serious challenging behavior is more than THREE instances in a 30-day period?
- How often are medication reviews being done?
- How often are providers ensuring information for crisis lines, suicide information, and resources for crisis is explained and provided?
- How often are providers utilizing other treatment modalities rather than talk therapy and medication such as yoga, psychotherapy (EMDR), skill building, etc.?

This issue is multifaceted, as the issues in which people are hospitalized vary greatly, are caused by different precipitating factors, and are managed differently based on member setting. On a general note, we often have issues getting hospital discharge documents in this category as opposed to inpatient psychiatric hospitalizations where documentation is usually uploaded shortly after discharge. Many providers simply do not ask for hospital documentation nor show evidence of follow up after a member is released from the hospital. Many CEs in this category are vague, and providers often don't have other information to add, even after more information is requested. Many of these cases are "administratively" closed due to lack of information, documentation, and provider follow up. This leads to re-admissions, and possible increased mobility and mortality. Things to be considered:

- If Coordination of Care letters are signed, what then is the barrier to receiving hospital discharge documentation?
- Are providers offering services to help members to get access to care and following up with appointments after hospitalizations?
- What can we implement in MH-WIN to have easy access to this information without having to go through the provider?

Opportunities for Improvement

To improve contractual compliance issues related to reporting requirements that DWIHN did not adhere to the following interventions and strategies have been established:

- Fall/Risk Protocols and Choking Hazard Protocols training throughout entire DWIHN system based on the number of falls and choking events reported in the past 1 ½ years.
- Inclusion of Constituents in making recommendations through their committee.
- Bring MCO into the notification process when CRSP providers are not responding to assist in contract compliance;
- Add to SEC/PRC Committee representation of Director/Designee from Clinical Practice departments.
- Updating Policies and Procedures and Contract language details for Critical/Sentinel Events Reporting.
- Clear and concise guidelines required when there is evidence of regression only face-2-face or telehealth face-2-face should be added to protocols for services.
- Every member has to have a Crisis Plan and it must be reviewed with the member as a reminder of what to do in times of crisis, loneliness, depression, etc.
- Is there adequate funding for chronic conditions – systems have to be designed to address the real issues.
- Residential providers not consistently notifying CRSP timely (or at all) of events involving members not providing hospital documentation or police reports.

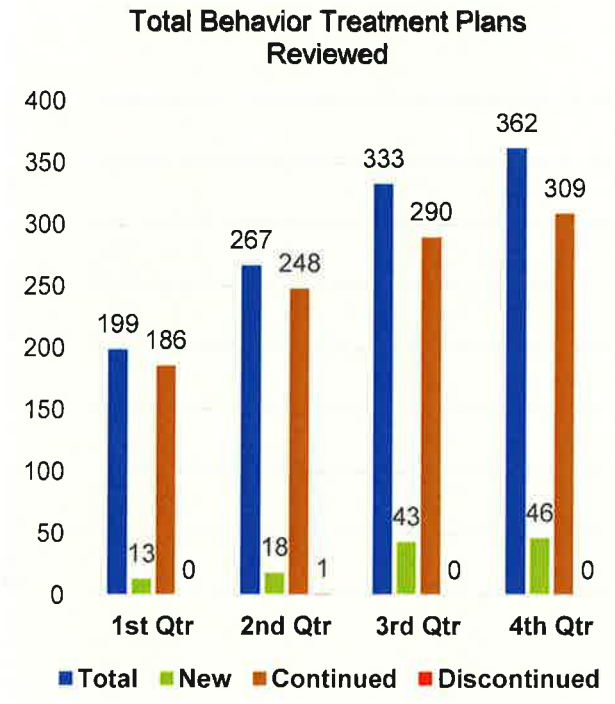
Behavioral Treatment Review

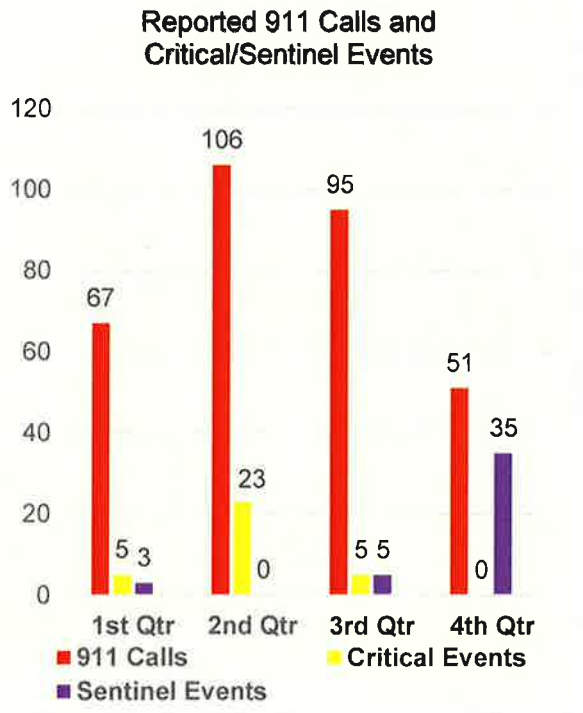
Activity Description

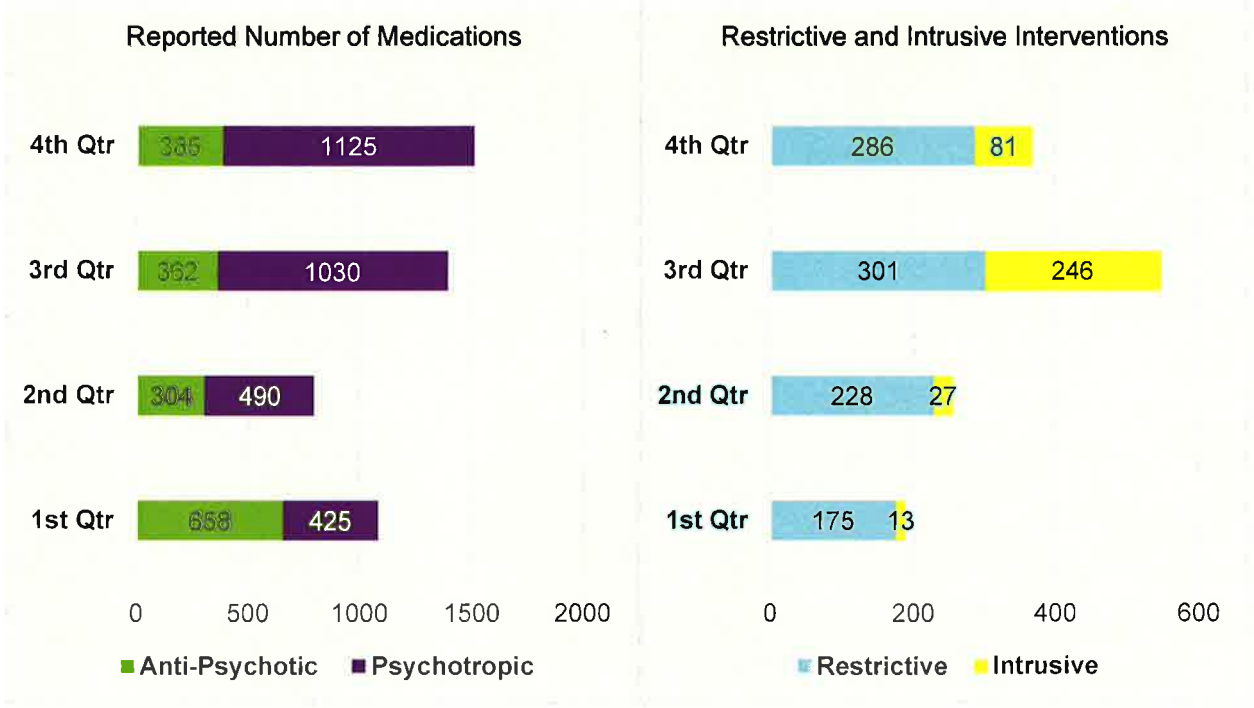
The QAPIP quarterly reviews analyses of data from the Behavior Treatment Review Committee (BTRC) where intrusive or restrictive techniques have been approved for use with members and where physical management has been used in an emergency. The data track and analyze the length of time of each intervention. The Committee also reviews the implementation of the BTRC procedures and evaluate each committee's overall effectiveness and corrective action as necessary. The Committee compares system-wide key indicators such as psychiatric hospitalization, behavior stabilization, reductions or increases in use of behavior treatment plans.

Quantitative Analysis and Trending of Measures

In FY21, DWIHN BTPRC reviewed 1,161 members on Behavior Treatment Plans which is a significant increase of 604 (108.43%) from the previous year. The data below depicts all the use of intrusive and restrictive techniques, 911 calls/critical events and use of medication per Individual receiving the intervention. The charts below illustrate the BTAC Summary of Data Analysis FY21.







Evaluation of Effectiveness

DWIHN prior year's performance goal was met. During FY21, DWIHN organized the two system-wide training events on the Technical Requirements of Behavior Treatment Plans (BTP). The first training event was for Habilitation Supports Waiver (HSW) providers on MDHHS requirements for the beneficiaries of HSW and BTP. DWIHN hosted the virtual technical assistance with MDHHS for network providers on the requirements of Behavior Treatment review and Occupational Therapy Evaluations, the event was attended by one hundred thirty-three (139) participants. With effect from October 1, 2020, DWIHN has delegated all contracted Mental Health (MH) Clinically Responsible Service Providers (CRSP) to have the BT review process in place. The BTPRC requirements are included in the CRSP written contract for FY 2020-2021. To date, DWIHN has a total of twenty (20) BTPRCs that are conducted at the MH CRSP. During FY20, there were a total of nine (9) BTPRCs at the MH CRSP, which demonstrate an overall increase of 122.2%. Behavior Treatment Category is now live in MH-WIN Critical and Sentinel Reporting Module to improve the systemic under-reporting of the four reportable sub- categories for the members on BTP: Death, Emergency Hospitalizations – including Emergency Medical Treatment; and Use of Physical Management. DWIHN continues submitting quarterly data analysis reports on system-wide trends of BTP to MDHHS. During FY 2020, the network providers presented the sixteen cases to the Behavior Treatment Advisory Committee for the case validation review process.

Barrier Analysis

There is a lack of formal transition planning at the system level for the members enrolled in Michigan Autism Benefits as they reach 21 years of age, and the Autism Benefit is discontinued. There is clinical evidence that when the ABA benefit ends, the behavior escalates. The data indicates that these individuals are high utilizers of emergency hospitalizations as MI Adults. Some of these individuals may benefit from the Home Help program of MDHHS, Habilitation Supports Waiver program, and some of them may have a better transition with the help of BTP. Another barrier is that in-service for direct care staff is not always provided by the appropriately licensed Clinically Responsible Service Provider staff on implementing the Behavior Treatment Plan. Lastly, per a recent Michigan Department Health and Human Services (MDHHS) Audit, it was determined that the Behavior Treatment Plan and Review Committee (BTPRC) process failed to include all of the elements as required by the Technical Requirement for Behavior Treatment Plan Review Committees.

Opportunities for Improvement

DWIHN has identified the following interventions and improvement efforts:

- Ensures the Supports Coordinator or Case Manager provide the Individual's IPOS and ancillary plans, before delivery of service at the service site.
- Ensures IPOS and Behavior Treatment Plans are specific, measurable, and are updated and revised per the policy/procedural guidelines.
- Conduct a training for network providers on the Technical Requirements of Behavior Treatment Plans.
- To implement a system-wide process for Behavior Treatment reviews.
- To improve the under-reporting of the required data of Behavior Treatment beneficiaries that includes 911 Calls, Deaths, Emergency Treatment, and Use of Physical Management.
- Case Validation Reviews of randomly selected cases as a step towards continuous quality improvement at PIHP level.

Performance Improvement Project

Activity Description

DWIHN Departments have been engaged in continuous process improvement. Some improvements projects are formalized as Quality Improvement Projects. Improving Practices Leadership Team and Quality Improvement Steering Committee provides oversight of these projects. The guidance for all projects included these areas: improving the identification of both outcome and process measurements, use of HEDIS measures, adding meaningful (and measurable) interventions, and use of cause and effect tools in the analysis of the progress. Clinical care improvement projects meant to improve member outcomes include:

Improving the availability of a follow up appointment with a Mental Health Professional with-in 7 and 30 days after Hospitalization for Mental Illness.

NCQA's HEDIS measures the percentage of discharges for members ages 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visits, an intensive outpatient encounter or partial hospitalization with a mental health practitioner (Adult Core Set, appendix C), received follow-up within 30days. Research suggests that follow-up care for people with mental illness is linked to fewer repeat ED visits, improved physical and mental function and increased compliance with follow-up instructions.

Quantitative Analysis and Trending of Measures

DWIHN has seen a decrease of the HEDIS measurement for FY 2021. FY 20 rate 30.62 compared to FY 21 rate (29.57%) with a goal of (45%) for the 7 Day Follow – Up Appointment with a Mental Health Professional. This is a 1.05 percentage point decrease. For the 30-Day Follow – Up Appointment with a Mental Health Professional there is a decrease of the HEDIS measurement for FY 21. FY 20 rate (50.47%) compared to FY 21 (48.20%). This is a percentage point decease 2.27 percentage points with a goal of 75%. COVID 19 continues to be a barrier to care. DWIHN pivoted to telehealth to bridge the gap to care. The chart below illustrates the quantitative analysis of the HEDIS measurements and the interventions used to achieve improvement in quality of care.

Time Period	Measurement	Numerator	Denominator	Rate	Goal	Comparison to goal
1/1/2020-12/31/2020	Measurement 7 days	1290	4212	30.62	45%	14.38 percentage points
1/1/2020-12/31/2020	Measurement 30 days	2126	4212	50.47	75%	24.53 percentage points
1/1/2021-12/31/2021	Re-measurement 7 days	1793	6062	29.57	45%	15.43 percentage points
1/1/2021-1/31/2021	Re-measurement 30 days	2923	6062	48.2	75%	26.80 percentage points

Evaluation of Effectiveness

Detroit Wayne Integrated Health in 2020 changed its data collection tool to Vital Data. This Tool captures HEDIS data. Despite the decrease, the interventions initiated that are felt to be strong interventions and had significant outcomes and will continue are the following:

- Contracted hospitals contact DWIHN Access Center to schedule a 7-day follow-up appointment prior to member discharge. The DWIHN Access Center has access to open appointments for follow up appointments via MHWIN calendar. Hospital case managers encouraged to involve member/caregiver in discharge planning date and time preferences for appointments.
- In the first and second quarter of 2020 a total of 7207 7-day follow-up appointments were scheduled through the Access Center and 7207 30-day follow-up appointments were scheduled through the Access Center.
- Texting clients to remind them of their upcoming FUH appointment: For the first two quarters of 2020, 3877members were texted reminders and (62.22%) kept their appointments.
- DWIHN staff began make calls to members at least forty-eight hours prior to their appointment. These clients were not in the texting program. DWIHN discuss any barriers keeping them from the appointment. In 2020, 525 members were contacted and of those (58%) kept their appointment.
- COVID was a barrier.

In FY20, telemedicine behavioral health appointments were made available to members that had transportation issues or other issues for in-person visits due to COVID 19. For the first two quarters of 2020, 531 telemedicine visits with a behavioral health practitioner were provided. For the last two quarters of 2020, 532 telemedicine visits with a behavioral health practitioner were completed.

Barrier Analysis

- Members having difficulty getting an appointment within timeframes required. (Referral access)
- Members choosing not to schedule and/or keeping appointment. (Member Knowledge)
- Members forgetting to schedule appointments and/or forgetting a scheduled appointment. (Member
- knowledge)
- Member not understanding process to notify provider if unable to keep appointment. (Member knowledge)
- Member lacks information regarding whom to follow-up with and where they are located and how to contact which can result in non-adherence to attending appointment. (Member knowledge)
- Transportation issues with either member not being able to schedule their own transportation with Medicaid vendor or Medicaid transportation vendor not showing up to pick up member for their appointment. (Referral access and member knowledge)
- Members cannot afford gas or to pay for gas if they use their car or someone else provides the
- transportation. (Referral access and member knowledge).
- Members have barriers of not having things like childcare issues that interfere with keeping appointments. (Access)
- Member following up with their primary care provider instead of a behavioral health provider due to not understanding importance of following up with a behavioral health provider after an inpatient behavioral health admission. (Member knowledge)
- Appointment time conflicts by members with other responsibilities such as childcare, work, school. (Referral access)

- Members not aware that compliance with aftercare can improve their treatment outcomes. (Member
- knowledge)
- Lack of coordination and continuity of care between inpatient and outpatient follow up services.
- (Provider/practitioner knowledge)
- Member not fully involved in discharge planning, as a result they are not engaged in follow-up. (Member knowledge)
- Practitioners and Providers do not understand the importance to seeing a member in follow-up within 7 days of discharge. (Provider/practitioner knowledge.
- Low health literacy. (Member knowledge and provider/practitioner knowledge)

Feedback was also elicited from contracted facilities and these barriers were identified from them; When facility called for seven-day follow-up appointment for member often no appointment available within timeframe needed at member's preferred provider. (Referral access). They suggested a written educational material be developed for member regarding follow-up appointment importance as discussing orally with members did not address those members who learn better via written information or members who require both oral and written education. (Member knowledge and low health literacy).

From the barriers above the following opportunities for improvement were identified:

- Improve ability for member to get appointments within timeframes required.
- Improve access to appointments with contracted behavioral health providers/practitioners within timeframes required.
- Improve process of who and how follow-up appointments are scheduled.
- Identification of ways that member can be reminded of appointments.
- Identify a process to address transportation issues when member is not able to schedule their own
- transportation with Medicaid vendor or not scheduling at least 5 days in advance of appointment and
- reminding transportation vendor to pick up member.
- Improve members knowledge regarding availability of gas reimbursement available if they use their own transportation and availability of transportation vendor.
- Improve members knowledge regarding importance of follow up with a behavioral health practitioner.
- Improve appointment time conflicts with other activities member has by addressing appointment availability times and exploring virtual technology(telehealth).
- Improve Member involvement in discharge planning and follow-up.
- Improve Practitioners and Providers knowledge regarding the importance to seeing a member in follow-up within 7 days of discharge.
- Providing information to members both verbally and written using simple language that is focused and using teach back method.

Opportunities for Improvement

- Ensuring members have a 7 and 30-day follow-up visit scheduled before being discharged.
- Hospital case managers encouraged to involve members in discharge planning date and time preferences for appointments.
- Created follow up post hospital visit checklist for providers/practitioners to help providers prepare for visit as well as targeting key items to cover during visit.
- Detroit Wayne Integrated Health Network (DWIHN) has a plan for conducting face to face contact with clients that are hospitalized due to psychiatric complications.
- Telephone calls are made to the client as a reminder of the follow up after hospitalization appointment.
- DWIHN will mail the Doctors letter stating the importance of follow up care along with the educational
- material that states the same.
- Text messaging members as a reminder of appointment for members that give permission.

Activity Description
This measure analyzes the percentage of members 19 to 64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least (80) percent of their treatment period.

Quantitative Analysis and Trending of Measures
Comparing the FY20 baseline data for Improving Adherence to Antipsychotic Medications for Individuals with Schizophrenia for re-measurement period of FY21, showed a decrease in this measure. FY20 rate (79.34%) compared to FY21 (46.42%). This is a (32.92) percentage point decrease. The (45%) goal was achieved. This decrease may be contributed to COVID 19 restrictions. DWIHN implemented the use of a new data collection system Vital data.

Time Period	Measurement	Numerator	Denominator	Rate	Goal	Comparison to goal
1/1/2020-12/31/2020	Measurement	4163	5247	79.34	45%	34.34 percentage points
1/1/2021-12/31/2021	Remeasurement	2462	5304	46.42	45%	1.42 percentage points

DWIHN meet its goal for both FY20 and FY21. DWIHN is performing below the Michigan health plan average for the HEDIS measures. It is important to provide regular follow up therapy to patients after they have been hospitalized for mental illness. An outpatient visit with a mental health practitioner is necessary to ensure that the patients transition to the home and work environment is supported and that gains made during hospitalization are not lost. A follow-up visit also helps healthcare providers detect early post-hospitalization reactions or medication problems, and demonstrates continuing care.

The key to improving performance in this area is managing the transition of care from the hospital to the ambulatory site. This can involve case management and systems that link scheduling of outpatient care within hospital discharge. Barriers to achieving objectives:

- Relationship with physician.
- Lack of consistent treatment approach by physicians.
- Stigma of the disease.
- Disorganized thinking/cognitive impairment.
- Enrollee/member's lack of insight about presence of illness or need to take to medication.
- Lack of family and social support.
- Medication side effects and/or lack of treatment benefits.
- Patients forget to take their medications.
- Patients forget to re-fill their medications.
- Lack of follow-up.
- Financial Problems.

Evaluation of Effectiveness

The interventions that are felt to be strong interventions are the following:

- Educational information posted on DWIHN website on customers site. Educational material that address the importance of medication adherence.
- Several of Detroit Wayne Integrated Health Network providers started providing text messages, to members that agree, medication reminders and refill reminders.
- DWIHN posted on their website under members, educational material, tools for medication adherence. DWIHN has listed several pharmacies that offer email and text reminders for refills of prescriptions.

Barrier Analysis

- Relationship with physician. (provider/practitioner knowledge)
- Lack of consistent treatment approach by physicians. (provider/practitioner knowledge)
- Stigma of the disease. (Member knowledge)
- Disorganized thinking/cognitive impairment. (Member knowledge)
- Enrollee/member's lack of insight about presence of illness or need to take to medication. (Member
- knowledge)
- Lack of family and social support. (Member knowledge)
- Medication side effects and/or lack of treatment benefits. (Member knowledge)
- Patients forget to take their medications. (Member knowledge)
- Patients forget to re-fill their medications. (Member knowledge)
- Lack of follow-up. (Member knowledge and provider/practitioner knowledge)
- Financial Problems. (Member knowledge and provider/practitioner knowledge)
- Opportunities for Improvement
- Improve the relationships with physician by providing member with key pre-appointment questions.
- Improve treatment approach by physician's by memo's sent to physicians quarterly regarding review of member's medication.
- Improve patient compliance with medication adherence.
- Improve patient adherence to medication refill.
- Improve patient follow up.

Improving Diabetes Monitoring for People with Schizophrenia and Bipolar Disorder

Activity Description
This measure analyzes the percentage of patients 18-64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening during the measurement year.

Quantitative Analysis and Trending of Measures
DWIHN saw a decrease in its HEDIS measure of Diabetes Screening for Schizophrenia and Bipolar Disorder members from (64.38%) in 2020 to (64.86%) in 2021 the first remeasurement period. This is a (0.48) percentage point increase. The 83.2% goal was not achieved.

Time Period	Measurement	Numerator	Denominator	Rate	Goal	Comparison to goal
1/1/2020-12/31/2020	Measurement	4891	7597	64.38	83.2%	18.82 percentage points
1/1/2021-12/31/2020	Remeasurement	5228	8061	64.86	83.2%	18.34 percentage points

Evaluation of Effectiveness
DWIHN will require a baseline assessment of HgA1C or FBS for clients prescribed psychotropic medications that are known to cause elevated blood sugar levels. Clinical Practice Guidelines developed by DWIHN will require that medications, labs and weight are monitored and education be provided to the enrollee/member regarding weight management, exercise and healthy living and that psychiatrist consider changing the medication if enrollee/members labs are not within normal limits and/or the enrollee/member experiences weight gain.

Barrier Analysis
- Lack of consistent practice among behavioral health (BH) and medical providers of the prevalence of
- diabetes in this population and the need for screening.
- Physician belief that diabetes prevalence is low in their practice.
- Lack of knowledge among behavioral health and medical providers of recommendations for screening for diabetes in members with schizophrenia and bipolar disorder.
- Lack of knowledge among behavioral health providers of which members have not been screened for
- diabetes.
- Lack of knowledge among provider support staff of HEDIS measure or DWIHN's HEDIS measure results.
- Behavioral Health and medical providers/practitioners not collaborating to address in an organized,
- consistent manner.
- Lack of knowledge by enrollee/members that they are at risk for diabetes if on atypical antipsychotic
- medication.
- Lack of follow-through by enrollee/members to have labs drawn when ordered.
- Lack of knowledge by enrollee/members on importance of healthy eating and exercise to help control any weight gain associated with antipsychotic medication.

Opportunities for Improvement

- Educate providers annually on post clinical practice guidelines on the DWHN website for
- Improving Diabetes Monitoring for People with Schizophrenia and Bipolar Disorder.
- Trainings to providers on MyStrength which is DWMHA's self-management tool vendor in which there are healthy eating and exercise modules.
- Quality Improvement Unit will continue to audit compliance with the Diabetes Screening clinical guidelines for Schizophrenic and/or Bipolar disorder enrollee/members on antipsychotic members. Providers that have compliance scores of < 95% are placed on Plans of Correction (POC) for monitoring.
- DWIHN has entered into a contract with Vital Data. This will allow the ability to provide a very detailed drill data in order to develop additional interventions. Providers will also have access to the data to identify their members requiring Diabetic Screening.

DWIHN also annually identifies opportunities to improve coordination across the continuum of behavioral healthcare services by collecting data and conducting quantitative and causal analysis of data to identify improvement opportunities.

Care Coordination

Activity Description

Improving coordination of care is one of DWIHN's core strategies for delivering on our mission and the Triple Aim of improved health, experience, and affordability. Overall, continuity and coordination of care improvement initiatives promote efficient, effective and safe care for members when they are transitioning between levels of care or receiving care from multiple providers. More specifically, continuity and coordination of medical care is the facilitation across transitions and settings of care:

- Members getting the care or services they need, and
- Practitioners or providers getting the information they need to provide member care.

Quantitative Analysis and Trending of Measures

Data shows that care coordination increases efficiency and improves clinical outcomes and member satisfaction with care. Through the provider self-monitoring for Coordination of Care providers scored, 82% with linking and coordinating with the Primary Care Physician (PCP), Natural and other Community Supports scored (84%), which is a decrease from the previous FY in which scores ranged from (95%) and (83%). This may be attributed to a shutdown of face to face services mandated except for the most critical services, in an effort to keep all persons safe from the virus. Tele-health services were provided to the persons that we served in an expedient and efficient manner. Staff were expected to provide these services from a home environment, with some limited staff continuing to provide crisis and/or medical services from the office, when it was impossible to do so via telehealth. Providers receiving evidence of requested documentation from the PCP, Natural and other Community Supports. Also, the results demonstrated a slight increase in the percentage of provider's participation from the previous year of 72%, compared to 71%, which is still considerably below the State Performance Measure goal of 95% set by the state of Michigan for the PIHP's for Continuity and Coordination of Care.

Evaluation of Effectiveness

DWIHN worked with the following health plans in FY21: AmeriHealth, Aetna, Michigan Complete, Molina and HAP Midwest. The Agency Profile within I-Dashboards indicates 5,864 MI Health Link members were enrolled with DWIHN in FY21, compared to the 5,271 members reported as enrolled last fiscal year. MI Health Link enrollees are a significantly small subset of DWIHN members (7%). There were 616 MI Health Link (MHL) members hospitalized during FY21. During FY20, DWIHN managed 560 community hospital admissions of MI-Health Link members. 92 MHL members were readmitted in FY20 and in FY21, there were 58 members who were readmitted within 30 days of discharge. The number of readmissions decreased by (47%) in FY21. Molina saw the highest number of admissions during FY21 at 251, (40%) of the DWIHN MHL admissions for FY20. AmeriHealth had the lowest number with 60 members admitted, followed by MI Complete, with 62 admissions.

Barrier Analysis

The COVID-19 pandemic continues to impact service delivery throughout the provider network by workforce shortages across disciplines, adjusting to the use of telehealth for the delivery of behavioral health services and limited resources. Providers reportedly experienced many barriers related to the COVID-19 pandemic, including but not limited to, staff turnover, adjusting to tele-health services, etc. It was noted that providers displayed a vast amount of adaptability and flexibility to ensure members received appropriate, high quality services throughout the pandemic.

Opportunities for Improvement

To improve continuity and coordination of care across DWIHN's health care network. DWIHN will continue to monitor the following aspects of continuity and coordination of medical care:

- All cause readmission rates (monitoring members getting care and services across transitions and settings of care)
- Provider satisfaction with the quality of information they receive from other providers
- Low intensity emergency room utilization
- Require providers to continue to document request and follow - up more than one time per year with the Primary Care Physician and or Community Supports.
- Continue training and technical assistance with our CRSP providers to help improve the effectiveness, efficiency, and sustainability of integrated services, which ultimately improves the health and wellness of individuals living with behavioral health disorders.

Workforce Pillar

Activity Description

To ensure a network of qualified practitioners, DWIHN provides effective and efficient workforce development training to the provider network and continuous support to the community through educational outreach and engagement while placing an emphasis on recovery and supporting resilience. Efforts continue to focus on maintaining and expanding a centralized training program for allied health professionals. Focusing on the development of new professionals is integral to achieving a collaborative integrated healthcare system.

Quantitative Analysis and Trending of Measures

In FY21, more than 60 mental health professionals engaged in interprofessional education to enhance competency in culturally responsive engagement, assessment, treatment planning, and intervention with individuals diagnosed with co-occurring disorders. By confirming that all Qualified Mental Health Professional (QMHP) and Child Mental Health Professional (CMHP) training and supplemental training, the professionals in the specialized training program were able to deliver services to individuals and increase the capacity of providers. The interprofessional training curriculum for social work, nursing, and psychiatry was converted to an online format to adjust to COVID-19 restrictions. In addition to the additional capacity to deliver services to the Wayne County community, the university partnerships have supported current staff professional development and retention in completing a certificate in integrated health and access to telehealth training.

The Trauma-Informed Care Project Initiative continues to strengthen and enhance professional development of clinicians and administrators through specific evidence-based practice trauma-informed care interventions. During FY 2021, DWIHN had been awarded a 2-year (2021-2022) grant from Michigan Department of Health and Human Services to build upon prior trauma training and supports and equip the provider workforce with a strong foundation for addressing the complexities of trauma among the individuals and families receiving services at participating provider agencies. Seven (7) provider partners had been awarded $15,000 to train and provide support for their respective staff to help them better understand how trauma contributes to a person's suffering and shapes a person's efforts to cope. Emphasis is placed on trauma screening, assessment tools and the use of evidence-based therapies and models.

During this first year of implementation, emphasis was placed on professional development. Three-hundred fifty (350) clinicians and administrators at the partnering provider agencies enhanced trauma-related competencies through various training and resources. These were SAMHSA's evidence-based trauma informed 101 curricula, understanding adverse childhood experiences, secondary trauma, and zero suicide prevention. Some staff received advance training in EMDR, CPT and PET. Thirty-five (35) clinicians were trained and certified to use TREM/MTREM. Organization leadership and clinicians received consultation from a national expert on the use of CAMS (Collaborative Assessment and Management of Suicidality), an EBP utilized in HHI's Suicide Prevention Care Path, and Zero Suicide consultants. DWIHN held a virtual 2-day Trauma-Informed Care Conference on February 18 -19, 2021, 267 clinicians attended. The conference equipped and effectively addressed post-traumatic stress symptoms, managing the risk of triggering individuals into episodes of mental illness symptoms or substance abuse relapse.

Evaluation of Effectiveness

During FY2021, staff supported 6,005 callers. Using the least restrictive methods to access services, callers that live, work, play, worship, and learn in Wayne County are able to access behavioral health support that is consistent with their current stage of change. As callers are often pre-contemplative, staff provided support and encouragement without requiring identifying information to receive services. The focus on engagement has led to a majority of individuals reporting an increased level of comfort in accessing services that positively affect their behavioral health. When callers demonstrate an ongoing need for services, staff provided a direct referral with a community mental health provider.

DWIHN hosted several events in recognition of suicide prevention and awareness month. There was a partnership event with the Wayne County Sherriff's Office that aimed to bring positive connections between the community, mental health, and law enforcement. COVID-19 vaccinations, COVID-19 testing, and behavioral health screening were offered. Over 400 meals were distributed and 1235 backpacks in partnership with various communities and organizations such as Detroit PAL, DABO, Center for Youth & Urban Family Development, etc. DWIHN also hosted a Suicidology Conference with 210 in attendance and a Self-Care Conference with 285 in attendance. The team director also participated in a panel for the Children's Center's Demystifying Suicide – Imperative for Black Boys and a panel for the Muskegon Suicide Prevention Coalition focusing on the increase in suicide rates in African American youth. In addition to partnerships with state and county organizations, community engagement has included hosting and participating in quarterly events that include representation from the provider network and sharing information and resources to community members at barbershops, hair salons, concerts, sporting events, and other events throughout Wayne County. By offering information, resources, screenings and immediate support, DWIHN has been introduced to thousands of Wayne County residents.

DWIHN's Veteran Navigator assisted 222 Veterans and their family members since during the fiscal year. On average there are 3 to 6 phone calls each day by Veterans, family members, and service providers requesting assistance over the phone. There has also been an increase in referrals via phone and email from service providers, detention centers, the hospitals, and the MVAA. There were over four dozen presentations/seminars provided to various veteran specific groups and audiences. Despite the challenges of the pandemic, the Veteran service community found new and creative ways to serve our veterans. The virtual approach was utilized to continue to inform and assist Veterans and their families with resources, education, therapy, medical assistance, and advocacy. The Workforce Training and Program Development completed 72 Live events, with 4454 Attendees across all of those events, meaning that our median attendance for all events combined is 61.8 attendees per event during FY21.

Barrier Analysis

Community engagement that includes awareness and education continues to be critical to the aims of DWIHN. Various community efforts were utilized to engage with individuals that are typically disengaged from community mental health resources. Building and maintaining relationships with allied systems within the Wayne County community continues to be a major component to increase accessibility to services while also gaining an awareness of the current needs of community members to ensure that clinical practices are relevant. Over the past three years, it has become evident that traditional methods of community engagement are not reaching the typical Wayne County resident.

Throughout FY 2021, partnering organizations identified common challenges related to the implementation practices, such as, the impact of COVID-19 global pandemic and workforce retention. They've informed that treatment services are modified to include telehealth beginning April 2020 – current. Also, staff turn-over increases once evidence-based trauma specific training is obtained, resulting in the need for new clinical staff to be trained and delay/interruption of treatment modalities. However, there is a commitment from all organizations to continue making an effective impact on the care of individuals, with an understanding that a trauma-informed approach is vital. The Attitudes Related to Trauma-Informed Care (ARTIC) Scale Sample Survey Version 1 was introduced to 65 clinicians. DWIHN has scheduled a consultation with the Trauma Stress Institute to further explore ways to best implement the tool and collect the data measures for FY 22.

Opportunities for Improvement

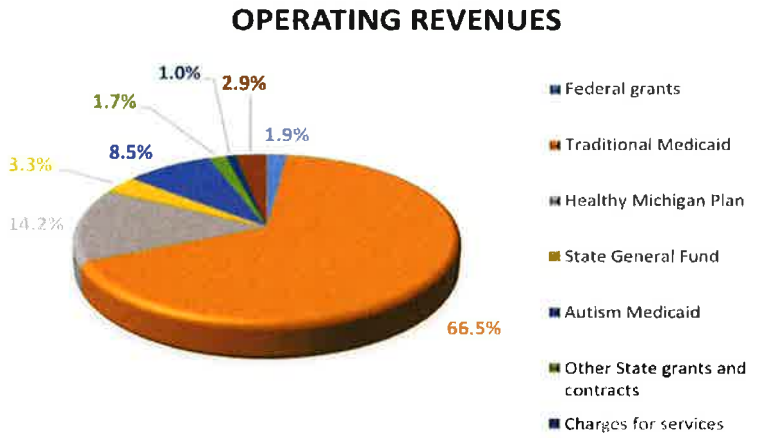
DWIHN plans to help build on the phases within DWIHN's System Transformation process. This momentum will assist and provide direct guidance on the measurable importance of holistic care. The network expansion will include technical assistance on the use of evidence-based screening and assessment tools, and interventions, in addition to learning the best method of tracking data, and integrating all elements of behavioral health, physical health, economic health, social well-being, and spiritual well-being.

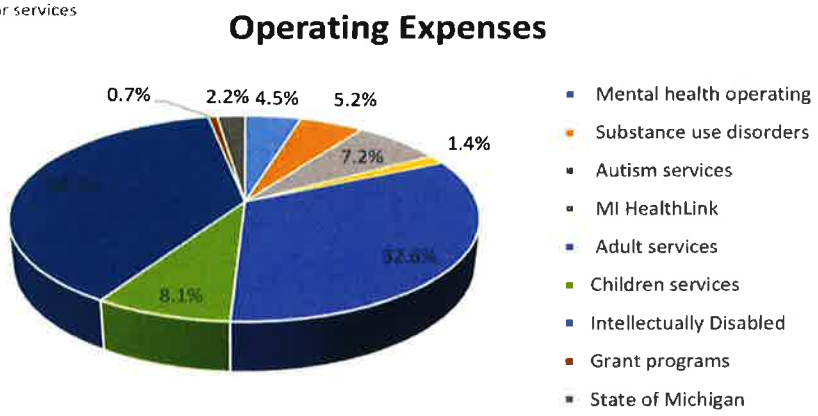
Finance Pillar

Verification of Services

Quantitative Analysis and Trending of Measures

The charts below indicate funding sources utilized to pay for an individual's service in FY20/21. It combines general Medicaid, Healthy Michigan, Habilitation Waiver and other waiver programs which are all Medicaid, accounting for (75%) of the funding source utilized. Block Grant and State Disability Assistance (SDA) which is used to pay for SUD and Room and Board with Substance Use Disorders is reflected as funding sources totaling (9%); decreased from (10%) last fiscal year. General Fund is reflected at 3.3% (a changed from 4.2% in FY19/20) and MI Health Link is at 1.4% (a change from 1.2% in FY19/20). The funding source mix is very similar to last year. Further analysis is required to determine if funding source impacts overall utilization.





Evaluation of Effectiveness

DWIHN analyzed trends in service delivery and health outcomes over time, including whether there have been improvements and barriers impacting in the quality of health care services for members as a result of the activities. In FY21, A total of 2,371 claims were randomly selected for verification. Of those claims 1,210 were reviewed and validated for 51.03%, which is a 13.3% increase from the previous fiscal year.

The COVID-19 Pandemic had a major impact on last year's review schedule and timeliness to complete the 1st and 2nd Quarter Reviews. This was for a variety of reasons, including but not limited to an inability to reach providers, providers being short staffed, building closures and program closures. To get back on schedule for FY 2020, it was decided that the focus of the 3rd and 4th Quarter reviews would include providers that had not been reviewed during the 1st and 2nd Quarters of FY 2020. In FY21, a total of 288 (23.8%) of the claims reviewed had scores <95% was required to complete a Plan of Correction. DWIHN failed to meet the minimum sampling standards established by the Office of Inspector General (OIG). This goal will continue.

Barrier Analysis

The Medicaid Claims review process continues to be impacted by the COVID 19 pandemic. Virtual reviews and desk audits continued, which created challenges for contracted providers and DWIHN staff. Providers experienced staffing shortages which hindered follow-up, some providers had difficulties displaying documentation virtually, and submitting documents through secured mail or electronic submission in MHWIN system.

Opportunities of Improvement

- Continue to identify patterns of potential or actual inappropriate utilization of services.
- Continue to investigate and resolve quality of care concerns.
- Continue to work with Finance to ensure that all quality of care concerns identified and forwarded to Quality for investigation.

Advocacy Pillar

Home Community-Based Services (HCBS)

Activity Description

The goal is to monitor network implementation of the Home and Community Based Services transition to ensure quality of clinical care and service. In FY21, DWIHN Quality performed fifty-two (52) residential treatment provider reviews and forty (40) Heightened Scrutiny reviews, which is a slight increase from the previous year. The Covid 19 Global Pandemic adversely impacted this project in FY20. This project will continue until complete. Completion date is expected to be March 17, 2023.

Evaluation of Effectiveness

DWIHN has developed a policy for HCBS describing the requirements under the HCBS Final Rule. These requirements aim to improve the quality of the lives of beneficiaries and allow them to live and receive services in the least restrictive setting possible with full integration in the community. DWIHN maintains a list of all contracted service providers that are HCBS compliant within the DWIHN's network. This information can be found on DWIHN's website under for Providers/Provider Resources tab.

Barrier Analysis

- DWIHN plans to provide on-site technical assistance on educating individuals, providers, and communities to better understand and come into compliance with the final rule.
- Create a residential provider report card that offers an overall view of performance and tracks compliance with standards, policy and procedures with the final rule.
- Advise providers on strategies to address the three core elements of implementation: assessment, remediation, outreach.
- Identify providers who have made the cultural shift to meet the HCBS standards to share best practices.
- Post HCBS resource materials on DWIHN website including direct linked resources from MDHHS.
- Work with other PIHP Leads in the regions through on-going training and sharing of best practices.

Opportunities for Improvement:

- Identify providers who have made the cultural shift to meet the HCBS standards to share best practices.
- Create a residential provider report card that offers an overall view of performance and tracks compliance with standards, policy and procedures with the final rule.
- Advise providers on strategies to address the three core elements of implementation: assessment, remediation, outreach.
- Post HCBS resource materials on DWMHA website including direct linked resources from MDHHS.
- Work with other PIHP Leads in the regions through on-going training and sharing of best practices.

Community Outreach

DWIHN distributed over 110,000 PPE items to the Provider network to assist them in their places of business and with the people we serve throughout this pandemic. DWIHN social media accounts are growing with an increase in impressions across all four channels. DWIHN content is trending upward. Posts that generated the greatest reach on DWIHN social media channels were posts acknowledging DWIHN Board Chair, Angelo Glenn for receiving a Men of Excellence award from the Michigan Chronicle newspaper. Another post that did very well was a Mental Health Care-No Child Left behind billboard post.

DWIHN's Chief Medical Officer Dr. Shama Faheem continues to educate the public with her bimonthly newsletter containing information about COVID-19, vaccinations and answers to questions that are sent in by staff, people we serve, etc. This publication is sent to Providers, stakeholders and posted on the DWIHN website and social media. The Communications Team has also moved the newsletter to a digital format visit AskTheDoc@dwihn.org.

DWIHN Website

DWIHN website was revamped with a new look, better accessibility and more streamlined functionality. In addition, one of the newest features is a searchable Provider directory. A new page designated just to COVID updates was also created.

CALL OUR 24-HOUR HELPLINE
1-800-241-4949
Crisis Info

Find a Provider

https://www.dwihn.org

- About Us
- Access Our Services
- For Members
- For Providers
- Contact Us

Sharing of Information

DWIHN produces and distributes quarterly Member and Provider Newsletters. The Newsletter's primary focus is to keep members updated with the latest information regarding programs and services, and providers updated with the latest information on regulations, reports, and contractual requirements that affect our Network. Types of information the Quality Improvement unit shares on a routine basis include:

- Quality Improvement Steering Committee (QISC)
  - QISC Agenda
  - QISC Minutes
- Quality Assurance Performance Improvement Plan (QAPIP)
  - QAPIP Description Plan FY 2019-2021
  - QAPIP Description Plan FY 2021-2023
- QAPIP Anuual Evaluation
  - QAPIP Annual Evaluation FY 2017
  - QAPIP Annual Evaluation FY 2018
  - QAPIP Annual Evaluation FY 2019
  - QAPIP Annual Evaluation FY 2020
  - QAPIP Annual Evaluation FY 2021

DWIHN Accreditation

DWIHN has been accredited for three years through the National Committee for Quality Assurance (NCQA). DWIHN received high marks and perfect scores in several critical areas including Member Experience, Self-Management Tools, Clinical Practice Guidelines, Clinical Measurement Activities, Coordination of Behavioral Healthcare and Collaboration between Behavioral Health and Medical Care. DWIHN scored 92.49 out of a possible 100 points. This goal will continue.

External Quality Reviews

The PIHP is subject to external quality reviews through Health Services Advisory Group (HSAG) to ensure compliance with all regulatory requirements in accordance with the contractual requirements with MDHHS. All findings that require opportunities for improvement are incorporated into the QAPIP Work Plan for the following year. HSAG completes three separate reviews annually: Performance Improvement Project (PIP), Performance Measure Validation (PMV) and the Compliance Monitoring review.

Quantitative Analysis and Trending of Measures

During FY21 validation period, DWIHN continued its state mandated PIP topic: Improving Diabetes Screening Rates for People with Schizophrenia or Bipolar Who Are Using Antipsychotic Medications. The PIP topic selected addressed Centers for Medicare & Medicaid Services (CMS) requirements related to quality outcomes—specifically, the quality, timeliness, and accessibility of care and services. The goal of statistically significant improvement over the baseline rate was not achieved during the second remeasurement. The study indicator demonstrated a statistically significant decrease (21.03%) over the baseline and did not achieve the plan-selected goal (target 80%). As displayed in the table below, the goal did not represent a statistically increase over the baseline performance for Remeasurement 1 and Remeasurement 2 reporting data.

PIP Topic	Validation Status	Study Indicator	Study Indicator Results			
			Baseline	R1	R2	Goal
Improving Diabetes Screening Rates for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	*Not Met*	The percentage of diabetes screenings completed during the measurement year for members with schizophrenia or bipolar disorder taking an antipsychotic medication.	81.4%	76.9% ↓	64.28 ↓	80.0 %

Evaluation of Effectiveness

The goal is to increase diabetes screening for members with schizophrenia or bipolar disorder who are dispensed atypical antipsychotic medications. For the first remeasurement period, DWIHN reported that 76.9% of people with schizophrenia and bipolar disorder who were dispensed atypical antipsychotic medications had a diabetes screening. In FY20, the Remeasurement 1 plan-selected goal was revised from 85% to 80%, and the overall goal of the PIP was to achieve statistically significant improvement over the baseline rate 81.4%. The study indicator did not achieve the goals during the remeasurement period, demonstrating a statistically significant decrease over the baseline rate. In FY21, for the second remeasurement period, DWIHN reported that 64.3% of people with schizophrenia and bipolar disorder who were dispensed atypical antipsychotic medications had a diabetes screening. The study indicator did not achieve the goals during the remeasurement period, demonstrating a statistically significant decrease over the baseline rate. The restrictions related COVID-19 pandemic, which occurred during the second remeasurement period, impacted members' ability to obtain face-to-face services, including the completion of lab draws, and interrupted DWIHN's ability to conduct some interventions.

Barrier Analysis

DWIHN determined the following barriers:

- Lack of knowledge among providers to recommend diabetes screening for members with schizophrenia and bipolar disorder.
- Lack of follow through by members to have labs drawn when ordered.
- Restrictions related COVID-19 pandemic

Opportunities for Improvement

To address these barriers, DWIHN initiated the following interventions:

- Monitor compliance with diabetes screening through clinical treatment chart audits.
- Measure and monitor compliance with having labs ordered and drawn no less than quarterly through review of the HEDIS-like data in Vital Data.
- Educate members on the importance of having labs completed through community outreach initiatives and training.
- Provide education on the Clinical Guidelines Procedures to service providers, practitioners, and DWIHN Detroit staff members through the Quality Operations Workgroup, Quality Improvement Steering Committee, and Improvement Practices Leadership meetings.
- Educate the provider network through community outreach initiatives and training on the importance of diabetes screening.
- Conduct monthly care coordination meetings with Medicaid health plans to develop care plans for members, including those diagnosed with diabetes who have been prescribed atypical antipsychotic mediations. The focus is on effective planning and communication for the care coordination of physical health conditions and behavioral health.

Performance Measures Validation (PMV)

Activity Description

The validation of performance measures is one of the mandatory external quality review activities that the Balanced Budget Act requires state Medicaid agencies to perform. The purpose of the PMV is to validate the data collection and reporting processes used to calculate the performance measure rates. Outcomes from the review was reported to Program Compliance and other appropriate committees as required.

Quantitative Analysis and Trending of Measures

In FY21, HSAG reviewed DWIHN's performance indicators reporting data for validation. The reporting cycle and measurement period was from October 1, 2020 through December 31, 2020. DWIHN received a full compliance score of 100% with no Plan of Correction (POC), which represents a 14.9% increase compared to last fiscal year (87.65%).

Evaluation of Effectiveness

DWIHN continues to monitor opportunities to improve transition of care services and supports for adult members to reduce the likeliness of readmissions. Though DWIHN's Recidivism Task Force which include the Clinically Responsible Service Providers (CRSPs) led by DWIHN Crisis/Access team these efforts have decreased the adult recidivism from 20.41% during Quarter 1 of FY 2019-2020 to 15.01% for Quarter 1 of FY 2020-2021. The efforts from this group produced a 26.45% drop in Indicator 10 as of Q1FY 2020-2021.

Barrier Analysis

Beginning Q3 of FY 2020, separate indicators were developed for PI#2a new persons receiving a completed Biopsychosocial Assessment within 14 calendar days of a non-emergency request for service, PI#2b SUD Services and indicator #3 new persons starting any medically necessary on-going covered service within 14 days of completing a non-emergent Biopsychosocial Assessment. There is no established standard set by MDHHS for these indicators. The indicators are for persons with mental illness, developmental disabilities and substance use disorder. During FY21, the total compliance rates ranged from (36.02%-50.12%) for 2a, (86.10%-89.81%) for 2b and (84.84%-88.4%) for #3. DWIHN is underperforming on PI2a performance measure compared to the other PIHPs in the state. DWIHN is lowest in in the state at 50.12%, the state average is (65.47%).

Opportunities for Improvement

DWIHN identified the following improvement efforts:

- Initiate a Value Based Performance Indicator 2a Incentive if Service Provider receives a metric of 80% or more for Performance Indicator 2a.
- Continue with existing provider and internal workgroups to regularly review progress on improving performance measure rates and data collection processes.
- Continue to monitor performance trends and targeting low performing areas, including an assessment of performance at the individual provider level, as well as within core member demographics, to identify systemic patterns of performance.
- Continue to use existing workgroups to identify root causes for low performance and disseminate best practices.

Compliance Review

Activity Description

To comply with the federal requirements, MDHHS contracts with HSAG, to conduct compliance reviews of its contracted PIHPs responsible for the delivery of comprehensive mental health and developmental disability services, as well as certain covered substance use services under the State's Medicaid managed care program. The new cycle of compliance reviews for DWIHN begin in FY21. The review focused on 13 performance areas. HSAG reviews ½ of the standards in year one (FY 2021) and the remaining ½ of the standards in year two (FY 2022). If applicable, in year three (FY 2023), HSAG will review the corrective plan for each element that did not achieve full compliance.

Quantitative Analysis and Trending of Measures

In FY 2018-2020 reporting cycle, DWIHN successfully addressed all prior recommendations and achieved full compliance on all standards, for an overall compliance score of 98%. In FY21 of the new reporting cycle (2021-2023), DWIHN received an overall compliance score of 77% with a corrective action plan. Below are the overall percentage of compliance scores across all six standards reviewed.

	Standards Reviewed	Number of Standards	Met	Not Met	Total Compliance Score
I	Member Rights and Member Information	19	16	3	84%
II	Emergency and Post stabilization	10	10		100%
III	Availability of Services	7	6	1	86%
IV	Assurances of Adequate Capacity and Services	4	0	4	0%
V	Coordination and Continuity of Care	14	11	3	79%
VI	Coverage and Authorization of Service	11	7	4	64%
	Total	65	50	15	**77%**

Evaluation of Effectiveness

DWIHN received a total compliance score of (77%) across all standards reviewed during the FY 2021 compliance monitoring review. DWIHN's performance measure (Emergency and Post stabilization) is above the MDHHS standard of 95% indicating strengths in this area.

Barrier Analysis

DWIHN's performance measure (Assurances of Adequate Capacity and Services) scored below the MDHHS standard of 95% indicating opportunities for improvement in this area.

Opportunities for Improvement

To address the areas requiring improvement, DWIHN will prioritize areas of low performance and develop a comprehensive and effective plan of action to mitigate any deficiencies identified during the 2020–2021 compliance monitoring review.

Utilization Management

The Annual Utilization Management (UM) Program Executive Summary is under a separate cover for FY 2021. It is the responsibility of DWIHN to ensure that the UM Program meets applicable federal and state laws and contractual requirements and is a part of the QAPIP. DWIHN is required to have a written Utilization Management Program Description which includes procedures to evaluate medical necessity criteria, and the processes used to review and approve the provision of mental health and substance abuse services. DWIHN is also required to have an Annual Utilization Management Program Evaluation report in order to:

- Critically evaluate Utilization Management Program goals
- Identify opportunities to improve the quality of Utilization Management processes
- Manage the clinical review process and operational efficiency
- MCG-Indicia medical necessity software
- Implementation of clinical protocols
- Complex case management

Adequacy of Quality Improvement Resources

The Quality Improvement (QI) Unit is staffed with a Director of Quality Improvement which oversees the Quality Improvement Unit (including two full-time Quality Administrators). The QI Director collaborates on many of the QI goals and objectives with the DWIHN Senior Leadership team and the QISC. The QI unit works in conjunction with DWIHN's Information Technology (IT) Unit. The IT unit plays a pivotal role in the QAPIP, providing internal and external data analysis, management for analyzing organizational performance, business modeling, strategic planning, quality initiatives, and general business operations, including developing and maintaining databases, consultation, and technical assistance. In guiding the QAPIP projects, the IT Unit performs complex analyses of data. The data analyses include statistical analyses of outcomes data to test for statistical significance of changes, mining large data sets, and conducting analyses to determine causes or contributing factors for outcomes or performance outliers; correlates analyses to assess relationships between variables. Based on the data, the IT unit will develop reports, summaries, recommendations, and visual representations to Quality Improvement Activities.

The following chart is an estimated summary of the internal staff included in the Quality Improvement Steering Committee (QISC), their title and the percentage of time allocated to the quality improvement activities.

Title	Department	Percent of time per week devoted to QI
Medical Director	Administration	100%
Director of Quality Improvement	Quality Improvement	100%
Quality Improvement Administrator	Quality Improvement	100%
Director of Utilization Management	Utilization Management	50%
Clinical Officer	Clinical Practice Improvement	50%
Director of Customer Service	Customer Service	50%
Director of Integrated Health Care	Integrated Health Care	60%
Director of Managed Care Operations	Managed Care Operations	10%
Strategic Planning Manager	Compliance	0%
Information Technology	Information Technology	0%
Practitioner Participation	Provider Network	100%

Overall Effectiveness

An evaluation of DWIHN's QI Work Plan for FY2021 has been conducted. This evaluation included review of trended results for QI measures over time, comparison against performance objectives, quantitative and qualitative analyses for completed and ongoing QI activities. Overall, improvements were achieved in planned QI initiatives, both clinical and service. In addition, programs that address member safety were implemented. The Quality Improvement Steering Committee (QISC) and the Program Compliance Committee (PCC) Board reviewed and approved the 2021 QAPIP Evaluation and FY2021 Work Plan (Attachment A). The 2021 QI Work Plan was implemented in accordance with the plan. The indicators measured cover a broad spectrum, including quality of clinical care, quality of service and safe clinical practices. The QI initiatives are relevant to the needs of the residents of Wayne County and in alignment with DWIHN's mission and vision. DWIHN's organizational structure and resources are adequate and supportive of the QI process.

The quality resource needs are determined based on the percentage of key activities completed and associated goals attained. After evaluating the performance of the Quality Program, DWIHN has determined there are adequate staffing resources to meet the current program goals and include highly educated and trained staff. DWIHN evaluated data, staff, resources, and software to ensure our health information system that collects, analyzes and integrates the data necessary to implement the QI program is adequate. DWIHN IT has successfully designed, tested and deployed the Provider Risk Matrix dashboard that is built upon scientific measurable goals for CRSP providers and implemented a new Business Intelligence platform built on Microsoft's world leader PowerBI platform which allows DWIHN to easily connect its data sources and share with staff and providers so they can focus on what's important to deliver quality care. IT also deployed a nationwide NCQA accredited Care Coordination platform that supports the calculation of HEDIS measures and enables us to partner with Health Plans to manage Behavioral and Physical Health services. As part of the 21st Century Cures Act, the Centers for Medicare & Medicaid Services (CMS) is requiring states to implement an Electronic Visit Verification (EVV) system, during FY' 2021 DWIHN finalized testing that integrates with our main MHWIN system for timely and accurate data delivery.

The DWIHN Medical Director chairs the QISC with the Quality Improvement Administrator. The Medical Director also is the designated senior official and is responsible for the QAPIP implementation. DWIHN supports the use of evidence-based practices and nationally recognized standards of care. The clinical practice guidelines are reviewed every two years and approved by the Medical Director. The Medical Director is also a member of the following committees:

- Improving Practices Leadership Team (IPLT)
- Critical Sentinel Event Committee
- Death Review Committee
- Peer Review Committee
- Behavior Treatment Advisory Committee (BTAC)
- Credentialing Committee
- Cost Utilization Steering Committee
- Compliance Committee

Analysis

DWIHN believes there are adequate practitioner involvement and consultation to meet the objectives of the Quality Program. No changes are anticipated for FY 2022.

Committee Structure

After evaluating the QI program committee structure, DWIHN committee involvement is adequate and all committee members regularly attend and actively participate in QISC committee meetings. DWIHN's commitment to quality is strong and shared across all levels of the organization. DWIHN believes the structure supports effective governance and align key strategic initiatives to ensure adequate guidance to help DWIHN reach goals and objectives. No changes are anticipated for FY2022.

Practitioner Participation

DWIHN continues to have substantial practitioner participation in our QISC committees, Quality Operations Workgroup and adhoc provider advisory workgroups as needed. This represents input from the provider network and practitioner leadership. The practitioners actively participate in the planning, design, implementation and program evaluation, through data collection and analysis. Their activities ensure program alignment with evidence-based care and overall population management between the health plan, care delivery systems and community partners. In addition to serving on the QISC committee, DWIHN enlists practitioner input regarding key initiatives. After evaluating the practitioner participation, DWIHN believes there are adequate practitioner involvement and consultation to meet the objectives of the Quality Program. No changes are anticipated for FY2022.

QI Program Effectiveness

An evaluation of DWIHN's QI program has been conducted. This evaluation included review of trended results for QI measures over time, comparison against performance objectives, quantitative and qualitative analyses for completed and ongoing QI activities. Overall, improvements were achieved in planned QI initiatives, both clinical and service. In addition, programs that address member safety were implemented. The QI program resources, QI Committee Structure, subcommittee, practitioner participation and leadership involvement has determined the current QI Program structure effective. No changes to the QI Program structure are needed at this time.

DWIHN's commitment to continuous improvement is integral to achieving excellent health outcomes and an excellent overall member experience. In 2022, DWIHN will continue to address identified opportunities for improvement to ensure optimal member experience.