Detroit Wayne
Integrated Health Network
707 W. Milwaukee St.
Detroit, MI 48202-2943
Phone: (313) 833-2500
www.dwihn.org

FAX: (313) 833-2156
TDD: (800) 630-1044 RR/TDD: (888) 339-5588

FULL BOARD MEETING
Wednesday, February 17, 2021
707 W. Milwaukee
(Virtual)
1:00 P.M. – 3:00 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 –January 20, 2021

VI. RECEIVE AND FILE – Approved Finance Committee Minutes – January 4, 2021
Approved Program Compliance Committee Minutes – January 13, 2021

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

VIII. PUBLIC AFFAIRS ASSOCIATES (PAA)

IX. NOMINATING COMMITTEE – Election of Officers

X. BOARD COMMITTEE REPORTS
A) Board Chair Report
1) Metro Region Virtual Meeting – DWIHN Hosts – Thursday, February 18th 6:00 p.m. to 8:30 p.m.
2) NatCon Annual Behavioral Health Virtual Conference – May 3rd – 5th
3) Mackinac Policy Conference – September 20th - 23rd Grand Hotel, Mackinac Island, Michigan

B) Executive Committee
1) Personnel Issue
2) CEO Contract
3) Update Annual Report to the Commission

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

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

XI. AD HOC COMMITTEE REPORTS

A) Policy/Bylaw Committee

XII. PRESIDENT AND CEO MONTHLY REPORT

XIII. FY 2020 ANNUAL QUALITY ASSURANCE PERFORMANCE IMPROVEMENT PROGRAM (QAPIP) EVALUATION *(Program Compliance)*

XIV. FY 2020/21 QUALITY ASSURANCE PERFORMANCE IMPROVEMENT PROGRAM (QAPIP) WORK PLAN *(Program Compliance)*

XV. REVISED FY 2020 ANNUAL UTILIZATION MANAGEMENT PROGRAM EVALUATION *(Program Compliance)*

XV. UNFINISHED BUSINESS

Staff Recommendations:

A. BA #19-24 (Revision 2) – ProAct/Interoperability Funding Modification – Relias Learning, LLC *(Program Compliance)*

B. BA #20-55 (Revised) SUD Recovery Home and Mobile Unit COVID-19 Funding Increase – DWIHN's Network Providers *(Program Compliance)*

C. BA#20-59 (Revised) Peter Chang Enterprises *(Finance)*

D. BA#21-19 (Revised) Crisis Intervention Services – Hegira Health, Inc. *(Program Compliance)*

E. BA#21-25 (Revision 1) DWIHN FY 2020-2021 Operating Budget *(Finance)*

F. BA#21-40 (Revised) School Success Initiatives *(Program Compliance)*

XVI. NEW BUSINESS

Staff Recommendations:

A. **BA #21-55** – Jail Plus Program – Black Family Development *(Program Compliance)*

B. **BA#21-57 –** DWIHN's Detroit Police Department (DPD) Pilot *(Program Compliance)*

XVII. PROVIDER PRESENTATION – FUTURES HEALTH

XVIII. REVIEW OF ACTION ITEMS

XIX. 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.

XX. ADJOURNMENT

DETROIT WAYNE INTEGRATED HEALTH NETWORK
FULL BOARD MEETING
Meeting Minutes
Virtual Meeting
Wednesday, January 20, 2021
1:00 p.m.

BOARD MEMBERS PRESENT

Bernard Parker, Chair
Commissioner Tim Killeen, Treasurer
Dora Brown, Secretary
Dorothy Burrell
Michelle Jawad
Kevin McNamara
William T. Riley, III
Kenya Ruth
Dr. Cynthia Taueg

BOARD MEMBERS EXCUSED: Lynne F. Carter, M.D.; Angelo Glenn

GUESTS: None

CALL TO ORDER
The meeting was called to order at 1:02 p.m. by Mr. Bernard Parker, Board Chair.

ROLL CALL
Roll call was taken by Ms. Dora Brown, Board Secretary and a quorum was present.

APPROVAL OF THE AGENDA
Board Chair, Mr. Parker welcomed everyone to the meeting and noted the agenda needed to be amended. The Chair notified the Board that there would be a closed session to discuss a personnel matter; the closed session would be added to the agenda as Item XIX and the Provider Presentation would be moved to the February meeting. The Chair called for a motion on the amended agenda.

It was moved by Commissioner Killeen and supported by Ms. Brown to accept the agenda with the recommended changes. Motion carried unanimously.

MOMENT OF SILENCE
The Board Chair, Mr. Parker called for a moment of silence and asked that everyone remember those that have passed away due to COVID-19 and those that may be dealing with COVID-19. Moment of Silence taken.

APPROVAL OF BOARD MINUTES
The Chair called for a motion on the Board minutes of the Full Board meeting of November 18, 2020. **It was moved by Ms. Brown and supported by Commissioner Killeen approval of the Full Board minutes of November 18, 2020. Motion carried unanimously.**

RECEIVE AND FILE
The Chair called for a motion to Receive and File the approved Finance Committee minutes of November 4, 2020 and the approved Program Compliance Committee minutes of November 12, 2020. **It was moved by Ms. Brown and second by Mr. McNamara to "Receive and File" the approved minutes from the Finance Committee meeting of November 4, 2020 and the**

approved Program Compliance Committee minutes of November 12, 2020. The motion carried unanimously.

ANNOUNCEMENTS
Network Announcements
There were no Network announcements.

Board Announcements
There were no Board announcements.

BOARD COMMITTEE REPORTS
Board Chair Report
Mr. Parker gave a verbal report. He noted the change in leadership at the White House and noted the inauguration of President Joseph Biden and Vice President Kamala Harris and that the next four years would be different than the last four years. He thought it was a great day not just here in Michigan, but throughout the country. He provided an update on the City of Detroit, Detroit Police Department and DWIHN program. A Press Conference was held in early December and DWIHN was well represented; he attended as well as Mr. Brooks; Mr. Doeh; Police Chief Craig; and Mayor Duggan of the City of Detroit. The Press Conference covered how the program would function and how it would move forward; there was limited press in attendance. Program will start at the beginning of the year. There was great excitement about the program from both the City and 911 Center. The Program Compliance Committee will monitor the program moving forward.

It was reported that a formal letter had been sent to Northeast Integrated Health; a copy of the document was provided for the record. In essence, the letter noted that we recognized the efforts that they have made with the Detroit Police and look forward to working with them.

The Board Chair announced the Nominating Committee and noted the following Board members had been appointed to the committee - Board member Mr. Angelo Glenn, Chair; Mr. Kevin McNamara; Ms. Kenya Ruth and Ms. Burrell. The Committee would be charged with determining if the vacancy of the Vice Chair would be filled because of the resignation of Dr. Taylor and with presenting a slate of Officers to the Full Board at the February Full Board meeting.

The Chair called for a motion on the appointment of the Nominating Committee. **It was moved by Mr. Riley, III and second by Dr. Taueg approval of the Nominating Committee. Motion carried unanimously.**

The Board Chair noted the following upcoming events - DWIHN will host the Metro Region Virtual Meeting scheduled for Thursday, February 18th 2021 from 6:00 p.m. to 8:00 p.m. All Board members are encouraged to attend.

The Community Mental Health Association of Michigan Virtual Winter Conference is scheduled for February 9th – 12th with half day sessions. The NACBHDD 2021 Legislative and Policy Virtual Conference is scheduled from February 23rd to March 25th 2021; the NatCon Annual Behavioral Health Conference is scheduled from May 3rd through May 5th. Any board member that is interested in attending should contact the Board Liaison.

The Mackinac Policy Conference is scheduled for September 20th – 23rd at the Grand Hotel, Mackinac Island, Michigan. It was noted that there were four board members that were

scheduled to attend the conference last year; however, there is one Board member that was approved to attend last year but would not be attending this year; therefore, a vacancy now exists; if there are other board members that are interested in attending the Mackinac Policy Conference they should notify the Board Liaison. Board members that were approved to attend last year should also notify the Board Liaison if they are still interested in attending this year as there has been a change in the conference dates

Executive Committee

The Board Executive Committee met on Monday, January 11, 2021. It was reported that Mr. Brooks', CEO contract would expire March 5th; negotiations will be taking place and the contract will come to the Executive Committee in February and then to the Full Board; any Board members that have any ideas on the contract were to contact the Board Chair. It was also noted that he will be meeting with Mr. Brooks over the next several weeks. The CEO Incentive Compensation is coming up for consideration and he has goals for an incentive packet that will determine how he has done; the document will go to the Executive Committee then to Full Board in February. The Board table for COVID 19 compliance was also discussed. The table will be redesigned to accommodate the six feet of spacing between board members and be relocated to the long wall where the food is normally placed. The table should be completed by the end of March and the audience will be facing the table. We are able to have virtual meetings until March 31; however if virtual meetings are not extended our April meeting will be held in person at the Milwaukee building; if the meetings are extended we will continue to meet virtually for the health and safety of all.

The Chair called for a motion on the Board Chair and the Executive Committee report. **It was moved by Commissioner Killeen and supported by Mr. Riley, III to accept the Board Chair Report and the Executive Committee report.** There was no further discussion. **Motion carried unanimously.**

Finance Committee

Commissioner Killeen, Chair of the Finance Committee reported the committee met virtually on Wednesday, January 6, 2021. The committee received the monthly finance report and the Cooperative Purchasing Report that is received on a quarterly basis per the DWIHN policy. Management can execute purchases under $50,000 as well as cooperative purchases which can be greater than $50,000 because of the nature of cooperative purchases. All purchases must be reported to the Board. Also discussed cash flow which is looking better. The CFO gave an overview of the cashflow and noted there has been a reduction in expenses across some of the lines of business – Autism and skill building. We received additional revenue due to the new Milliman rates that went into effect. The Finance department has developed an incentive model for the AMI homes. The model has been reviewed for sustainability and will work better for our Providers. There have been some increased costs in the Wayne County Jail due to COVID-19 thus the per diem rate has been increased. We have requested the State to allow us to cost settle with the Autism program and we are requesting a waiver that limits the GF carryover so any unspent General Fund monies will not have to be sent back; we have not received a response from the state.

We were able to help thirteen of our Autism Providers by covering their operating loses out of the CARES dollars that were received. The State has recovered $2.3 million dollars for the Direct Care Workers. It was also reported that non-union employees have received their increases and negotiations with the union is still ongoing. The committee considered and moved to Full Board several board actions –BA#20-26(Revision 5) Revision to the DWIHN FY 2019-2020 Operating; along

with board actions #21- 51; NexVortex Phone System; 21-52 Gregory Terrell & Company; and Board Action #21-54 Accuform Printing & Graphics, Inc.

The Board Chair called for a motion on the Finance Committee Report. **It was moved by Ms. Brown and supported by Mr. Riley, III acceptance of the Finance Committee Report.** There was discussion regarding the State and the reduction of Block grant funding for Substance Use Disorder; the use of Medicaid funding and the rates paid to AFC homes. **Motion carried unanimously.**

The Chair noted that unfortunately Dr. Iris Taylor has resigned from the Detroit Wayne Integrated Health Network and from her role of Board Vice Chair and the Program Compliance Committee Chair as she has taken a position with the City of Detroit. Her resignation is effective from the date she started the position with the City of Detroit. It was noted this is in the Enabling Resolution and the Mental Health Code that one cannot be employed with the City of Detroit or Wayne County and serve as a DWIHN Board member. His thoughts were to move the Vice Chair of the Programs Compliance Committee to the Chair for the one month and new Committee Chairs would be appointed in April. However, Dr. Taueg is prepared to give the Program Compliance Committee report today as the Vice Chair of the Committee and it is his intent to appoint her to the Chair of the Program Compliance Committee directly following the Full Board meeting.

Ms. Turner, Corporation Counsel noted that the Nominating Committee Charter stated the Nominating Committee may meet to fill a vacancy should one occur during the year as well as the Bylaws which state that the committee can meet annually or as necessary to fill a vacancy. The Chair noted that if the Nominating Committee made a recommendation to fill the Board Vice Chair position that recommendation would need to be confirmed at the February meeting and the individual would only serve for the month of March. The Nominating Committee would also bring to the Full Board in February a full slate of officers that would need to be confirmed by the Full Board and those individuals would take office in April, however he would leave the decision of the electing of a Vice Chair to the Nominating Committee.

<u>Program Compliance Committee</u>

Dr. Taueg, Vice Chair of the Program Compliance Committee reported verbally. It was reported the Program Compliance Committee met virtually on Wednesday, January 13, 2021. The committee received several reports which included the Corporate Compliance Report and the Children's Redesign program; there was an extensive report made by Mr. Doeh and Ms. Reynolds and the program was well received. There was a Workplan given on an upcoming RFP for Autism Spectrum Disorder and the following Board actions BA#21-23 (Revised) Provider Network System and BA#21-53 HUD Permanent Supportive Housing – Coalition on Temporary Shelter (COTS) and Central City Integrated Health (CCIH) were considered and moved for approval to Full Board. Dr. Taueg noted that she was unable to stay for the entire meeting and unfortunately was unaware of the pending resignation of the Program Compliance Committee Chair. She encouraged all Board members to review the full minutes from the Program Compliance Committee meeting. It was also noted by Ms. Moody, Chief Clinical Officer that COVID-19 was continuing to be monitored in the residential settings and our recovery homes, the numbers are continuing to rise and additional Providers have been put in place. It is our hope that the numbers will begin to decrease once the vaccine is rolled out.

The Board Chair called for a motion on the Program Compliance Committee Report. **It was moved by Mr. Riley, III and supported by Ms. Jawad acceptance of the Program Compliance Committee Report.** There was no further discussion. **Motion carried unanimously.**

Recipient Rights Advisory Committee

Mr. Riley, III Chair of the Recipient Rights Advisory Committee (RRAC) provided a written report for the record. It was reported the committee met virtually on January 4, 2021. The Recipient Rights office hired a new employee Nicole Starks for Clerical Support and there is also a new committee member, Jamie Junior. The state of Michigan required our committee to develop guidelines to hold our meetings remotely. The guidelines were prepared and approved on January 4, 2021 and we will be moving them forward.

The Office of Recipient Rights submitted their annual report for the years 2019 and 2020. The report was submitted on December 22, 2020, and the following showed the ORR received 1,383 allegations, investigated 1,106 cases and substantiated 371 investigations. ORR received allegations from 474 recipients and 376 employees which represents the highest number of individuals that filed complaints. This is significant and supports the fact that recipients and employees are one of our greatest resources in protecting the rights of the ones we serve.

We also submitted our State of Michigan three-year assessment and the ORR scored 423 out of 462. The State has three scoring ranks, which are Full compliance is 439; **416-438 substantial compliance which is what was received by our Office of Recipient Rights. This is the first time DWIHN has received 2nd place which is outstanding!** The rating of less than substantial compliance is 416 and below.

During the month of November our office received 64 allegations, 12 were Outside of Provider Jurisdiction, three No Rights involved, 49 were actual investigations, five cases were closed and 44 remain open. During the month of December our office received 29 allegations, 5 were found to be Outside Provider Jurisdiction, 0 were no rights involved, we opened 24 investigations, we closed 2 and 22 remain open.

During the months of November to December, our trainers Registered-121 individuals, 47 attended and 74 were no shows. The ORR are requesting all providers and contractors ensure their employees are trained within 30 days of their hiring day to remain in compliance with the Mental Health Code Citation MHC 1755(5)(f), Standard 3.3.1. C. Witcher presented a discussion on his team the Elliott Team Explores Cultural Diversity Implications for Recipient Rights Protection.

The Chair called for a motion on the Recipient Rights Advisory Committee Report. **It was moved by Ms. Ruth and supported by Dr. Taueg to accept the Recipient Rights Advisory Committee Report.** There was discussion on the number of cases that remain open. **Motion carried unanimously.**

SUBSTANCE USE DISORDER OVERSIGHT (SUD) POLICY BOARD REPORT

Mr. Angelo Glenn, SUD Oversight Policy Board Chair was excused from the meeting however a written report was provided for the record. The SUD Board meeting was held Tuesday, January 19, 2021. The SUD Department requested board approval for Prevention, Treatment, and Recovery providers' contract for fiscal year 2021. The approval is for Block Grant expansion of Prevention Services programs; this would be with unallocated prevention funds, no new money. Care of Southeast Michigan $100,000; Chance For Life $100,000; Detroit Association of Black Organizations (DABO) $50,000; Leaders Advancing and Helping Communities (LAHC) $80,000; The Youth Connection $100,000 for a total of Total: $430,000.00. This Board Action was approved by the SUD board members. SUD Provider Contracts -The SUD Department requested $45,000. in PA 2 funding for women specialty services for SHAR House for Prevention, Treatment, and Recovery providers' contract for fiscal year 2021. The approval is for women with children room and board cost, childcare for women while in treatment or receiving primary medical

care services; or pediatric care for a child; acupuncture as appropriate; Progressive Muscle Relaxation as appropriate; EFT Tapping Procedure as appropriate; Transportation to treatment, medical and therapeutic interventions for the parent and child only. This Board action was approved by the SUD board members. Jail Plus The SUD Department requested board approval for the Jail Plus Program for $362,194.00. The providers were selected by the Wayne County Department of Health, Human & Veterans Services. DWIHN received its Jail Plus letter from Wayne County, December 21, 2020. The providers (Black Family Development, Inc., Detroit Recovery Project, Elmhurst Home/Naomi's Nest, Detroit Rescue Mission Ministries/Genesis III) will provide case management/relapse prevention, community based cognitive behavioral therapy, women's specialty and drug testing services. The term of the agreement is from October 1, 2020 through September 30, 2021. This Board action was approved by the SUD Board members. SUD Staff provided brief highlights of services in prevention, treatment, recovery, and SOR activities. The SUD Director did announce reductions in SUD treatment Block Grant of 2.4 million and SOR No Cost Extension FY 21 a reduction of $223,150.00. The SUD Board and executive leadership staff will draft a letter to MDHHS about these cuts and how it will impact on SUD treatment services.

Ms. E. Reynolds, Clinical Officer noted that there was discussion regarding the board actions which were approved by the SUD Oversight Policy Board; the reduction in block grant funding and the delivery of prevention services. It was noted that there would be a communication sent to MDHHS regarding the reduction of the block grant funding.

The Chair noted that if there were any questions regarding the written report Board members should reach out to SUD Oversight Policy Board Chair Mr. Glenn after the meeting.

The Chair called for a motion on the SUD Oversight Policy Board report. **It was moved by Dr. Taueg and supported by Ms. Ruth to accept the SUD Oversight Policy Board report.** There was no further discussion. **Motion carried unanimously.**

AD HOC COMMITTEE REPORTS

Policy/Bylaws Committee

Dr. Taueg, Chair Policy/Bylaws Committee noted there was no report as the committee had not met however there would be a meeting scheduled soon to cover two outstanding matters.

PRESIDENT AND CEO MONTHLY REPORT

Mr. Brooks reported. A written report was provided for the record. Mr. Brooks reported on both the Governors State and the Wayne County Diversion Councils. There was a lot of focus on partnerships with the Sheriff's Office and others that requested partnerships with Michigan's Mental Health System and Law Enforcement Agencies. He also noted the plan is to have a statewide program however the biggest issue with the partnerships would be the funding mechanisms as Medicaid dollars cannot be used and General fund dollars are very limited. He noted this is something that should be done statewide as these programs save and improve the quality of life and also makes it safer for Law Enforcement and those with mental health concerns. The request will be taken to the state level with lobbying efforts for more state funding.

The Wayne County Diversion Council discussed extending video court hearing conferences indefinitely. The Wayne County Sheriff's position has been temporarily filled until the next election. Also reviewed the methods of alternative settings for individuals with mental illness.

The City is in the process of building a new jail with a capacity of 2,000 beds. Discussions have taken place on how to fill the beds; he noted that it was not his goal to fill those beds with individuals with mental health concerns and they are seeking alternatives outside of incarceration.

An update on the Telehealth Committee was provided. There was discussion regarding the measures that may still be in effect after the pandemic and vaccinations have taken place such as working remotely and the continued use of face masks.

The DWIHN and City of Detroit Partnership is on target and the biggest concern will be to measure the success of the program so that it can be reported to the County and the State for implementation in other areas. CIT training and travel will possibly resume depending on the climate.

Health Plan Integration – the State has cancelled the Specialty Integrated Plan (SIP) program; however, the State is still looking at this and he is working with the department and staying on top of this project to avoid any surprises. The effort is being led by Representative Whiteford who is pushing for some type of structure change in the behavioral health system.

The death audit is a critical issue. The Department has not had time to address this issue because of COVID-19, but they have noted that it is still on their list. There were no reported changes with the Autism issue as the State has not had time to address this issue as well.

It was reported that the building (Crisis Center) did have an abatement in December and we are continuing to work on an 18- month plan; we are continuing to evaluate staff and long term staffing plans. Staff safety remains a top priority and we are still conducting COVID 19 testing; we are also looking at the pros and cons and legal side of having staff vaccinated. The Access Center should be operational in February and he is excited to bring the service in-house. There are a number of activities that are going on and have been noted in the media. A high- level overview was given on the Key Mental Health Indicators and it was noted that in patient costs are going down; however there has been a slight increase since people are beginning to go out; incarceration rates have seen a slight uptick; trauma in the schools have gone down as well as the homelessness and suicide rates.

The Chair called for a motion on the President and CEO Report. **It was moved by Ms. Ruth and supported by Mr. Riley, III to accept the President and CEO Report.** There was discussion regarding the reporting of the Integrated Health Pilots and there was a request that a financial analysis be presented and reporting be made to the Executive Committee. **The motion carried unanimously.**

FY2020/2021 & FY2021/2022 Quality Assurance Performance Improvement Program (QAPIP) Description Plan

Ms. A. Siebert, Director of Quality Improvement reporting. A written document was provided for the record. It was reported the document had been approved by the Program Compliance Committee at the January meeting. It was noted that pursuant to the contract with Michigan Department of Health and Human Services we are required to have a documented QAPIP Program plan that meets required federal regulations. This is a two- year plan that covers FY2020/2021 and FY 2021/2022 and defines the program purpose; our governance structure and the framework of our Mission, Values and Vision statements and it contains the core functions of the Board approved pillars of the Strategic Plan which serve as our commitment to quality improvement. The Plan has been approved by the Quality Improvement Steering Committee (QISC) and the Program Compliance Committee.

The Chair called for a motion on the FY2020/2021 & FY2021/2022 Quality Assurance Performance Improvement Program (QAPIP) Description Plan. **It was moved by Mr. William Riley, III and supported by Ms. Ruth approval of the FY2020/2021 & FY2021/2022 Quality Assurance**

Performance Improvement Program (QAPIP) Description Plan. There was discussion regarding last year's QAPIP. **Motion carried unanimously.**

FY 2019/2020 Annual Utilization Management Program Evaluation
Mr. John Pascaretti, Director, Utilization Management reporting. A written document was provided for the record. The Annual Utilization Management Program Evaluation is driven by DWIHN's commitment to the provision of effective, consistent and equitable behavioral health services that produce functional outcomes as noted in the Strategic Plan; of the eight goals we met six of those goals. The Utilization Management Program Evaluation reflects the expectations and standards of the Michigan Department of Health and Human Services (MDHHS) and the Center for Medicare and Medicaid Services. The report was approved by DWIHN Utilization Management Committee (UMC); the Quality Improvement Steering Committee (QISC) and the Program Compliance Committee.

The Chair called for a motion on the FY2019/2020 Annual Utilization Management Program Evaluation. **It was moved by Dr. Taueg and supported by Ms. Ruth approval of the FY2019/2020 Annual Utilization Management Program Evaluation.** There was no further discussion. **Motion carried unanimously.**

FY 2019/2021 & FY 2021/2022 Utilization Management Program Description
Mr. John Pascaretti, Director, Utilization Management reporting. A written document was provided for the record. The purpose of the Utilization Management Program Description is to define and describe processes that will align the Utilization Management program with DWHIN's Board of Directors approved Strategic Plan. The program Description has been approved by the Program Compliance Committee); and the Utilization Management Committee (UMC) and the Quality Improvement Steering Committee (QISC).

The Chair called for a motion on the FY2019/2021 and FY2021/2022 Utilization Management Program Description. **It was moved by Dr. Taueg and supported by Ms. Ruth approval of the FY2019/2021 and FY2021/2022 Utilization Management Program Description.** There was no further discussion. **Motion carried unanimously.**

RFP/RFQ WORK PLAN – AUTISM SPECTRUM DISORDER (ASD) – Applied Behavior Analysis (ABA)
Ms. Ebony Reynolds, Clinical Officer reporting. A written document was provided for the record. The RFP/RFQ Work plan is for Applied Behavior Analysis (ABA) services that not been bid out in the past. There has been an increase interest from more providers delivering this service along with some smaller organizations closing their ABA programs. There is a need to procure these services to ensure DWIHN has the most qualified providers delivering these services across Wayne County who are able to sustain this program with the rates identified by DWIHN.

The Chair called for a motion on the RFP/RFQ Work Plan – Autism Spectrum Disorder (ASD) – Applied Behavior Analysis (ABA) **It was moved by Ms. Ruth and supported by Mr. Riley, III approval of the** RFP/RFQ Work Plan – Autism Spectrum Disorder (ASD) – Applied Behavior Analysis There was discussion regarding timelines of when the RFP would be sent out. **Motion carried unanimously.**

XII. UNFINISHED BUSINESS
Staff Recommendations:

A. **BA# 20-26 (Revision 5) –** DWIHN FY 2019-2020 Operating Budget. The Chair called for a motion on BA#20-26 (Revision 5) **Motion:** It was moved by Ms. Jawad and supported by Mr. Riley, III approval of BA #20-26 (Revision 5). S. Durant reporting. This Board Action is requesting approval for Budget Adjustment#20-35-023. The budget adjustment revised the FY 2020 Budget to reflect the certification of additional Medicaid to fully fund FY2020 payments to Direct Care Workers in the DWIHN System per approved BA 20-06 R5 for the next six month period April 1 through September 30, 2020. The adjustment increases HRA revenue and expenses for $6 million to actual amounts received/disbursed for the year. HRA is pass through funding from MDHHS to the community hospitals based on days of stay. There was no further discussion. **The motion carried unanimously.**

B. **BA#21-23 (Revised)** Provider Network System. The Chair called for a motion on BA#21-23 (Revised) **Motion:** It was moved by Dr. Taueg and supported by Mr. Riley, III approval of BA #21-23 (Revised). J. White reporting. This Board Action is requesting approval for the revised board action to include Genoa Healthcare, LLC, formerly known as Advance Care to DWIHN Network Provider system. Genoa Healthcare is our Med-drop provider. The program is designed for individuals who have chronic problems taking their medications. This service improves the individual's overall mental health and daily functioning by improving the symptoms treated by medications. Note 1: The amounts include Children's Waiver, SED Waiver and SUD Medicaid, HMP and Block grant treatment, and EBSE claims based activity. The amounts are estimated and subject to change. There was no further discussion. **The motion carried unanimously.**

NEW BUSINESS
Staff Recommendations:

A. **BA#21- 51** – NexVortex Phone System The Chair called for a motion on BA#21-51. **Motion:** It was moved by Commissioner Killeen and supported by Mr. Riley, III approval of BA #21-51. M. Singla reporting. This Board action is requesting approval for a three-year term for the procurement of additional services, software, modifications, programming, and maintenance to our phone system to support the added need due to in-house migration of the WellPlace Call Center. **The motion carried unanimously.**

B. **BA# 21-52**– Gregory Terrell & Company. The Chair called for a motion on Board Action #21-52. **Motion:** It was moved by Mr. Riley, III and supported by Mr. McNamara approval of BA #21-45. S. Durant reporting. The Board Action is requesting approval of a two year contract, with two one year options for an amount not to exceed $100,000. Effective October 1, 2020, MDHHS discontinued the use of H0043 and mandated community living supports report under H2015. This mandate requires providers to bill using certain modifiers and associated rates based on the number of staff and consumers that reside in the home. In an effort to ensure residential providers are billing with the proper modifier/rate, DWIHN is required to perform payroll audits. In response to an Invitation For Bid (IFB), Gregory Terrell & Associates, a Detroit based minority accounting firm, was deemed the lowest bidder. The firm will assist with accumulating the staff hours and consumers in the home whereby DWIHN finance staff will evaluate whether the proper modifier/rate was used for reimbursement of services. The amount of the contract is estimated as the contract is based on hours billed; DWIHN has over 200 providers subject to audit. There was discussion regarding the experience and competency of the selected firm. **The motion carried unanimously.**

C. **BA #21-53** – HUD Permanent Supportive Housing – Coalition on Temporary Shelter (COTS) and Central City Integrated Health (CCIH). The Chair called for a motion. **Motion:** It was moved by Dr. Taueg and supported by Mr. Riley, III approval of BA#21-53. K. Flowers reporting. This Board Action is requesting approval to renew and disburse U.S. Department of Housing and Urban Development Supportive Housing funds for existing grant programs: Coalition on Temporary Shelter (COTS); Development Centers, Inc. (DCI), Central City Integrated Health (CCIH), Southwest Counseling Solutions and Wayne Metropolitan Community Action Agency. This Board action also recommends approval for the disbursement of the required local match to DCI/COTS and CCIH. Approval of this Board Action will allow for renewal, acceptance and disbursement of HUD Continuum of Care (CoC) permanent supportive housing grant funds and the DWIHN state general fund match. The Providers listed in this Board Action submitted applications for renewal to the local Continuum of Care and awaiting the NOFA (Notice of Funding Availability) and grant agreements from HUD. This Board Action is based off of the previous year's contract amount with the expectation of approval and renewal of the existing grants. This Board Action will be revised, if necessary, upon notification from HUD and/or the local Continuum of Care. These programs will continue to provide permanent supportive housing and supportive services to individuals and families in Detroit and Wayne County who have a serious mental illness/disability and are experiencing homelessness. There was no further discussion. **The motion carried unanimously.**

D. **BA# 21-54 –** Accuform Printing & Graphics, Inc. The Chair called for a motion. **Motion:** It was moved by Commissioner Killeen and supported by Ms. Brown approval of BA #21-54. B. Blackwell reporting. This Board action is requesting approval of a three -year contract for an amount not to exceed $358,420. There was an Information for Bid (IFB) and the purchasing department recommended the award to the lowest bidder, Accuform. The DWIHN's Customer Serviced Department is responsible for the development of printed educational materials for its mental health Members, new applicants, and the community at large. Per the Michigan Department of Health and Huan Services (MDHHS) Customer Service Standards, the DWIHN and its affiliates are required to provide Members with educational materials at the time of intake and at least on an annual basis. These materials are used for the education of Members on how to access mental health services and should be made available to Members upon request. Also, per the National Committee for Quality Assurance (NCQA) DWIHN is required to mail the Members Rights and Responsibilities Statement on a monthly and annual basis. The chosen vendor will be delegated the mail preparation and mailing of said document. There was no further discussion. **The motion carried unanimously.**

The Provider Presentation – Futures Health was deferred to the February Full Board meeting.

The Chair noted the agenda had been amended for the Board to go into closed session under Section 8 (a) of the Open Meetings Act to discuss a personnel issue**.** The Chair called for a motion to move into closed session.

PURPOSE OF CLOSED SESSON

It was moved by Commissioner Killeen and supported by Mr. Riley, III to move into closed session to discuss a Personnel matter under Section 8 (a) of the Open Meetings Act. A roll call vote was taken with Mr. Parker, Ms. Burrell; Mr. Riley, III; Commissioner Killeen; Ms. Ruth; Ms. Jawad; Dr. Taueg; Mr. McNamara and Ms. Brown voting yea. **Motion carried unanimously.** The Full Board went into closed session to discuss agenda item XIX. Personnel Matters at 2:48 p.m.

The Full Board requested to return to the public virtual meeting room. A motion was made by Dr. Taueg and supported by Commissioner Killeen to come out of closed session. **The motion carried unanimously.** The Full Board came out of closed session at 4:09 p.m.

REVIEW OF ACTION ITEMS
There was a request to present a financial reporting on the Health Plan Integration.

GOOD AND WELFARE/PUBLIC COMMENT
The Board Treasurer read the Good and Welfare/Public Comment statement. There was no public comment or Good and Welfare.

ADJOURNMENT
There being no further business, the Chair, Mr. Parker called for a motion to adjourn. **Motion:** It was moved by Mr. Riley, III and second by Ms. Brown to adjourn. **The motion carried unanimously and the meeting was adjourned at 4:21 p.m.**

Submitted by:
Lillian M. Blackshire
Board Liaison

FINANCE COMMITTEE

MINUTES **JANUARY 6, 2021** **1:00 P.M.** **VIRTUAL CONFERENCE(BLUEJEANS)**

MEETING CALLED BY	I. Commissioner Tim Killeen, Chair called the meeting to order at 1:04 p.m.
TYPE OF MEETING	Finance Committee Meeting
FACILITATOR	Commissioner Tim Killeen, Chair – Finance Committee
NOTE TAKER	Nicole Smith, Management Assistant
ATTENDEES	**Finance Committee Members Present:** Commissioner Tim Killeen, Chair Mr. McNamara, Vice Chair Ms. Dorothy Burrell Mr. Angelo Glenn **Committee Members Excused:** Ms. Dora Brown **Board Members Present:** Mr. Bernard Parker, Board Chair and Mr. William Riley, III **Board Members Excused:** None **Staff:** W. Brooks, CEO; E. Doeh, DCEO/COO; S. Durant, CFO; B. Blackwell, Chief of Staff; M. Singla, Chief Information Officer **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 Chair, Commissioner Killeen called for any Committee remarks. Mr. Glenn wished the committee, staff, and guests a Happy New Year. Mr. McNamara gave Thanks to the DWIHN staff for all their efforts in serving the community.

IV. Approval of Agenda
The Chair, Commissioner Killeen called for changes or corrections to the agenda. There were no changes to the agenda. The Chair called for a motion. **Motion:** It was moved by Mrs. Burrell and supported by Mr. McNamara approval of the agenda. **Motion carried.**

V. Follow-up Items: Items Follow-up
Item A: Update Operational Efficiency Plan (S. Durant) A written report was provided for the record and will be covered under the Finance Report.

VI. Approval of the Meeting Minutes

The Chair called for a motion on the Finance Committee minutes from the meeting of Wednesday, November 4, 2020. **Motion:** It was moved by Mr. Glenn and supported by Mr. McNamara approval of the Finance Committee minutes from the meeting of Wednesday, November 4, 2020. 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 for two months ending November 30, 2020 was provided for the record. Cash flow is very stable and should continue to remain stable throughout the year as liquidity ratio = 2.50. Authority Finance accomplishments and noteworthy items were as follows:

1. Finance team developed AMI Incentive payment model with two categories and at this time, upside risk only. The two categories are (1) top three performers and (2) reduction of hospital costs with FY18 and FY19 as the tiered base. Finance presented the model to DWIHN leadership and subsequently formed a provider group consisting of Hegira, SWCS and Team Inc. to review model for attainability and reasonableness. Although we will continue to work with providers on data integrity issues related to assignment of consumers to proper CRSP, we will move forward with the model as there is no penalty to either party and only a financial gain for both parties. On December 22, 2020, DWIHN submitted the incentive plan to MDHHS for approval. Mr. McNamara recommended a 3rd party vendor to monitor the funding program. Committee request presentation of the funding model. (Action)

2. In March 2020, DWIHN liquidated $7.5 million from investment managers. Based on current cash flow, DWIHN will restore the investment account in January 2021.

3. Effective October 1, 2019, DWIHN increased the Wayne County Jail per diem from $125 to $135. This increase was necessary to address the additional costs due to the pandemic. Retroactive payments to the providers were completed by the finance department June 2020. Discussion ensued at the request of Mr. Glenn regarding the purpose of the increase to providers. Staff E. Doeh explained the purpose was part of contract negotiations. Mr. Parker, Board Chair requested the CFO report the percentage of increase in per diem by March 2021 committee meeting. (Action)

4. To date, MDHHS has not responded to the Autism cost settlement or the 5% general fund carryover requested. At this point, DWIHN will proceed with the assumption that the general fund request has been approved. CFO will know the exact dollar amount in early February 2021 however the estimate is approximately $3 million. Based on the estimate, management will recommend increasing the Wayne County Jail allocation by $1.75 million.

5. DWIHN provided approximately $3.6 million to thirteen (13) Autism, skill building and supported employment providers based on the financial stability reports received from the providers. Essentially, DWIHN covered the operating losses of the providers and took into consideration all CARES funding received. CFO noted, funding was only for any losses obtained to providers, for DWIHN line of business.

6. DWIHN estimates the return of $4,665,809 in DCW premium pay to MDHHS. MDHHS requires PIHP's cost settle the DCW increase and return unspent funds. DWIHN paid out $17.6 million and received $22.3 million. DWIHN included a nominal contingency in the event additional claims are paid and require retroactive payment.

7. October and November Medicaid actual revenue received based on Milliman rates are higher than anticipated and upon receipt of December and January payment, Finance will

prepare budget adjustment accordingly. Committee requested when Board action is present to provide background on Milliman history. (Action)

8. On December 18, 2020, non-union staff were paid their merit increases which went up to five percent (5%) based on evaluations. In the past, non-union staff awaited the signed union contracts to receive merit pay. This practice could have a negative influence on union negotiation, and non -union increases are based on individual evaluations therefore CEO ceased practice.

9. HUD notified DWIHN that contracts are delayed therefore DWIHN will be unable to drawdown federal funds for several months. DWIHN contracts with providers and reimburses them despite the delay. Such contracts include the housing and homeless programs.

The Chair, Commissioner Killeen called for a motion on the Monthly Finance Report.
Motion: It was moved by Mr. McNamara and supported by Mr. Parker to accept the Monthly Finance Report. There was no further discussion. **Motion carried.**

VIII. 4th Quarter FY20 Board Report for Contracts $50,000 and Cooperative Purchasing
The 4th Quarter Procurement Report was presented by staff J. Mira, Procurement Administrator. The report was provided to the Finance Committee meeting and is included in the agenda packet for informational purposes. Noteworthy information includes purchasing percentages: Contract Percentage for Wayne County is 6.5% and Out of County is 93.5%; Funding Percentage w/o IT for Wayne County is 11.6% and Out of County is 88.4%. It was requested by the committee that a report be provided on a quarterly basis that shows the percentage of total purchases that come to the Board for approval compared to those that do not need Board approval. (Action)

The Chair called for a motion to accept the 4th Quarter Procurement Report. The motion was moved by Mr. McNamara and supported by Ms. Burrell. **Motion carried.**

X. Unfinished Business – Staff Recommendations:
a**. Board Action #20-26 (Revision 5):** DWIHN FY 2019-2020 Operating Budget – This board action is a modification to the FY 2020 Budget to reflect the certification of additional Medicaid totaling $12,966,704 to fully fund FY2020 payments to Direct Care Workers in the DWIHN system per approved BA 20- 06 R5 for the six-month period April 1 through September 30, 2020. In addition, the adjustment increases HRA revenue and expenses for $6 million to actual amounts received/disbursed for the year. HRA is pass through funding from MDHHS to the community hospitals based on days of stay. The board action was presented by staff S. Durant, CFO. Commissioner Killeen called for a motion on Board Action #20-26 (Revision5). **Motion**. It was moved by Ms. Burrell and supported by Mr. McNamara approval of Board Action #20-26 (Revision 5). **Motion carried.**

XI. New Business – Staff Recommendations:
a. **Board Action #21-51:** NexVortex Phone System – Request 3 yr. term for the procurement of additional services, software, modifications, programming, and maintenance to our phone system to support the added need due to in-house migration of the WellPlace call center. One time cost of 45,700.00, Monthly SIP/DID service cost (est) $1025.62 x 36 mo.= $36922.32, and Annual maintenance/support costs: $18,543.04 x 3 = $55629.12 for a total cost of $138.251.44. Board Action presented by staff M. Singla, Chief of Information Officer. Commissioner Killeen called for a

motion on Board Action #21-51. **Motion**. Moved by Ms. Burrell and supported by Mr. McNamara approval of Board Action #21-51. **Motion carried.**

b. **Board Action #21-52:** Gregory Terrell & Company – This board action is requesting the approval of a two-year contract, with two one-year options for an amount not to exceed $100,000. In response to an Invitation For Bid (IFB), Gregory Terrell & Associates, a Detroit based minority accounting firm, was deemed the lowest bidder. The firm will assist with accumulating the staff hours and consumers in the home. Board Action presented by staff S, Durant, CFO. Commissioner Killeen called for a motion on Board Action #21-52. **Motion**. Moved by Ms. Burrell and supported by Mr. McNamara approval of Board Action #21-52. **Motion carried.**

c. **Board Action #21-54:** Accuform Printing & Graphics – This board action is requesting the approval of a three (3) year contract for an amount not to exceed $358,420. There was an Information For Bid (IFB) and the purchasing department recommended the award to the lowest bidder, Accuform. The DWIHN's Customer Service Department is responsible for the development of printed educational materials for its mental health Members, new applicants, and the community at large. Board Action presented by staff B. Blackwell, Chief of Staff. Commissioner Killeen called for a motion on Board Action #21-54. **Motion**. Moved by Mr. McNamara and supported by Ms. Burrell approval of Board Action #21-54.
Motion carried.

XII. 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. Mr. McNamara gave acknowledgment of the tools provided to the committee members by DWIHN, such as the virtual meeting platforms, and requested all committee member use the tools provided to engage in the meetings.

XIII. Adjournment – There being no further business; the Chair called for a motion to adjourn. **Motion:** It was moved by Mr. McNamara and supported by Ms. Burrell to adjourn the meeting. **Motion carried**.

The meeting adjourned at 2:59 p.m.

FOLLOW-UP ITEMS	A. Provide a report that shows financial impact of transitioning to code 2015. Report should have its own section on financial report. CFO noted the report will only cover 30 days of billings. It was also noted the report should be given on a monthly basis. (S. Durant) B. CFO Durant to investigate to determine if CARES Act monies can be used for COVID-19 Building renovations – Board Action #21-49 COVID-19 Building Renovations. (S. Durant) C. Presentation of funding model by Steve Zawisa. (S. Durant) D. Board Chair requested the CFO report the percentage of increase in per diem by March 2021 committee meeting.

	E. Quarterly Procurement Report- Provide on a quarterly basis the percentage of total purchases that come to the Board for approval compared to those that do not need Board approval. (J. Mira)		

PROGRAM COMPLIANCE COMMITTEE

MINUTES **JANUARY 13, 2021** **1:00 P.M.** ***VIRTUAL MEETING***

MEETING CALLED BY	I. Dr. Iris Taylor, Program Compliance Chair at 1:00 p.m.
TYPE OF MEETING	Program Compliance Committee
FACILITATOR	Dr. Iris Taylor, Chair
NOTE TAKER	Sonya Davis
TIMEKEEPER	
ATTENDEES	**Committee Members:** Dr. Lynne Carter; Michelle Jawad; Chief William Riley, III; Kenya Ruth; Dr. Cynthia Taueg; and Dr. Iris Taylor **Staff:** Brooke Blackwell; Willie Brooks; Jacquelyn Davis; Eric Doeh; Nasr Doss; Kimberly Flowers; Shirley Hirsch; Bernard Hooper; Melissa Moody; Darlene Owens; Crystal Palmer; John Pascaretti; Ebony Reynolds; April Siebert; Manny Singla; Michele Vasconcellos; June White; and Nakia Young

AGENDA TOPICS

II. Moment of Silence

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

III. Roll Call

DISCUSSION	The Chair called for a roll call.
CONCLUSIONS	Roll call was taken by Board Liaison, Lillian Blackshire. There was a quorum.

IV. Approval of the Agenda

DISCUSSION/ CONCLUSIONS	The Chair called for approval of the agenda. **Motion:** It was moved by Chief Riley and supported by Dr. Taueg to approve the agenda. Dr. Taylor asked if there were any changes/modifications to the agenda. Dr. Taylor requested that Children's Redesign Update under "Reports" be moved to the first item on the agenda to ensure that they have enough time for discussion. **Motion:** It was moved by Chief Riley and supported by Mrs. Ruth to approve the agenda as amended. **Motion carried.**

V. Children's Redesign Update

DISCUSSION/ CONCLUSIONS	Eric Doeh, Deputy CEO and COO, Melissa Moody, Chief Clinical Officer, Ebony Reynolds, Clinical Officer of Clinical Practice Improvement and Crystal Palmer, Director of Children's Initiatives submitted and gave an update on the Children's Redesign. **A. Phase I (Increasing Accessibility-Prevention Services)** – Developed and finalized the mental health prevention training modules to address the four Identifiable Risks – Suicide; Anxiety/Depression; Dating Violence; and Bullying. A pre/post-test may be developed county-wide using a survey platform to collect data responses from students and staff attending each session. The primary focus is to purchase the Michigan Model for Health (MMH) to provide to the 11 Community Mental Health Agencies a comprehensive health education curriculum that targets Pre-K through 12th grade students utilizing a skilled-based approach. **B. Phase II (Enhance Partnerships)** - A letter communicating DWIHN services was distributed to the district superintendents by Wayne RESA's Associate Superintendent. School representatives have started reaching out to gain more insight to the School Success Initiatives' purpose, goals and services. Nine providers are interested in expanding services in a variety of ways within the Detroit Public Schools Community District (DPSCD) and Syllabi has been presented to DPSCD and is awaiting approval. DWIHN is collaborating with hospital/clinics to identify a structure and referral network process. DWIHN is also collaborating with other CMHs to develop and implement a curriculum to roll out to schools within Wayne County. **C. Phase III (Identifying Deliverables and Measurables)** – Staff will be reviewing and modifying our current databases for children's services; survey CMH agency involvement in Wayne County Schools in order to create the best plan to implement the rollout of the curriculum; and developing a baseline to determine the number of schools receiving services and what services are being delivered. A PowerPoint presentation on Bullying will be presented as one of the curriculums and modules for the Children's Redesign. Discussion ensued. Dr. Taylor opened the floor for further discussion. The committee requested that the Children's Redesign Update be moved to the Executive Committee for review and then to Full Board for final approval. (Action) The Chair called for a motion to move the Children's Redesign update to the Executive Committee for review and then to Full Board for final approval. Motion: It was moved by Chief Riley and supported by Mrs. Ruth to move the Children's Redesign to Executive Committee for review and then to Full Board for final approval. **Motion carried.**

VI. Follow-Up Items from Previous Meetings

DISCUSSION/ CONCLUSIONS	A. **COVID Update** – Darlene Owens, Director of Substance Use Disorder submitted and gave an update on SUD COVID. Ms. Owens reported that in the first quarter the number of staff that tested positive went up but the number of deaths were down. B. **Year-End Reports** 1. **Customer Service** – Provide a summary of the provider satisfaction surveys administered to the providers and practitioners. Michele Vasconcellos,

	Director of Customer Service submitted and gave an update on the provider satisfaction surveys administered to the providers and practitioners. Ms. Vasconcellos reported that the survey was administered during the month of September 2020. It is designed to measure DWIHN's contracted provider organizations and practitioner's assessment of its' performances. It was distributed to approximately 450 provider organizations and approximately 2,000 individual practitioners. The response rate increased by 25% but was still below the targeted rate of 50%-75% participation. An ad-hoc group is scheduled to meet on January 22, 2021 to review the FY 2019 and 2020 survey results, survey tool as well as the specific requests for improvement submitted by providers/practitioners as noted in the comment section. 2. **Integrated Health Care** – Provide a breakdown of referrals by ICOs – Kim Flowers, Provider Network Clinical Officer submitted and gave a breakdown of referrals by ICOs. DWIHN received 5, 137 MI Health Link referrals from the five Integrated Care Organizations (ICO) during FY 2020. **A.** Aetna – 210 (4%); **B.** AmeriHealth – 91 (2%); **C.** HAP – 91 (2%); **D.** Michigan Complete Health – 204 (4%); and **E.** Molina - 4560 (88%) Michigan Complete Health restructured internally and submitted their referrals via secure fax during FY 2020. The other ICOs submitted their referrals electronically to DWIHN. Discussion ensued. The Committee requested that staff pull out duplicative number of ICO referrals that were sent and counted and report back the correct number of referrals to the committee at next month's meeting. **(Action)**

VII. Approval of Meeting Minutes

DISCUSSION/ CONCLUSIONS	The Chair called for approval of the November 12, 2020 meeting minutes. **Motion:** It was moved by Ms. Jawad and supported by Dr. Carter to approve the November 12, 2020 meeting minutes. Dr. Taylor asked if there were any changes/modifications to the meeting minutes. There were no changes/modifications to the meeting minutes. **Motion carried.**

VIII. Reports

DISCUSSION/ CONCLUSIONS	A. **Corporate Compliance Report** - Bernard Hooper, Director of Corporate Compliance submitted and gave an update on the Corporate Compliance report: 1. **HAP ICO Plan of Correction** – The Compliance Audit Plan will be completed on or before January 15, 2021 and will be submitted to HAP along with other final documents for the Plan of Correction associated with the 2020 Annual Compliance Review. 2. **DWIHN Compliance Committee** - The FY 20-21 Annual Risk Assessment was presented to the Compliance Committee on December 21, 2020. The Assessment comprises risks identified as a result of the HSAG and ICO audits as well as in preparation for the pending NCQA review. The Assessment is also the basis for the development of the Compliance Audit Plan. 3. **Attorney General Consultation regarding DWIHN's investigations of Harbor Oaks Hospital** – Mr. Hooper consulted with the Attorney General's Office on several audits and monitoring actions conducted by DWIHN

	regarding the operations of Harbor Oaks Hospital. The Attorney General's Office has indicated that no further action is required by DWIHN in this matter. The Chair called for a motion to accept the Corporate Compliance report. **Motion:** It was moved by Chief Riley and supported by Dr. Carter to accept the Corporate Compliance report. Dr. Taylor opened the floor for discussion. There was no discussion. **Motion carried.** B. **Utilization Management's Quarterly Report** - John Pascaretti, Director of Utilization Management submitted and gave an update on the Utilization Management's quarterly report. DWIHN has filled 1,058 slots (97.6%) out of 1, 084 assigned slots for the Habilitation Supports Waiver. The Chair called for a motion to accept the Utilization Management quarterly report. **Motion:** It was moved by Chief Riley and supported by Dr. Carter to accept Utilization Management quarterly report. Dr. Taylor opened the floor for discussion. There was no discussion. **Motion carried.**

IX. Utilization Management Review(s)

DISCUSSION/ CONCLUSIONS	A. **Annual Utilization Management (UM) Program Evaluation FY 2020** – The UM Program Goals were aligned with and evaluated using the Strategic Plan Pillars of Access, Finance, Quality, Customer, Workforce Development and Advocacy. There were eight UM Program Goals in FY 20. Six goals were partially met and two goals have room for improvement. The committee requested that the correct fiscal year be added before going to Full Board for approval. (Action) B. **Utilization Management (UM) Program Description FY 2019-2021** – The UM Program Description was reviewed and approved with no changes at the Utilization Management Committee on December 15, 2020. The Chair called for a motion to accept the Annual Utilization Management Program Evaluation FY 2020 and the Utilization Management Program Description FY 2019-2021. **Motion:** It was moved by Chief Riley and supported by Dr. Carter to accept the Annual Utilization Management Program Evaluation FY 2020 and the Utilization Management Program Description FY 2019-2021. **Motion carried.**

X. Strategic Plan – Access Pillar

DISCUSSION/ CONCLUSIONS	***The Strategic Plan – Access Pillar was deferred to the February 10, 2021 Program Compliance Committee meeting.***

XI. RFP/RFQ Work Plan Questionnaire – Autism Spectrum Disorder (ASD) ABA

DISCUSSION/ CONCLUSIONS	Ebony Reynolds, Clinical Officer of Clinical Practice Improvement submitted and reported on RFP/RFQ Work Plan Questionnaire – Autism Spectrum Disorder (ASD) Applied Behavior Analysis (ABA). Ms. Reynolds reported that there has been an increased interest from more providers delivering this service along with some smaller organizations closing their ABA programs. Therefore, there is a need to procure these services to ensure DWIHN has the most qualified providers delivering these services across Wayne County who are able to sustain this program with the

	rates identified by DWIHN and to cover service gaps. The Chair called for a motion to accept the RFP/RFQ Work Plan Questionnaire – Autism Spectrum Disorder (ASD) ABA. **Motion:** It was moved by Chief Riley and supported by Dr. Carter to accept the RFP/RFQ Work Plan Questionnaire – Autism Spectrum Disorder (ASD) ABA. Dr. Taylor opened the floor for discussion. Discussion ensued. **Motion carried.**

XII. Quality Review(s)

DISCUSSION/ CONCLUSIONS	**A. QAPIP Description Plan (October 2020 – September 2022)** – April Siebert, Director of Quality Improvement submitted and gave a report on the QAPIP Description Plan (October 2020 – September 2022). Ms. Siebert reported that The Michigan Department of Health and Human Services (MDHHS) requires that each PIHP has a documented Quality Assurance and Improvement Plan (QAPIP) that meets required federal regulations. The QAPIP Program Description is a two-year plan and it covers FY 2020-2021 and FY 2021-22. The Description defines the program purpose, structure and the framework of DWIHN's Mission, Vision and Values. There were very few updates from the previous year that was made to the QAPIP. The updates made were to ensure the QAPIP aligns with NCQA focus areas (Quality and Safety of Clinical Care; Quality of Service; and Member Experience). The Chair called for a motion to accept the QAPIP Description Plan (October 2020 – September 2022). **Motion:** It was moved by Dr. Carter and supported by Chief Riley to accept the QAPIP Description Plan (October 2020 – September 2022). Dr. Taylor opened the floor for discussion. There was no discussion. **Motion carried.**

XIII. Chief Clinical Officer's (CCO) Report

DISCUSSION/ CONCLUSIONS	Melissa Moody, Chief Clinical Officer submitted a full report and gave highlights on the Chief Clinical Officer's report. Mrs. Moody reported that: 1. **COVID-19 and Inpatient Psychiatric Hospitalization** - Hospitalization data showed an increase in admissions for the month of November by approximately 11%, but then a decrease in December by 13%. There were six reported cases of COVID-19 Inpatient in November and an additional six reported cases of COVID-19 Inpatient in December. 2. **COVID-19 Intensive Crisis Stabilization Services** – COPE had an increase for the months of November (212 served) and December (219 served); and Team Wellness had a decrease in the month of November (34 served) but an increase for the month of December (57 served). 3. **COVID-19 Pre-Placement Housing** – There were more residential options and homes for the months of November and December. There was an increase in December of COVID-19 positive or symptomatic cases. 4. **Residential Department Report of COVID-19 Impact** – From 3/30/20 to 12/3120, 221 positive cases were reported and 35 reported deaths. 5. **COVID-19 Recovery Housing/Recovery Support Services** – There were nine (9) clients served in the month of November and 13 clients served in the month of December for Quality Behavioral Health; and eight (8) served in the month of November and 9 clients served in the month of December for the Detroit Rescue Mission Ministries (DRMM).

	6. **Michigan COVID-19 Update** – In an effort to reach the goal of having at least 70% of Michigan residents vaccinated, Michigan has now moved into the next phase of COVID-19 vaccinations: Phase 1C (Group A): Persons 65-74 years of age and pre-k teachers and childcare providers. The Chair called for a motion to accept the Chief Clinical Officer's report. **Motion:** It was moved by Chief Riley and supported by Dr. Carter to accept the Chief Clinical Officer's Report. Dr. Taylor opened the floor for discussion. The committee requested the number of staff in residential homes that have received the COVID-19 vaccine. (Action) **Motion carried.**

XIV. Unfinished Business

DISCUSSION/ CONCLUSIONS	A. **BA# 21-23 (Revised) –** Provider Network System – The Chair called for a motion on BA #21-23 (Revised). **Motion:** It was moved by Chief Riley and supported by Dr. Carter to move BA #21-23 (Revised) to Full Board for approval. Staff requesting approval for this revised board action to include Genoa Healthcare, LLC (formerly known as Advance Care) to the DWIHN's Network Provider system. Dr. Taylor opened the floor for discussion. There was no discussion. **Motion carried.** B. **BA #21-40 (Revised)** – School Success Initiatives – The Chair called for a motion on BA #21-40 (Revised). Discussion ensued. The committee had concerns that the content in the board action was too generic and should include how the money will be distributed. Staff requested that the board action be deferred and brought back next month with the requested changes. **Motion:** It was moved by Chief Riley and supported by Dr. Carter to defer BA #21-40 (Revised) to next month's Program Compliance Committee meeting. Dr. Taylor opened the floor for discussion. There was no discussion. **Motion carried.**

XV. New Business: Staff Recommendation(s) -

DISCUSSION/ CONCLUSIONS	A. **BA# 21-53** – HUD Permanent Supporting Housing – Coalition on Temporary Shelter (COTS) and Central City Integrated Health (CCIH) –The Chair called for a motion on BA #21-53. **Motion:** It was moved by Dr. Carter and supported by Chief Riley to move BA #21-53 to Full Board for approval. Staff requesting board approval to renew and disburse U.S. Department of Housing and Urban Development (HUD) Supportive Housing funds for existing grant programs (Coalition on Temporary Shelter (COTS); Development Centers, Inc. (DCI); Central City Integrated Health (CCIH); Southwest Counseling Solutions; and Wayne Metropolitan Community Action Agency). Dr. Taylor opened the floor for discussion. There was no discussion. **Motion carried.**

XVI. Good and Welfare/Public Comment

DISCUSSION/ CONCLUSIONS	The Chair asked if there were any Good and Welfare/Public Comment. There was no Good and Welfare/Public Comment.

ACTION ITEMS	Responsible Person	Due Date
1. Children's Redesign Update – Move the Children's Redesign update to the Executive Committee for review and then to Full Board for final approval.	Lillian Blackshire	**TBD**
2. Follow-Up Items from Previous Meeting: **A. Integrated Health Care** - Pull out duplicative number of ICO referrals that were sent and counted and report the correct number of referrals to the committee at next month's meeting.	Kim Flowers	**February 10, 2021**
3. Utilization Management Review: **A. Annual Utilization Management (UM) Program Evaluation FY 2020** –Correct fiscal year on document before going to Full Board for approval.	John Pascaretti	**COMPLETED**
4. Chief Clinical Officer's Report - Provide the number of staff in residential homes that have received the COVID vaccine.	Melissa Moody	**February 10, 2021**

The Chair called for a motion to adjourn the meeting. **Motion:** It was moved by Chief Riley and supported by Dr. Carter to adjourn the meeting. **Motion carried.**

ADJOURNED: 2:57 p.m.
NEXT MEETING: Wednesday, February 10, 2021 at 1:00 p.m. ***(Virtual Meeting)***

PAA PUBLIC AFFAIRS associates
REPUTATION MATTERS

120 N. Washington Square, Suite 1050, Lansing, MI 48933 | (517) 371-3800 www.paaonline.com

MEMORANDUM

TO: Hon. Bernard Parker, Chairperson, DWIHN Board of Directors
Members, DWIHN Board of Directors
Willie Brooks, President & CEO, DWIHN

FROM: Public Affairs Associates, LLC.

DATE: February 17, 2021

RE: Michigan Issue Advocacy Board Summary (January – February 2021)

The following is an updated summary of the issues/activities being monitored by DWIHN's lobbying teams:

I. POLITICAL ENVIRONMENT

NEW LEADERS OPEN 2021-22 LEGISLATIVE SESSION

With stringent COVID-19 protocols in place, the Michigan State Legislature opened its 2021-22 Session on January 5, 2021. New Speaker of the House Rep. Jason Wentworth (R – Farwell) will hold the gavel for the next two years, while the Democratic Caucus will be led by 3rd termer Rep. Donna Lasinski (D – Scio Twp.). In the Michigan Senate, Sens. Mike Shirkey (R – Clarklake) and Jim Ananich (D – Flint) will maintain their roles as Majority Leader and Minority Leader, respectively.

While the nation is gripped in political turmoil, it is at even a higher fervor here in Michigan. Following the elections that basically maintained the status quo in state government, other than giving the Democrats a majority on the Supreme Court, there was a prolonged fight over certifying the presidential election results and challenges to the legitimacy of the November Election. In the end, the legislature acknowledged the results but not without a lot of political infighting.

Moving into 2021, the environment has not improved much. Between business and school shutdowns and continuing investigation in the 2020 election process there has been little accomplished. The Republican controlled legislature has said they will not approve Covid-19 funding

without the Governor giving up some of her power in ordering shutdowns of various industries, schools and athletics. The Governor has said repeatedly she has no plans to relinquish any of those powers.

While tensions are high, there is some hope that both sides will come together to some extent and this was shown in the Governors State of State speech that focused in part on unity. While there may be some hope for unity, most are expecting a drawn out battle over Covid-19 relief funding, appointments, and budgets. It is unclear what this will mean for other legislative priorities in the early months of session in 2021.

II. LEGISLATIVE/ADMINISTRATIVE ENVIRONMENT

SENATE SET TO REVIEW WHITMER'S MDHHS DIRECTOR NOMINATION

After being selected by Governor Whitmer to replace former Michigan Department of Health and Human Services (MDHHS) Director Robert Gordon, Elizabeth Hertel's nomination will be reviewed by the Senate Committee on Advice and Consent on February 25th. Hertel, formerly the department's Senior Chief Deputy Director for Administration, is unlikely to be rejected by the Senate despite the ongoing conflict between GOP legislators and the governor's office regarding COVID-19 restrictions.

GOVERNOR DELIVERS VIRTUAL STATE OF THE STATE ADDRESS

Governor Gretchen Whitmer delivered her third State of the State address (albeit a bit differently from years past) on Wednesday, January 27th. Due to COVID-19 precautions, Whitmer decided to deliver this year's address virtually. In her speech, the governor announced Michigan Back to Work: her plan to help grow our economy and get Michiganders back on their feet. Over the next year, the Whitmer Administration will announce initiatives and projects big and small – from tech, mobility and manufacturing growth, to clean energy and road construction.

Other Highlights from Governor Whitmer's Address:

1. BIPARTISAN ACCOMPLISHMENTS: Governor Whitmer highlighted a number of bipartisan actions she took with the Republican legislature last year, including signing two bipartisan budgets, creating the bipartisan Michigan Reconnect Program, and passing and signing historic Clean Slate legislation to make Michigan's criminal justice system more fair.

2. MI COVID RECOVERY PLAN: Governor Whitmer called on the Michigan Legislature to work with her to pass the Michigan COVID Recovery plan focused on distributing vaccines, getting our kids back on track, supporting small businesses, and jumpstarting our economy. The governor's plan will support small businesses long after the pandemic is over. The governor's

MI COVID Recovery Plan includes a call on the Michigan Legislature to permanently extend unemployment benefits from 20 weeks to 26 weeks.

3. FUNDING FOR LOCAL ROADS: Governor Whitmer called on the Michigan legislature to work with her to provide local communities more options to fix local roads and bridges, which has received bipartisan support. Last year, Governor Whitmer announced the Rebuilding Michigan Bonding Plan to create and sustain tens of thousands of jobs and start fixing the damn roads without an increase at the pump. Since then, our hardworking construction workers have completed the I-496 Rebuilding Michigan project in November, with hundreds of more projects on the horizon, Including heavily traveled sections of I-96 in Oakland County, I-69 in Calhoun County and I-94 in Berrien County.

4. MI CLASSROOM HEROES: The governor announced the MI Classroom Heroes grants of up to $500 each for teachers and support staff. These grants will go out in February, and will help offset some expenses and the extraordinary efforts Michigan's educators have made throughout the pandemic.

5. GOOD JOBS FOR MICHIGAN: The governor called on the legislature to pass Good Jobs for Michigan legislation to retain and grow our businesses and create jobs. Pfizer was the first business to utilize Good Jobs for Michigan, and did so to build their sterile drug manufacturing plant and create 450 good-paying jobs in Portage. Passing this legislation will be good for our families, our businesses, and our economy. Let's get it done.

6. MI CLEAN WATER: The governor called on the legislature to pass the MI Clean Water plan, a $500 million comprehensive water investment in Michigan's water infrastructure that she announced last year. MI Clean Water will direct dollars to communities for safe, clean water to residents and expanding green infrastructure, and it supports over 7,500 Michigan jobs.

7. LOWERING THE COST OF PRESCRIPTION DRUGS: The bipartisan Prescription Drug Task Force that the governor announced last year has developed a plan to lower prescription drug costs and create more transparency in how drugs are priced. The governor announced that members of her cabinet worked with bipartisan, bicameral members of the legislature to support legislation that requires transparency, holds accountable those profiting from skyrocketing prices, and makes necessary medications affordable for all Michigan families. She called on the legislature to pass this legislation and send it to her desk.

8. FIXING THE DAMN ROAD AHEAD: The governor announced the "Fixing the Damn Road Ahead" tour to engage with and learn from Michigan voters – whether they're Democrats, Republicans, or Independents. She will engage with people across the state to focus on what unites us, improve how we talk to each other, and fix the damn road ahead.

To review Governor Whitmer's full State of the State remarks, click here.

WHITMER PRESENTS FY 2021-22 BUDGET

Following better than expected state revenues, Governor Whitmer presented her FY 2021-22 budget to the legislature on Thursday, February 11th. The Governor's third executive budget is centered around equitably growing the state's economy by expanding skills training and childcare for families, providing a further down payment on rebuilding the state's crumbling bridges and water infrastructure, and helping small businesses recover from the pandemic. According to the Governor, the budget recommendation provides investments that will foster the success of Michigan students and teachers, improve the state's infrastructure, address the public health crisis, protect our Great Lakes, and provide help and opportunity for families and businesses. To review an itemized summary of the Governor's key budget recommendations, click here.
The outlook for the state budget improved significantly over the last few months, as federal stimulus and online retail have helped soften the COVID-19 virus' economic impact, with the state's current FY 2021 revenues totaling $1.2 billion more than August projections. FY 2021 estimates expect the state's FY 2021-22 general fund and school aid fund revenue to total $24.8 billion, a 3.3% increase from FY 2020-21.

CORONAVIRUS UPDATE

Governor Whitmer's Michigan Coronavirus Task Force on Racial Disparities "Making Lasting Structural Change"

- A recent study by the Duke-Margolis Center for Health Policy and the National Governors Association Center for Best Practices found that Governor Whitmer's Michigan Coronavirus Task Force on Racial Disparities, which is led by Lt. Governor Garlin Gilchrist II, has made significant and sustainable progress towards its goal of reducing health-based racial disparities associated with the COVID-19 pandemic.
- The study also recommended that the lessons learned from the Michigan Coronavirus Task Force on Racial Disparities "can be applied in states and territories across the nation to address this longstanding and difficult challenge."
- The **case study** found that Governor Whitmer and the Michigan Task Force have substantially reduced the number of confirmed and probable COVID-19 deaths among Michiganders of color. Additionally, under Governor Whitmer's leadership, racism was declared a statewide public health crisis, six million free masks were distributed, more than 24,000 free COVID-19 tests were administered in underserved communities, and 30 community organizations were funded to address community needs.

Social Vulnerability Index (SVI) and COVID-19?

- Part of **Michigan's COVID-19 Vaccination Strategy** includes a high priority focus on achieving zero disparity in vaccination rates across racial and ethnic groups or by social vulnerability index.

- The Social Vulnerability Index (SVI) is a tool that uses census data to identify and map places where a community may have more difficulty preventing human suffering and financial loss in a disaster.
- The SVI includes vulnerabilities related to socioeconomic status, family composition & disability, minority status & language minority, and housing type & transportation.
- Vaccine administrators use the SVI to develop targeted outreach strategies while planning vaccine clinics. A summary of this information is available **here** on the MDHHS's vaccine website at **www.michigan.gov/COVIDvaccine**.

Vaccinations:

- Michigan has distributed 2,022,350 total vaccines and administered 1,339,129 vaccine doses including 968,542 first doses and 370,587 second doses.
- Included in the above, under the Federal Long-Term Care Pharmacy Program a total of 146,376 total vaccines have been administered in Michigan.
- The percent of total doses administered in Michigan is 66% as compared to 69% nationally. The percent of Michigan controlled doses administered is 78%.
- The percent of people in Michigan who are fully vaccinated is 3.7% as compared to 3.0% nationally.
- Newly announced, the Federal Retail Pharmacy Program has started delivering vaccine directly to retail pharmacies in Michigan including Rite Aid, Meijer and Cardinal Pharmacy. Meijer has plans to administer up to 25,000 COVID-19 vaccine doses by the end of this week to people 65 years and older who have pre-registered with Meijer.

New Cases

- The number of confirmed coronavirus cases has risen to 569,980 as of Tuesday. This includes 563 new confirmed cases.
- The daily case total is Michigan's lowest since Sept. 22, and the first time a single day has had fewer than 1,000 cases since Oct. 6.

Deaths

- Sixty additional COVID-19 deaths were reported Tuesday including 31 from a Vital Records Review.
- The total number of confirmed COVID-19 deaths is 14,965.

Hospitalizations

- With 1,165 confirmed or suspected COVID-19 patients, hospitalizations continue to decline.

Testing

- Testing has been steady with more than 40,000 diagnostic tests reported per day on average.
- The 7-day percent positivity rate stands at 4.0%.

Visit **Michigan's COVID-19 Response** page and the **COVID-19 Vaccine Dashboard** for Michigan's response and vaccine data. **F**or the most recent information on the vaccine in Michigan visit **Michigan.gov/COVIDVaccine** to get your questions answered, access the state's vaccine data, attend an upcoming town hall and view guidance, resources, strategies and materials.

For more information on the MDHHS orders, click on the following links:

Full Gatherings order: https://www.michigan.gov/documents/coronavirus/2021.01.22_Masks_and_Gatherings_order_713774_7.pdf

Indoor Dining Guidelines: https://www.michigan.gov/documents/coronavirus/Indoor_Dining_Guidelines_v7_713766_7.pdf

III. **LEGISLATIVE/ADMINISTRATIVE ISSUES** – Below is a summary of some of the policy issues that are encountering some movement within the State Legislature:

MENTAL HEALTH LEGISLATION

Any bill that failed to pass both chambers died once the Legislature adjourned its 2019-20 session. Some of the bills from last session have already been reintroduced in the 2021-22 session. Below are mental health-related bills that have been introduced and assigned to committee:

SB 0101 of 2021	Senate Bill	Mental health: other; mental health transport for involuntary psych hospitalization; create standards and licensing requirements for.
HB 4043 of 2021	House Bill	Mental health: other; information gathered by the electronic inpatient bed registry; require to be reported to the Michigan crisis and access line.
HB 4044 of 2021	House Bill	Mental health: other; state-operated registries related to mental health; require to report data to the Michigan crisis and access line.
HB 4045 of 2021	House Bill	Corrections: other; mental health discharge planning; provide for.
HB 4057 of 2021	House Bill	Mental health: other; definition of restraint; expand.

2021-22 ADVOCACY GOALS

To review PAA's comprehensive 2021-22 plan of work for DWIHN, click here. Below is a general summary of our legislative/administrative advocacy goals:

I. Overall Advocacy Goals
- Position DWIHN as the leading voice in Michigan on community mental health service delivery and funding
- Educate stakeholders on the importance of maintaining a public vs. a private mental health system
- Ensure DWMHA's funding is not negatively impacted by future changes to the state's mental health funding methodology

II. Committed to identifying mutually-beneficial partnerships and collaboration with like-minded advocacy interests, including improved collaborative efforts in the following areas:
- Addressing mental health issues related to the State's Coronavirus mitigation efforts
- Addressing mental illness in our corrections system
- Combating mental illness, substance use and trauma within the school systems
- Community crisis needs & reducing emergency room visits
- Reducing the cost of inpatient care
- Monitor and address homelessness within the community
- Addressing suicide & mortality rates

III. Secure the appropriation of resources to adequately and equitably fund the State's community mental health system and its COVID-relief efforts.

IV. Support the enactment of transformational policies that support a self-determined and recovery-oriented mental health system that provides and manages an array of supports, services, and treatment which honors choice, dignity and advances the quality of life for persons served, their families and supports community inclusion.

Detroit Wayne
Integrated Health Network
707 W. Milwaukee St.
Detroit, MI 48202-2943
Phone: (313) 833-2500
www.dwihn.org

FAX: (313) 833-2156
TDD: (800) 630-1044 RR/TDD: (888) 339-5588

Tri-County Virtual Metro Region Meeting

Detroit Wayne Integrated Health Network

Thursday, February 18, 2021
6:00 p.m. – 8:30 p.m.
AGENDA

I. Welcome and Introductions (6:00 p.m. to 6:15 p.m.)
   Eric Doeh, Deputy CEO
   Bernard Parker, Board Chair

II. Legislative Update - CMHAM, Alan Bolter (6:15 p.m. to 6:25 p.m.)

III. CEO Updates (10 minutes each) (6:25 p.m. to 6:55 p.m.)
   a. Dana Lasenby, OCHN
   b. Dave Pankotai, MCCMH
   c. Eric Doeh, DWIHN

IV. Current Challenges & Issues Open Discussion: (6:55 p.m. to 7:45 p.m.)
   a. Changes in Procedure Codes
   b. Telehealth
   c. COVID Concerns / Addressing Population Needs

V. Integration Open Discussion – Behavioral Health Structure (7:45 p.m. to 8:30 p.m.)

VI. Adjournment

METRO REGION MEETING

Hosted by Detroit Wayne Integrated Health Network

Thursday, February 18, 2021

6:00 P.M.

VIRTUAL

To access the Metro Region meeting please use the link below:

JOIN as PRESENTER

(If the join button above doesn't work, please click on the link below, or copy and paste it into your browser)

https://primetime.bluejeans.com/a2m/live-event/dcepfxgq

To Join by Phone: 1 (408) 740-7256
Meeting ID: 528 451 086#
Passcode: 8226#

If there is an agenda item you would like included, or if you have any questions, please contact Lillian Blackshire at lblackshire@dwihn.org.

NATIONAL COUNCIL
FOR BEHAVIORAL HEALTH

Registration for NatCon21 – the most anticipated conference in mental health and addiction treatment – **opens next week**! Join us from May 3-5 for the learning event of 2021.

The health care landscape is changing – we can help you change with it. Personalize your learning journey at NatCon21 by taking advantage of our can't-be-matched curriculum.

Get solutions to pressing issues, discover how to supercharge your service delivery and contribute to forward-looking conversations on topics that matter to you, including:

- The role of the new administration in the future of health care.
- The ripple effects of the COVID-19 pandemic on community health and wellness.
- The latest innovations and technologies to accelerate your impact.
- The importance of caring for caregivers post-pandemic.
- The fight to end social injustices in health care.

Get your calendar ready, have a marker within reach and watch for our email next week! We look forward to seeing you and 6,000+ of your colleagues at NatCon21.

Registration Now Open: 2021 Mackinac Policy Conference

Registration is now open for the **2021 Mackinac Policy Conference**. Held at the historic Grand Hotel on Mackinac Island from **Monday, Sept. 20 to Thursday, Sept. 23**, the Conference will bring nationally recognized speakers and statewide thought leaders together to discuss driving Michigan's economic recovery and growth following the COVID-19 pandemic.

The 2021 Conference Chairman **Wright L. Lassiter III**, president and CEO of Henry Ford Health System, will lead a planning committee of CEOs from across the state. The committee's work will ensure the Conference tackles critical issues, while also guaranteeing a safe and comfortable environment for attendees.

For future speaker, agenda, and program announcements, visit **detroitchamber.com/mpc**. Grand Hotel and other island hotels will begin taking reservations in **March 2021**.

.

Detroit Wayne
Integrated Health Network
707 W. Milwaukee St.
Detroit, MI 48202-2943
Phone: (313) 833-2500
www.dwihn.org

FAX: (313) 833-2156
TDD: (800) 630-1044 RR/TDD: (888) 339-5588

Angelo Glenn, Chair

Substance Use Disorder (SUD) Oversight Policy Board (OPB)

Monday February 15, 2021 Report

Board Reports

a. Stay Well Presentation, Krystal Reyes, Neighborhood Services Organization
b. PA 2 Update, Stacie Durant, Chief Financial Officer
c. SUD Stability Plan, Stacie Durant, Chief Financial Officer

Old Business

Board Action (1) SUD Provider Contracts

The SUD Department recommended board approval for Prevention, Treatment, and Recovery providers' contract for fiscal year 2021. The approval was for Block Grant funded Prevention Services programs for $430,000.00.

The SUD Director was informed by finance that the unallocated amount was $300,000. Therefore, it was recommended by the CFO to adjust each provider by 35% to be equitable and fair. This is a revision to January's board meeting.

The providers listed below would receive if approved by both boards the allocated amounts. This will have to go before the PCC Committee and the Governance Board in March 2021. **This board action was approved.**

New Allocations

Care of Southeast Michigan $
Chance For Life $
Detroit Association of Black Organizations (DABO) $
Leaders Advancing and Helping Communities (LAHC) $
The Youth Connection $

Board Action (2) SUD Provider Contracts

The SUD Department is recommended $45,000. in PA 2 funding for women specialty services for SHAR House for Prevention, Treatment, and Recovery providers' contract for fiscal year 2021. The approval is for women with children room and board cost, childcare for women while in treatment or receiving primary medical care services; or pediatric care for a child; acupuncture as appropriate; Progressive Muscle Relaxation as appropriate; EFT Tapping Procedure as appropriate; Transportation to treatment, medical and therapeutic interventions for the parent and child only.

This board action was denied as SHAR House did not write on WSS services in their RFP. As a result, SHAR is unable to add on this sub-contractor service.

New Business

None

Informational

SUD Director's Report
Prevention Services Manager Report
Treatment Services Administrator Report
State opioid Response (SOR) Coordinator Report

Submitted by Chair Angelo Glenn

Board of Director's Report
Willie E. Brooks, Jr.
February 2021

Jail Diversion

Jail Diversion Projects
Updates on the two (2) Jail Diversion projects that I represent.

Committee 1: Governor's Mental Health Diversion Council
I received notification of reappointed to the Governor's Mental Health Diversion Council for a second four (4) year term effective February 1, 2020.

Action Plan for Upcoming Year

- Strengthen and expand preemptive diversion by fostering community support services.
- Strengthen and expand law enforcement diversion for individuals with mental illness and co-occurring conditions upon initial encounter.
- Develop strategies to deliver treatment and divert individuals prior to first court appearance.
- Develop strategies to deliver treatment and divert individuals after first court appearance up to and including disposition.
- Improve re-entry outcomes, by enhancing pre-release planning, individualized connections and follow up supports between institutions and community services
- Promote and implement a continuum of care that enables the individual to maintain long-term community stability to reduce recidivism.
- Oversight and implementation of statewide pilot initiatives and administering best practices through data collected.
- Identify statutory, policy and fiscal barriers to achieving diversion goals.
- Identify specific best practices at each intercept point to create a statewide master model.
- Follow up statewide knowledge sharing conference to share Diversion Council findings and promote technical assistance from the Center for Behavioral Health and Justice

The Diversion Committee is focused on partnerships with Mental Health Agencies and Law Enforcement Agencies. DWIHN communicated the Detroit Police Department partnership to the council for future plans of expansion to throughout the Wayne County area and the state.

Meeting Updates:

- Courts are experimenting with having remote jury trials in result to the pandemic
- Vaccines are rolling out state wide. It is important for communities to speak put on lack of vaccine availability, site availability and any disparities.
- Juvenile Justice Report: Continued progress with Youth Advocate programs.

- Continuing Juvenile Urgent Response Team (JURT) pilots are now at two sites. Continued the pilot work with the three pilots for trauma focused, CBT, and strong family's program. Going to have presentation by each group in March and April in the subcommittee. More info forthcoming. Those interested can join.
- Significant participation in the juvenile competency stakeholder training this past Fall due to overwhelming response, two more sessions are being offered this spring. Greater participation rate from those who work in the courts due to virtual. Two more sessions offered at the end of April. Juvenile Competency training will be held in May. Hoping to video that training.
- Legislation - SB681 makes changes to eligibility of juveniles to obtain expungement of their records. SB682 – juvenile court records to be confidential.
- The Council is evaluating opportunities for investment in jail and youth pilot projects

Committee 2: Wayne County Diversion Council (WCDC)
Chief Wayne County Probate Court Judge Freddie G. Burton, Jr. heads this program. The Wayne County Diversion Council (WCDC) is dedicated to diverting non-violent people with Mental Illness and Co-occurring Mental Illness and Substance Abuse (CMISA) from the criminal legal system and into the appropriate level of treatment.

Members:
Hon. Nancy Blount (Chief Judge, 36th District Court), Laura McLaughlin (Special Projects 36thDC), Hon. Freddie G Burton, Jr. (Chief Wayne County Probate Court Judge), Hon. Timothy Kenny (Chief Judge, 3rd Circuit Court), Andrea Cole (CEO Flinn Foundation),Dean Sheryl Kubiak (Center for Behavioral Health and Justice at WSU) Scott Smith (Center for Behavioral Health and Justice at WSU), Nanci Hambrick (Center for Behavioral Health and Justice at WSU), Stacey Campbell (Center for Behavioral Health and Justice at WSU), Sojourner Jones (Community/Law Enforcement, DWIHN), Julie Black (Clinical Manager, DWIHN) Andrea Smith (Director of Program Services, DWIHN), Reid Wilson (Executive Manager, Detroit Police Department), Amanda Rzotkiewicz (Analyst, Detroit Police Department), Gary Bresnehan (Wayne County Prosecutor's Office) Alisha Bell (Chair, Wayne County Commission) Dr. Debra Pinals (Medical Director, MDHHS) Willie Brooks (CEO DWIHN).

The Wayne County Diversion Council (WCDC) discussed extending video conference court hearings indefinitely.

Meeting Notes:

- The council discussed Cash Bail issues and unnecessary jail time in result to bail funding
- Council is reviewing racial disparities in the system and ways to level the field
- Re-entry programs and processes are being reviewed for recommendations.
- The council is reviewing facilitation plans in the new facility
- Wayne County currently have 842 inmates, down from +1400 pre-COVID-19.

- DPD currently has plans to train 20% of police responders in Crisis Intervention training (CIT) by the end of 2021. DWIHN funds four (4) training sessions per year.
- The group discussed the new jail being built with a capacity for over 2000 beds and whether there was any conversation at the county about re-appropriating the beds.
- Wayne County appointed Raphael Washington to replace Benny Napoleon unfulfilled term.

Telehealth Workgroup

The committee is made up of individuals through the state and is Co-Chaired by Myself and Jametta Lily, CEO of Detroit Partner Network.

The purpose of the committee is to evaluate the need for Telehealth within the state and access methods to connect the state.

Some concerns discussed:

1. Lack of infrastructure
    a. 30% of Children within Detroit have no internet
    b. Lack of computer infrastructure
    c. Elderly acceptance and usage of Telehealth
2. Poverty Level Among Minorities
3. Educational Shortfalls and need for virtual learning options
4. Support Systems
5. Fraud concerns with providing Telehealth infrastructure
    a. Assuring equipment and assistance goes to the correct hands
    b. Assuring equipment is used properly
6. Changing the Culture
    a. Slow but steady acceptance of Telehealth
    b. Realistic expectations
7. Segregation creates segregation

Facts

1. COVID-19 forced businesses to utilize technology that has already been existence
2. Concerns of work integrity
    a. Monitoring productivity
    b. Assuring integrity of services and work
    c. Credentialing
    d. Monitoring
3. Exposure
    a. COVID-19 exposed issues that were already in existence
        i. Disparity in Economics
        ii. Disparity in Education
        iii. Disparity in Health Care
        iv. Selected ignorance of disparity issues

Updates

1. **Closing the Racial Disparities Gap with the Vaccine**
   We have all agreed that Telehealth is a viable strategy to increase access and utilization of COIVD testing and health services in general. D**iscussion, brainstorm and prepare shared strategies and recommendations that the council can forward to the Racial Disparity Task Force (RDTF), MDHHS and the Lt. Governor this week.**

   Brainstorming and cogent recommendations to address the widening disparities in the information, access and implementation of the Vaccine to black and communities of color in Michigan. Michigan has done much to close racial disparities with COVID testing and awareness strategies overall. However, the gap in information and implementation of the vaccine in communities hardest hit by COVID demands our quick attention, support and actionable recommendations.

2. **Telehealth-Vaccines-Promotions Strategies**
   We will review the State Plan for how we can actualize relevant items. Additionally, if any of you are currently using Telehealth or health based communication to inform or link your customers, staff and/or partners to the Vaccine, please come prepared to share this.

   The State has a contractor for COVID communications. The group previously asked that the contractor engage with the Telehealth Workgroup for how we can better communicate the efficacy and benefits of Telehealth during the Pandemic. We're trying to determine if any from this Workgroup have been contacted about Telehealth and/or other COVID awareness and promotions.

DWIHN and City of Detroit (COD) Partnership

The purpose of this workgroup is to improve police and community relationships, along with addressing improved relationships with the people we serve under mental health and substance use with the Detroit Police Department.

DWIHN and COD Partnership Goals:

- Pilot a 911 mental health crisis call diversion and response
- Increase police officer access to mental health supports
- Develop adequate places to house individuals in need of crisis services
- Evaluate and expand Crisis Intervention Team (CIT) training of police officers
- DWIHN is proposing the approval of funding to assist in this effort. This effort should reduce overall incarceration cost and provide better treatments to the people we serve.

The DWIHN and Detroit Police Department project was successfully implemented and communicated to the public. DWIHN is currently monitoring the progress and success of this project.

Health Plan Integration / MDHHS Behavioral Health Restructure (SIP)

DWIHN is finalized agreements with two Health Plans. Currently working with clinicians, on the program design and implementation for next fiscal year.

Specialty Integrated Plan (SIP) Model

MDHHS initially announced a proposal, Specialty Integrated Plan (SIP) to promote integration of care within Behavioral Health and Health Care. This proposal was later cancelled in result to limited success and detailed involvement with other items such as COVID-19 response and other MDHHS projects.

DWIHN Updates:

- MDHHS announced that legislature members, led by Representative Mary Whiteford are requesting an evaluation of the Behavior Health System for potential restructuring and renewed integration efforts of Behavior Health and Physical Health.
- New initiatives of integration are being considered by the PIHP's.
- DWIHN is working with MDHHS to come up with alternative options

2021 Funding Updates

Medicaid:

- Death Audit
  - Potential recovery of $9 million pending. Currently pushed back as MDHHS analyzes the impacts on the audit to the PIHP system. DWIHN must continue to count this as loss revenue until a decision is made by MDHHS.
- Autism
  - MDHHS is reviewing DWIHN's request to cost settle $21 million in overspend for Autism. Autism rates and guidelines are set by MDHHS, which makes it somewhat difficult for DWIHN to control. I discussed the Autism circumstances with MDHHS on several occasions and expressed DWIHN's concerns with this process and the lack of a cost settlement by MDHHS. MDHHS is taking a serious look at the impacts of Autism on the PIHP system.
- Provider Rate Reduction
  - DWIHN has eliminated the proposed 7% rate reduction. Evaluation of current revenue is ongoing.
- Provider Assistance
  - DWIHN issued approximately $4 million in Provider Stability funding to counteract provider losses in result to COVID-19.

General Fund:

Michigan Department of Health and Human Services (MDHHS) put together a task force made up of Community Mental Health agencies to determine a method of rebasing General Fund dollars to the PIHPs. The group's decision was to lower DWIHN General Fund dollars by $4.5 million each year to a cumulative total reduction of $22.5 million by year five. DWIHN is in the second year of this reduction with a slated $9 million in reductions to occur this fiscal year.

DWIHN is currently pursuing a long-term solution for the overall $22.5 million slated reduction. I discussed this issue with MDHHS on Tuesday June 2, 2020. There is no resolution as of today.

Building

DWIHN will review the Crisis Continuum project and the building requirements to assure it meets the needs of the new MDHHS proposal. COVID-19 is changing the way DWIHN and the provider network does business.
DWIHN is implementing return to work procedures in result to COVID-19. This process will include:

- Personal Protection Equipment (PPE) usage guidelines for staff as outlined by the Governor's office.
- Assuring social spacing practices are maintained in the work setting
- Provide on-site routine COVID-19 testing for staff
- All staff and security Are being tested on regular intervals.
- DWIHN is continuously reviewing building policies in light of current COVID-19 situations.

Staffing

DWIHN is reviewing all positions to assure it meets the future needs of the MDHHS integration design along with COVID-19 changes.

This includes:

- Restructuring of Access and Customer Service areas is currently occurring
- Constant evaluating mobile staff and internal staff requirements
- Establishing a functional onsite work force
- Review processes learned from offsite processing.
- Re-examine building requirements
    - New Center One (NCO) potential elimination
    - Update Central Building design with spacing and hoteling needs
    - Online video conference meetings long term goals

- Off-site
    - Clearly define functions that can be performed off-site
    - Establish methods of measuring productivity
    - Establish meeting requirements and technology
    - Protocol for returning for providers and staff

Provider Network

Provider Contracting

DWIHN is working out the details and transition of the SUD provider network changes. DWIHN is in the process of evaluating the overall provider network and needs of the community to assure that the provider network meets our community goals of a holistic network for FY 2022.

Crisis Center

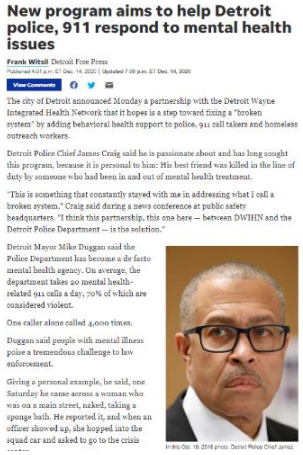
DWIHN started the first phase of Asbestos Abatement in December 2020.

Communications

In the Media

Detroit – The City of Detroit held a press conference where DWIHN Deputy CEO Eric Doeh gave remarks on the accessibility of COVID-19 vaccinations are available for Detroit residents and employees which will include Provider staff and people we serve. This was livestreamed on Facebook and Channel 7 covered it.
https://www.facebook.com/watch/live/?v=181148317123778&ref=watch_permalink

Free Press – The DWIHN/DPD/DOH Behavioral Health Co-Pilot partnership was covered by the Free Press in January in which the city and DWIHN announced its partnership in training more police officers in Crisis Intervention Training (CIT) as well as having clinicians work alongside 9-1-1 operators in answering potential mental health calls.
https://www.freep.com/story/news/local/michigan/detroit/2020/12/14/detroit-police-mental-health-issues/6540691002/



New program aims to help Detroit police, 911 respond to mental health issues

Frank Witsil Detroit Free Press

The city of Detroit announced Monday a partnership with the Detroit Wayne Integrated Health Network that it hopes is a step toward fixing a "broken system" by adding behavioral health support to police, 911 call takers and homeless outreach workers.

Detroit Police Chief James Craig said he is passionate about and has long sought this program, because it is personal to him: His best friend was killed in the line of duty by someone who had been in and out of mental health treatment.

"This is something that constantly stayed with me in addressing what I call a broken system," Craig said during a news conference at public safety headquarters. "I think this partnership, this one here — between DWIHN and the Detroit Police Department — is the solution."

Detroit Mayor Mike Duggan said the Police Department has become a de facto mental health agency. On average, the department takes 20 mental health-related 911 calls a day, 70% of which are considered violent.

One caller alone called 4,000 times.

Duggan said people with mental illness poise a tremendous challenge to law enforcement.

Giving a personal example, he said, one Saturday he came across a woman who was on a main street, naked, taking a sponge bath. He reported it, and when an officer showed up, she hopped into the squad car and asked to go to the crisis

The Freep also covered Oakland County's new program which would also have social workers working with officers to help with deescalating and identifying people with mental illness. DWIHN's Behavioral Health Co-Pilot Partnership was mentioned.
https://www.freep.com/story/news/local/michigan/oakland/2021/01/29/oakland-county-sherriffs-office-trains-clinicians-deputies/4055946001/?utm_source=freep-Daily%20Briefing&utm_medium=email&utm_campaign=daily_briefing&utm_term=list_article_headline

Channel 7 – WXYZ covered a story on DWIHN's Mindwise Mental Health Check-Up which is an anonymous, free assessment tool available to everyone. Mindwise reviews mental health concerns and connects people to resources when needed. The assessment link is located on the home page of the DWIHN website.
https://www.wxyz.com/news/detroit-wayne-integrated-health-network-launches-free-mental-wellness-assessment-tool

Fox 2 News Detroit - DWIHN Provider Hegira Health was featured on the importance of police mental health training to bridge law enforcement, community outreach and those suffering from mental illness.
https://www.fox2detroit.com/news/livonia-close-to-adding-social-workers-to-police-for-suspects-in-mental-health-crisis

BLAC Magazine – BLAC covered a story on DWIHN's ReachUsDetroit.org COVID-19 Therapy Collaborative.

COVID-19 Therapy Collaborative Offers Free Behavioral Health Help to Youth & Families

DETROIT, MI - The Detroit Wayne Integrated Health Network (DWIHN) with support from the Ethel and James Flinn Foundation, Skillman Foundation, Community Foundation for Southeast Michigan, and Michigan Health Endowment Fund launched the first of its kind, the Detroit COVID-19 Therapy Collaborative, which provides free behavioral health supports and counseling to those who need help. This virtual platform provides access to a safe and private network of behavioral health resources and therapy supports by trained counselors for children and families ages 14 years and older.

"This is a remarkable partnership," said DWIHN President and CEO, Willie E. Brooks, Jr. "I am grateful that other organizations share our passion to reach out to young people and families during these unprecedented times as we try and get a handle on the impact COVID-19 is having on our young people."

The Detroit COVID-19 Therapy Collaborative launched May 21, 2020 and is available to teens and adults ages 14 years and up through the rest of the year. Individuals are able to receive up to 12 therapy sessions via phone, tablet or computer. These sessions are with professional counselors to provide screenings, brief interventions and treatment. This is available for youth and adults who are approaching a crisis related to or triggered by the COVID-19 pandemic.

"We've never experienced this before, we're facing so much uncertainty, and we shouldn't have to do it alone. African Americans have been hit particularly hard" said Executive Director & CEO of the James and Ethel Flinn Foundation Andrea Cole. "This is a trying time for all of us, but especially for young people who may already be struggling with mental health issues such as anxiety, depression, suicidal thoughts, hopelessness or substance use disorder."

An array of comprehensive, culturally responsive supports and counseling services will be available to individuals who live, work or worship in Detroit/Wayne County.

Due to the pandemic, there has been an increase in individuals feeling anxious, depressed, and hopeless. Several individuals reaching out for support are concerned about school, work, and social and emotional well-being. Often school or work is the place of gathering and provides a sense of connectedness. A lot of people are missing the face-to-face interaction and just don't know what to do. Services are available, don't suffer in silence, Reach Us Detroit, (or something like that).

Reach Us Detroit is spearheaded by Andrea L Smith, MSW, Director of Workforce Training & Program Development.

To access services, call or text 313-488-HOPE or visit www.ReachUsDetroit.org

The Detroit Wayne Integrated Health Network (DWIHN) is the largest and most diverse Community Mental Health system offering integrated health care in Michigan. Through programs and services that utilize promising best practices we promote a community that is supportive and embraces people with mental illness, intellectual and developmental disabilities and substance use disorder. We offer help with Infant Mental Health, Supportive Housing, and Recovery to support self- determination and improve the health, safety and quality of life for nearly 75, 000 people and their families.

910 AM – Sojourner Jones was on the "Empowered" Show with Angela T. Moore on 910 AM Superstation live. She spoke about the January Kevin's Song conference and her role as a speaker/educator. Chief Clinical Officer, Melissa Moody was featured on Robert Ficano's show where she discussed mental health and depression stats since COVID. She also discussed the signs/symptoms of depression and how to contact DWIHN and gave information on the mental health screenings available on our website. Trent Sanford and former DWIHN employee Brandon Davis of CPI/WFD along with partner Brian Berry of Beasley Radio had a 60-minute segment with Horace Sheffield where they discussed environmental trauma, violence, graduation rates, and unemployment.

Hometown Life – DWIHN Provider Hegira Health was also featured in Hometownlife.com on adding social workers to the Livonia Police force.
https://www.hometownlife.com/story/news/local/livonia/2021/01/26/livonia-council-delays-decision-add-social-workers-police-force/4248723001/

C&G Newspapers – Andrea Smith, Director of CPI/WFD, was featured in an online article listing DWIHN as a resource for those suffering due to mental health issues during COVID.
https://www.candgnews.com/news/local-resources-available-for-those-suffering-from-mental-health-strain-119591?utm_medium=social&utm_source=facebook_C_&_G_Newspapers&fbclid=IwAR1kFd7v5u1-5znzYTJjoFIPoykB59LFXxq85AOzLuvSWQDIIZWn1aqp7c4

OutFront Media – New billboards are up throughout several locations in Wayne County including Detroit, Hamtramck, Dearborn and Southwest Detroit, promoting coping during COVID-19, mental health awareness, stigma, SUD, and recovery.

Community Newspapers - DWIHN partnerships continue with the The Latino Press, The Hamtramck Review and the Arab American News. Messaging in all publications includes information on mental health resources, the DWIHN Access Center, disability-related information as well as substance use prevention, treatment and recovery. The latest stories in the Latino Press and Hamtramck Review focus on Parent Support during COVID-19, Seasonal Affective Disorder, and DWIHN's police pilot program to assist the homeless.

Manifest Thirty-One – Tay Ford, President of Manifest Thirty-One, which connects people with mental health and wellness resources, interviewed Andrea Cole, Exec. Dir/CEO of the James and Ethel Flinn Foundation. Cole has been instrumental in helping DWIHN with its ReachUsDetroit.org partnership. The 30-minute interview discussed the program and mental health issues. The interview is posted on YouTube.
https://www.youtube.com/watch?v=tARvKr3aC-g&feature=youtu.be

Crisis Intervention Training (CIT) – CIT included DPD and Canton PD in its newsletter acknowledging the work they have done throughout the Community in Wayne County.

CPI/WFD & Grind Time Fitness – As part of DWIHN's Behavioral Health Co-Pilot project with DPD and the city of Detroit Housing department, DWIHN is sponsoring self-care and wellness sessions with 9-1-1 dispatchers and call takers in collaboration with Grind Time Fitness.

SUD

DWIHN received a philanthropic grant for $151,984 from the Community Foundation of Southeast Michigan for an opioid intervention using Medication Assisted Treatment (MAT) for two Wayne County jails for FY 21. Inmates will be screened using the Rapid Opioid Dependence Screen (RODS), COVID testing and contact tracing by Disease Intervention Specialists (DIS) housed in the jails. Once the inmate leaves out of the jail with a positive RODS indicating they have an Opioid Use Disorder (OUD) they will be assessed for the appropriate MAT medication using our mobile units/RVs consisting of medical, therapeutic and peer recovery coach staff they will transport these individuals directly to treatment services based on a 24-hour service model.

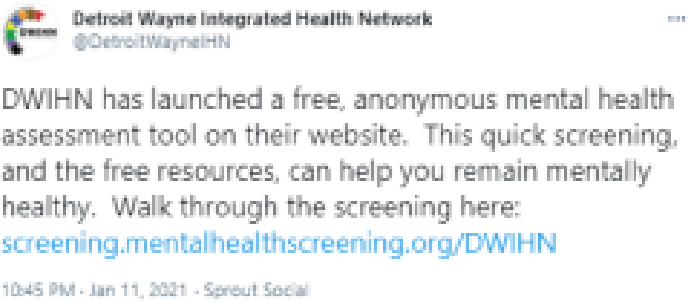
What's Coming Up Videos

The Customer Service Department along with the Communications Department has been producing an ongoing series of videos for What's Coming Up. These videos cover the community outreach

calendar and news to keep the people we serve engaged. These videos are published on DWIHN's website and social media including YouTube.

Social Media

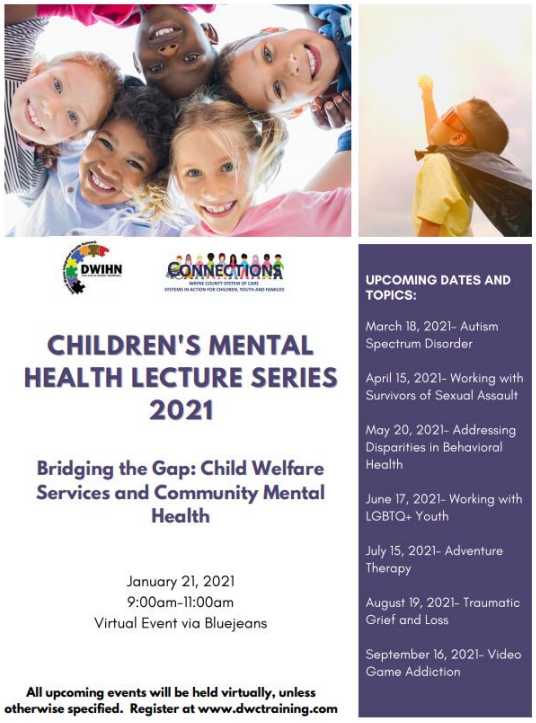
The top performing Facebook post for January included the announcement of our partnership with DPD to bring additional health support to police officers (450 reached with 102 engagements). Our top performing Instagram post was a graphic promoting Self-Love month (18 engagements). Twitter's top performing post promoted MindWise (10 engagements), and lastly, the MDHHS StayWell Michigan campaign post was promoted on Facebook, Instagram, LinkedIn, and Twitter (with 500+ reached and 15 total engagements). Total impressions were 19,321 (up 7.7%) and total engagements were 862 (up 21.4%).



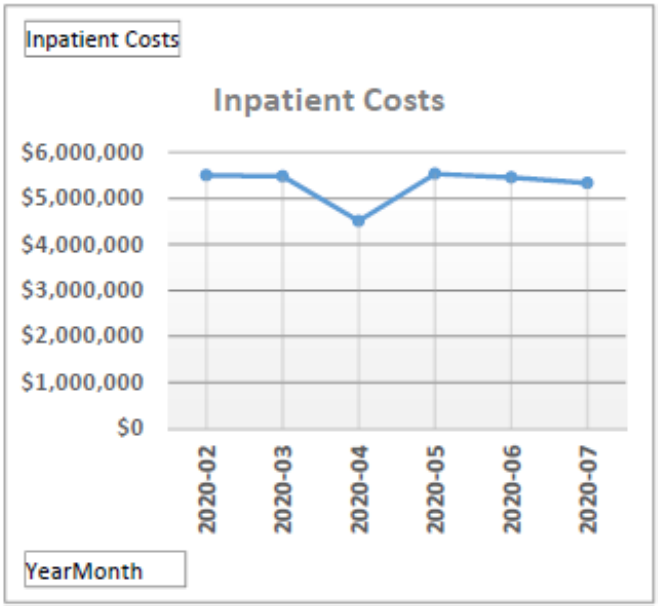
Community Outreach – DWIHN participated in and sponsored the Kevin's Song Conference. Sojourner Jones presented during the conference on Suicide and was awarded the "Save a Life" Award.

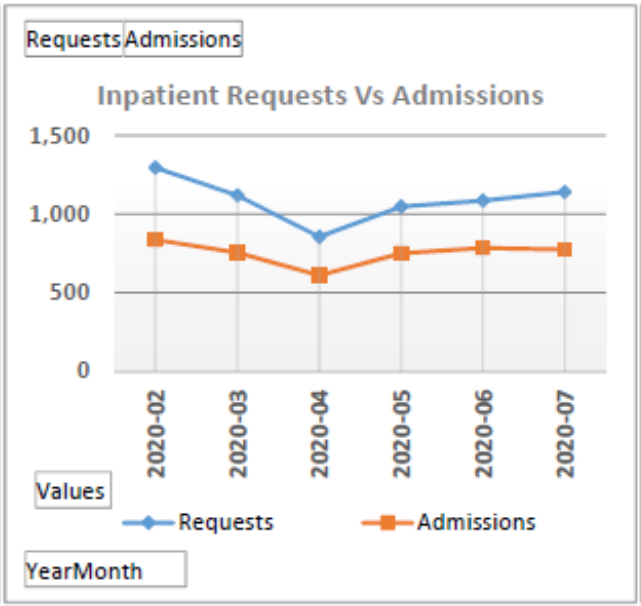
Youth United East Region completed a virtual focus group with SER Metro Youth and discussed the impact of COVID on their lives in and outside of school. They also shared their perspective on the COVID vaccine and described the type of workshops that would benefit them. Children's Initiatives held their Mental Health Lecture Series last month in partnership with Michigan Department of Health and Human Services where 3 supervisors from Child Protective Services spoke on bridging the gap between mental health and child welfare.

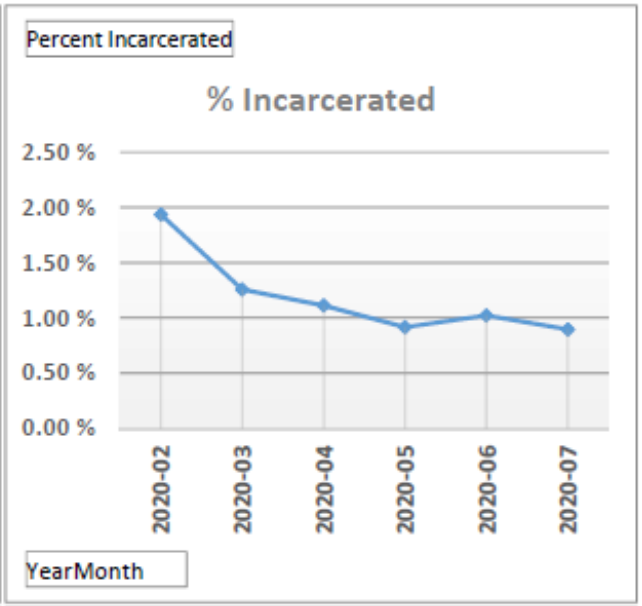
The Customer Service department continued their community outreach efforts by holding their Constituents' Voice meetings, Action Groups, and S.O.U.L. chats.

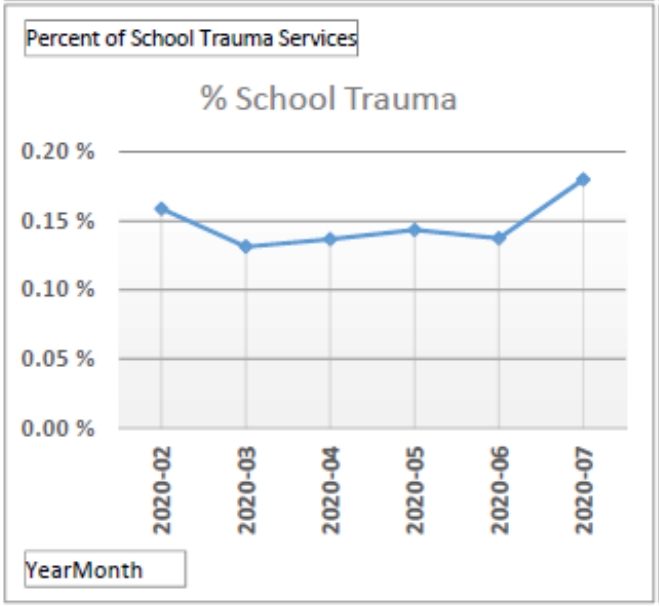


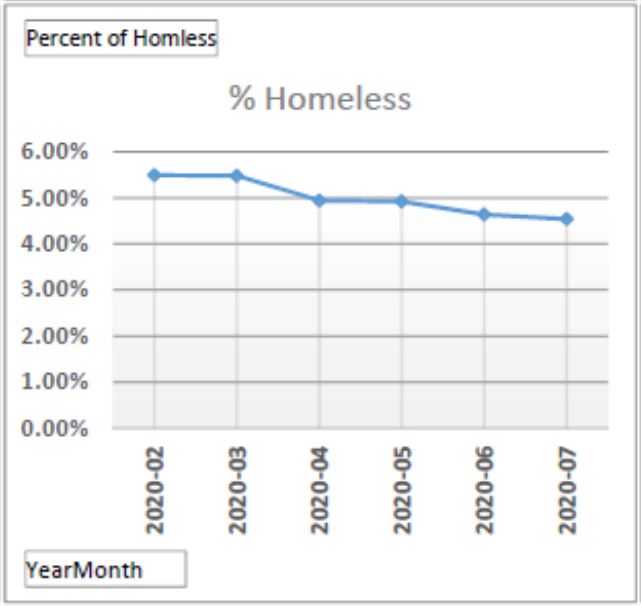
Key Mental Health Indicators

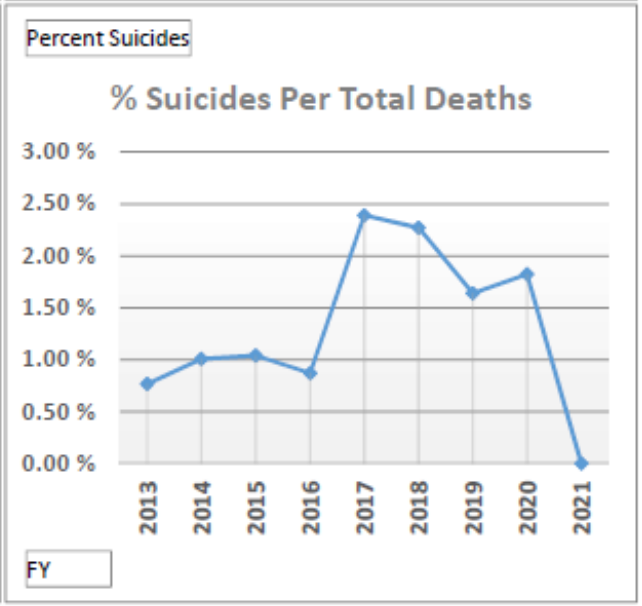












DETROIT WAYNE INTEGRATED HEALTH NETWORK
BOARD ACTION

Board Action Number: 19-24R(2) Revised: [Y] Requisition Number: 11,807

Presented to Full Board at its Meeting on: 2/17/2021

Name of Provider: Relias Learning, LLC

Contract Title: ProAct / Interoperability BA19-24R Funding Modification

Address where services are provided: 'None'

Presented to Program Compliance Committee at its meeting on: 2/10/2021

Proposed Contract Term: 3/1/2018 to 3/31/2018

Amount of Contract: $ 212,691.65 Previous Fiscal Year: $ 197,000.00

Program Type: Modification

Projected Number Served- Year 1: 50,000 Persons Served (previous fiscal year): 50000

Date Contract First Initiated: 10/1/2017

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).

DWIHN is requesting approval to secure additional funding to complete all payment transactions/outstanding balances for services rendered through CMT, Relias and their ProAct Analytics tool. ProAct supports our strategic plan initiatives surrounding integrated care and NCQA accreditation. Proact targeted measures were utilized in our NCQA Performance Improvement Plans (PIPs). Additionally, ProAct allows the Authority to monitor performance expectations of the PHIP contracts.

Previously approved $197.000.00.

Additional request: $15,691.65, not to exceed $212,691.65

Payment for invoice CMTSI-1993, dated March 1, 2018.

Source of Funds: Multiple

Fee for Service (Y/N): Y

Revenue	FY 19/20	Annualized
Multiple	$ 212,691.65	$ 212,691.65
	$ 0.00	$ 0.00
Total Revenue	$ 212,691.65	$ 212,691.65

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

Type of contract (Business/Clinical): Business

ACCOUNT NUMBER: 64934.827211.00000

In Budget (Y/N)? N

Approved for Submittal to Board:

Willie E. Brooks, President/CEO

Signature/Date:

Willie E Brooks

Signed: Monday, February 1, 2021

Stacie Durant, Chief Financial Officer

Signature/Date:

Stacie Durant

Signed: Monday, February 1, 2021

Board Action #: 19-24R(2)

Board Action Taken

The following Action was taken by the Full Board on the __17th__ day of February, 2021.

X Approved

☐ Rejected

☐ Modified as follows:

_____
_____
_____

Executive Director -initial here:_ _____

☐ Tabled as follows:

_____
_____

Signature: *Lillian M. Blackshire* Date: February 17, 2021
Board Liaison

_

DETROIT WAYNE INTEGRATED HEALTH NETWORK
BOARD ACTION

Board Action Number: BA #20-55R Revised: Y Requisition Number:

Presented to Full Board at its Meeting on: 2/17/2021

Name of Provider: DWIHN Provider Network - see attached list

Contract Title: SUD Recovery Home and Mobile Unit COVID-19 Funding Increase

Address where services are provided: 'None'

Presented to Program Compliance Committee at its meeting on: 2/10/2021

Proposed Contract Term: 5/1/2020 to 9/30/2021

Amount of Contract: $ 408,973.00 Previous Fiscal Year: $ 393,973.00

Program Type: Modification

Projected Number Served- Year 1: 1,500 Persons Served (previous fiscal year): 1087

Date Contract First Initiated: 5/1/2020

Provider Impaneled (Y/N)? Y

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

This revised board action is requesting an additional $15,000 in funding from the original award $393,973 (approved 05/20/2020) for SUD Block Grant to implement COVID-19 withdrawal management (detox), residential, mobile unit and recovery homes services. DWIHN currently has two providers Detroit Rescue Mission Ministries (DRMM) and Quality Behavioral Health (QBH) servicing our COVID-19 clients with symptoms or who are positive for the virus in recovery homes specifically for the SUD population. DRMM would receive $7,500; QBH would receive $7,500.

The aforementioned providers were selected as they were the providers accepting COVID-19 cases and/or had existing mobile units in place. Many recovery homes would not take COVID-19 cases and the selected providers became the de facto COVID-19 providers.

Total amount of the request is $408,973 for the fiscal year ended September 30, 2021.

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

Source of Funds: Block Grant

Fee for Service (Y/N): Y

Revenue	FY 20/21	Annualized
SUD Block Grant	$ 408,973.00	$ 408,973.00
	$ 0.00	$ 0.00
Total Revenue	$ 408,973.00	$ 408,973.00

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

Type of contract (Business/Clinical): Clinical

ACCOUNT NUMBER: 64932.826600.07100

In Budget (Y/N)? Y

Approved for Submittal to Board:

Willie E. Brooks, President/CEO

Signature/Date:

Willie E Brooks

Signed: Wednesday, February 3, 2021

Stacie Durant, Chief Financial Officer

Signature/Date:

Stacie Durant

Signed: Wednesday, February 3, 2021

Board Action Taken

The following Action was taken by the Full Board on the __17th__ day of February, 2021.

X Approved

☐ Rejected

☐ Modified as follows:

_____
_____
_____

Executive Director -initial here:_ _____

☐ Tabled as follows:

_____
_____

Signature: *Lillian M. Blackshire* Date: February 17, 2021
Board Liaison

_

DETROIT WAYNE INTEGRATED HEALTH NETWORK
BOARD ACTION

Board Action Number: 21-19R Revised: Y Requisition Number:

Presented to Full Board at its Meeting on: 2/17/2021

Name of Provider: Hegira Health Inc.

Contract Title: Crisis Intervention Services

Address where services are provided: 'None'

Presented to Program Compliance Committee at its meeting on: 2/10/2021

Proposed Contract Term: 10/1/2020 to 9/30/2021

Amount of Contract: $ 8,400,000.00 Previous Fiscal Year: $ 8,400,000.00

Program Type: Modification

Projected Number Served- Year 1: 14,000 Persons Served (previous fiscal year): 13,000

Date Contract First Initiated: 1/1/2016

Provider Impaneled (Y/N)? Y

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

The Detroit Wayne Integrated Health Network (DWIHN) is requesting approval to Revise Board Action #21-19 Hegira Health Inc. crisis intervention services via the Community Outreach for Psychiatric Emergencies (COPE), for continuum of services and revise from an extension to a comparable source procurement.

This revision is a correction to the initial Board Action that referred an extension opposed to a new contract. The initial contract and related extensions were exhausted on approved board action ending September 30, 2020. DWIHN will not issue a formal solicitation (RFP) for the COPE services at this time as it is DWIHN's intention to procure the full array of crisis continuum services in the renovated Woodward building.

The approved Board Action and contract is from October 1, 2020 through September 30, 2021 is not to exceed $8,400,000.00. This board action does not revise the amount or term.

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

Source of Funds: Multiple

Fee for Service (Y/N): N

Revenue	FY 19/20	Annualized
Multiple	$ 8,400,000.00	$ 8,400,000.00
	$ 0.00	$ 0.00
Total Revenue	$ 8,400,000.00	$ 8,400,000.00

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

Type of contract (Business/Clinical): Clinical

ACCOUNT NUMBER: 64931.825004.01668

In Budget (Y/N)? Y

Approved for Submittal to Board:

Willie E. Brooks, President/CEO

Signature/Date:

Signed: Tuesday, February 2, 2021

Stacie Durant, Chief Financial Officer

Signature/Date:

Signed: Tuesday, February 2, 2021

Board Action Taken

The following Action was taken by the Full Board on the __17th__ day of February, 2021.

X Approved

☐ Rejected

☐ Modified as follows:

_____
_____
_____

Executive Director -initial here:_ _____

☐ Tabled as follows:

_____
_____

Signature: *Lillian M. Blackshire* Date: February 17, 2021
Board Liaison

_

DETROIT WAYNE INTEGRATED HEALTH NETWORK
BOARD ACTION

Board Action Number: BA 21-55 Revised: N Requisition Number:

Presented to Full Board at its Meeting on: 2/17/2021

Name of Provider: Black Family Development, Detroit Rescue Mission, Elmhurst Home Inc., Detroit Recovery Project

Contract Title: Jail Plus Progam

Address where services are provided: See attached scopes

Presented to Program Compliance Committee at its meeting on: 2/10/2021

Proposed Contract Term: 10/1/2020 to 9/30/2021

Amount of Contract: $ 362,194.00 Previous Fiscal Year: $ 388,500.00

Program Type: New

Projected Number Served- Year 1: 200 Persons Served (previous fiscal year): 0

Date Contract First Initiated: 10/1/2020

Provider Impaneled (Y/N)? Y

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

The Wayne County Department of Health, Human and Veterans Services (HHVS), Clinical Services Division, Adult Community Corrections, is requesting approval of a sub-recipient Intergovernmental Agreement (IGA) between the County of Wayne and Detroit Wayne Integrated Health Network (DWIHN).

DWHIN is the Prepaid Inpatient Health Plan (PIHP) for Wayne County and manages federal and state prevention treatment and recovery services in Wayne County, in addition to mental health services. The IGA with the DWIHN is based on DWIHN's ability to bring added value to our contracted services not funded via the Community Corrections grant, including, access to its network of providers for intensive wrap-around services, utilization of its Access Management System for immediate client placement

The term of the agreement is from October 1, 2020 through September 30, 2021. The total amount of this contract is $362,194.00, which includes Black Family Development ($119,375.00), Detroit Recovery Project($149,097.00),Detroit Rescue Ministries ($43,111.00), Elmhurst Home/Naomi's Nest ($43,111.00) and a $7,500.00 DWIHN administrative fee allocation. This IGA is entirely state funded, and does not include federal dollars, nor any match requirements.

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

Source of Funds: Other

Fee for Service (Y/N): Y

Revenue	FY 20/21	Annualized
Local Grant	$ 362,194.00	$ 362,194.00
	$ 0.00	$ 0.00
Total Revenue	$ 362,194.00	$ 362,194.00

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

Type of contract (Business/Clinical): Clinical

ACCOUNT NUMBER: VARIOUS

In Budget (Y/N)?

Approved for Submittal to Board:

Willie E. Brooks, President/CEO

Signature/Date:

Willie E Brooks

Signed: Wednesday, January 20, 2021

Stacie Durant, Chief Financial Officer

Signature/Date:

Stacie Durant

Signed: Wednesday, January 20, 2021

Board Action Taken

The following Action was taken by the Full Board on the __17th__ day of February, 2021.

X Approved

☐ Rejected

☐ Modified as follows:

_____
_____
_____

Executive Director -initial here:_ _____

☐ Tabled as follows:

_____
_____

Signature: *Lillian M. Blackshire* Date: February 17, 2021
Board Liaison

_

DETROIT WAYNE INTEGRATED HEALTH NETWORK
BOARD ACTION

Board Action Number: 21-40R Revised: [Y] Requisition Number:

Presented to Full Board at its Meeting on: 2/17/2021

Name of Provider: Black Family Development, Children's Center of Wayne County Inc., Community Care Services Inc., Development Centers Inc., Guidance Center, The, Hegira Health Inc., Southwest Counseling Solutions, Starfish Family Services (MH), Northeast Integrated Health , Access Behavioral Healthcare LLC, Arab-American & Chaldean Council

Contract Title: School Success Initiative

Address where services are provided: Various

Presented to Program Compliance Committee at its meeting on: 2/10/2021

Proposed Contract Term: 2/1/2021 to 9/30/2021

Amount of Contract: $ 3,600,000.00 Previous Fiscal Year: $ 6,000,000.00

Program Type: Continuation

Projected Number Served- Year 1: 8,182 Persons Served (previous fiscal year): 5285

Date Contract First Initiated: 2/1/2016

Provider Impaneled (Y/N)? Y

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

This board action is requesting the approval to extend funding for 11 Community Mental Health (CMH) entities to continue providing services in the School Success Initiative project based on the approved program design. The funding will allow the CMHs to provide school-based behavioral health services to children and their families, across Wayne County and implement the approved program design to improve outreach and provide school-based services, through Fiscal Year 2021.

During the first four months of FY-21, funds were allocated to the 11 CMH entities for a total of $1,161,637.09. In addition, $11,242.00 was utilized to the Michigan Model for Health curriculum for the approved program design. This board action is requesting that the remaining funds of $2,427,120.91, be allocated to the 11 CMH entities for the remaining eight (8) months of FY-21.

In order to increase penetration rates, a new curriculum was created, based on the Michigan Model for Health. The new curriculum provides educational tools that address the top four (4) risk factors, which were identified from the MiPHY and TRAILS data as depression/anxiety, bullying, dating violence, and suicide, which is able to be

delivered across age ranges and grade levels. As such, the newly developed curriculum, will positively impact the behavioral health and outreach goals that the School Success Initiative program has outlined for the schools and community partners.

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

Source of Funds: General Fund

Fee for Service (Y/N): N

Revenue	FY 20/21	Annualized
State General Fund	$ 1,161,637.09	$ 1,161,637.09
State General Fund	$ 2,438,362.91	$ 2,438,362.91
Total Revenue	$	$ 3,600,000.00

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

Type of contract (Business/Clinical): Clinical

ACCOUNT NUMBER: 64931.827206.06200

In Budget (Y/N)? Y

Approved for Submittal to Board:

Willie E. Brooks, President/CEO

Signature/Date:

Stacie Durant, Chief Financial Officer

Signature/Date:

Board Action Taken

The following Action was taken by the Full Board on the __17th__ day of February, 2021.

X Approved

☐ Rejected

☐ Modified as follows:

_____
_____
_____

Executive Director -initial here:_ _____

☐ Tabled as follows:

_____
_____

Signature: *Lillian M. Blackshire* Date: February 17, 2021
Board Liaison

_

DETROIT WAYNE INTEGRATED HEALTH NETWORK
BOARD ACTION

Board Action Number: 21-57 Revised: N Requisition Number:

Presented to Full Board at its Meeting on: 2/17/2021

Name of Provider: See attached list

Contract Title: DWIHN/DPD Pilot - Mental Health Diversion Pilot Partnership

Address where services are provided: 'None'

Presented to Program Compliance Committee at its meeting on: 2/10/2021

Proposed Contract Term: 10/1/2020 to 9/30/2021

Amount of Contract: $ 400,000.00 Previous Fiscal Year: $ 0.00

Program Type: New

Projected Number Served- Year 1: 800 Persons Served (previous fiscal year): 0

Date Contract First Initiated: 2/1/2021

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).

This board action is requesting the approval of $400,000 for the Mental Health Diversion Pilot program for the fiscal year ended September 30, 2021.

The pilot program is a partnership between the Detroit Wayne Integrated Health Network (DWIHN), Detroit Police Department (DPD), and City of Detroit Housing and Revitalization Department (HRD). The pilot is modeled after evidence-based programs used by law enforcement agencies in Houston, Dallas, Portland, San Diego and Denver. These agencies each take a three-pronged intervention approach to identify, respond, connect and ultimately increase services to citizens with mental health needs. The overall goal of the Mental Health Diversion Pilot is to improve the city's response to individuals experiencing mental health crises and to prevent future crises by connecting them early on to supportive services. The pilot will take a continuum of care approach to reduce harm to individuals in crisis, reduce their use of emergency services and reduce arrests of individuals experiencing mental health or substance abuse disorders. The program's three pronged approach will consist of a Crisis Intervention Team (CIT), 911 Integrated Response, and a Detroit Homeless Outreach Team (DHOT).

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

Source of Funds: General Fund

Fee for Service (Y/N): N

Revenue	FY 20/21	Annualized
State General Fund	$ 400,000.00	$ 400,000.00
	$ 0.00	$ 0.00
Total Revenue	$ 400,000.00	$ 400,000.00

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

Type of contract (Business/Clinical): Clinical

ACCOUNT NUMBER: 64931.827206.06425

In Budget (Y/N)?

Approved for Submittal to Board:

Willie E. Brooks, President/CEO

Signature/Date:

Signed: Monday, February 8, 2021

Stacie Durant, Chief Financial Officer

Signature/Date:

Signed: Monday, February 8, 2021

Board Action Taken

The following Action was taken by the Full Board on the __17th__ day of February, 2021.

X Approved

☐ Rejected

☐ Modified as follows:

_____
_____
_____

Executive Director -initial here:_ _____

☐ Tabled as follows:

_____
_____

Signature: *Lillian M. Blackshire* Date: February 17, 2021
Board Liaison

_

DETROIT WAYNE INTEGRATED HEALTH NETWORK
BOARD ACTION

Board Action Number: 21-25 R1 Revised: N Requisition Number:

Presented to Full Board at its Meeting on: 1/20/2021

Name of Provider: Detroit Wayne Integrated Health Network

Contract Title: FY 2020-2021 Operating Budget

Address where services are provided: 'None'

Presented to Finance Committee at its meeting on: 1/6/2021

Proposed Contract Term: 10/1/2020 to 9/30/2021

Amount of Contract: $ 849,014,139.00 Previous Fiscal Year: $ 833,066,765.00

Program Type: Continuation

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

Date Contract First Initiated: 10/1/2020

Provider Impaneled (Y/N)?

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

The Detroit Wayne Integrated Health Network is requesting board approval to amend BA 21-25 per the budget adjustment #21-35-005 - FY21 Substance Use Disorder (SUD) allocation from the Michigan Department of Health and Human Services. The budget adjustment de-certifices SUD revenue of $2,527,483.

The revised FY 2021 operating budget, in the amount of $849,014,139, includes revenues of $30,449,269 (State General Funds); $647,753,130 (Medicaid, DHS Incentive, Medicaid-Autism, Children's/SED Waiver, HAB); $7,486,123 (MI Health Link); $114,952,550 (Healthy MI - Mental Health and Substance Abuse); $17,686,447 (Wayne County Local Match Funds); $4,040,539 (PA2 Funds); $3,507,941 (State Grant portion of SUD and OBRA); $21,735,490 (Federal Grants/Federal Block Grants/SUD); $362,650 (Local Grant Revenue); $1,000,000 (Interest Income); and $40,000 (Misc Revenue).

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

Source of Funds: Multiple

Fee for Service (Y/N): N

Revenue	FY 20/21	Annualized
VARIOUS	$ 849,014,139.00	$ 849,014,139.00
	$ 0.00	$ 0.00
Total Revenue	$ 849,014,139.00	$ 849,014,139.00

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

Type of contract (Business/Clinical): Business

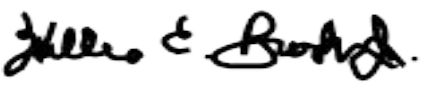
ACCOUNT NUMBER: VARIOUS

In Budget (Y/N)? N

Approved for Submittal to Board:

Willie E. Brooks, President/CEO

Signature/Date:



Signed: Tuesday, January 26, 2021

Stacie Durant, Chief Financial Officer

Signature/Date:

Signed: Tuesday, January 26, 2021

Board Action Taken

The following Action was taken by the Full Board on the __17th__ day of February, 2021.

X Approved

☐ Rejected

☐ Modified as follows:

_____
_____
_____

Executive Director -initial here:_ _____

☐ Tabled as follows:

_____
_____

Signature: *Lillian M. Blackshire* Date: February 17, 2021
Board Liaison

_

DETROIT WAYNE INTEGRATED HEALTH NETWORK
BOARD ACTION

Board Action Number: 20-59R Revised: Y Requisition Number: 11,624

Presented to Full Board at its Meeting on: 2/17/2021

Name of Provider: Peter Chang Enterprises

Contract Title: PCE/MHWIN Maintenance Contract Extension #2

Address where services are provided: 'None'

Presented to Finance Committee at its meeting on: 2/3/2021

Proposed Contract Term: 3/1/2021 to 2/28/2022

Amount of Contract: $ 1,163,220.00 Previous Fiscal Year: $ 870,034.00

Program Type: Continuation

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

Date Contract First Initiated: 3/1/2017

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 board approval of a 1 year extension (final extension) with Peter Change Enterprise Inc. for the MHWIN System Maintenance for an amount not to exceed $1,163,220. The amount comprises the following:

- **One-time payment $258,000.00** (for billable out-of-scope work performed during prior contract years especially as part of System Transformation related changes in the system.)
- 4% annual increase

FY 20/21: $603,490 (3/1/21-9/30/21) + ($258,000.00 one time payment) = **$861,480**
FY 21/22 (4 months)**: $301,740.**

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

Source of Funds: Multiple

Fee for Service (Y/N): Y

Revenue	FY 20/21	Annualized
Multiple	$ 1,163,220.00	$ 1,163,220.00
	$ 0.00	$ 0.00
Total Revenue	$ 1,163,220.00	$ 1,163,220.00

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

Type of contract (Business/Clinical): Business

ACCOUNT NUMBER: 64915.817000.00000

In Budget (Y/N)? Y

Approved for Submittal to Board:

Willie E. Brooks, President/CEO

Signature/Date:

Signed: Tuesday, January 19, 2021

Stacie Durant, Chief Financial Officer

Signature/Date:

Signed: Tuesday, January 19, 2021

Board Action Taken

The following Action was taken by the Full Board on the __17th__ day of February, 2021.

X Approved

☐ Rejected

☐ Modified as follows:

_____
_____
_____

Executive Director -initial here:_ _____

☐ Tabled as follows:

_____
_____

Signature: *Lillian M. Blackshire* Date: February 17, 2021
Board Liaison

_

QAPIP Work Plan
FY 2020-2021

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Responsible Department	Timeframe for Each Activity's Completion	Monitoring of Previously Identified Issues	Evaluation	Outcomes	Oversight of QI Activities by Committee
	Customer Pillar						
Goal I	**Enhance the quality of services based on member feedback**						
I.1	ECHO Adult Satisfaction Survey	Customer Service	FY 2020-2021	Increase response rates and improve member access to behavioral health services for the 5 reporting measures scoring < 50% 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.			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 2020-2021	Identify areas for system enhancement 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.			Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
I.3	Provider Survey	Customer Service	FY 2020-2021	Increase response rates and improve service access, service provision, treatment experiences and outcomes in the network.			Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
I.4	Grievance/Appeals	Customer Service	FY 2020-2021	Improve outcomes and member experience for the top five (5) grievances identified for FY 18/19. (1). Delivery of Service, (2). Interpersonal, (3) Program Issues, (4) Access to Staff, (5) Customer Service.			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 2020-2021	Meet performance set by the state for timely UM decisions making, timeframes and notification. Threshold 90% .			Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Responsible Department	Timeframe for Each Activity's Completion	Monitoring of Previously Identified Issues	Evaluation	Outcomes	Oversight of QI Activities by Committee
I.6	Cultural and Linguistic Needs	Customer Service, Managed Care Operations, Quality Improvement and Information Technology	FY 2020-2021	Advance health equity, improve quality, and help eliminate health care disparities by implementing culturally and linguistically appropriate services.			Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
	Access Pillar						
Goal II.	**Assess Needs and Manage Demand, Implement Holistic Care Model**						
	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 2020-2021	Meet performance on required state performance indicators. Outcome: FY 18/19 standard met for all populations for all quarters. Threshold 95% for each quarter.			Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
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 2020-2021	Meet performance on required state performance indicators. Outcome: FY 18/19 standard met for all populations for all quarters. Threshold 95% for each quarter.			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 2020-2021	Meet performance on required state performance indicators. Outcome: FY 18/19 standard met for all populations for all Quarters except for Quarter 3 (88%). Threshold 95% for each quarter.			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 2020-2021	Meet performance on required state performance indicators. Outcome: FY 18/19 Quarter 1 (57%), Quarter 2 (88%) did not meet the standard; Standard met for Quarter 3 (96%) and Quarter 4 (95%). Threshold 95% for each quarter.			Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
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 2020-2021	Meet performance on required state performance indicators. Outcome: FY 18/19 Quarter 1 (57%), Quarter 2 (88%) did not meet the standard; Standard met for Quarter 3 (96%) and Quarter 4 (95%). Threshold 95% for each quarter.			Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Responsible Department	Timeframe for Each Activity's Completion	Monitoring of Previously Identified Issues	Evaluation	Outcomes	Oversight of QI Activities by Committee
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 2020-2021	Meet performance on required state performance indicators. Outcome: FY 18/19 Standard not met for Adults for Quarter 2 (17%), Quarter 3 (17%) and Quarter 4 (20%). Outcome: FY 18/19 Standard met for Children for all quarters with the exception of Quarter 4 (16%). Aggregate score for Children and Adults for FY 18/19 (17%). Threshold 15% for each quarter.			Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
II.7	Complex Case Management	Integrated Health Care	FY 2020-2021	Ensure members are move towards optimum health, improved functional capability, and a better quality of life by focusing on their own health goals. CCM will be measured against the following benchmark for participating members.			Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
II.8	Crisis Intervention	Utilization Management	FY 2020-2021	Decrease number of re-hospitalization within 30 days of discharge to 15% or lower. Baseline FY 18/19 (17%).			Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
	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 2020-2021	Increase the capacity of staff and providers to work effectively with diverse cultural and linguistic populations (expand cultural competency trainings as well as develop additional practice policies).			Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
	Finance Pillar						

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Responsible Department	Timeframe for Each Activity's Completion	Monitoring of Previously Identified Issues	Evaluation	Outcomes	Oversight of QI Activities by Committee
Goal IV	**Maximize Efficiencies and Control Costs**						
IV.1	Claims and Compliance Monitoring	Quality Improvement, Compliance and Finance	FY 2020-2021	Eliminate Fraud, Waste and Abuse in the network by identifying patterns and trends of behavioral health service utilization by funding source and by monitoring over and underutilization of services.			Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
	Quality Pillar						
Goal V.	**Improve Quality Performance, Member Safety and Member Rights system-wide**						
V.1	Performance Monitoring - Clinically Responsible Service Provider (CRSP)	Quality Improvement	FY 2020-2021	Improve performance rates on regulatory audits (acute care discharge, IPOS and crisis and response planning). Measurement will include the number of providers reviewed during FY19 with reported outcomes.			Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
V.2	Specialized Residential Settings	Quality Improvement	FY 2020-2021	Targeted goal is to review 60% of the Specialized Residential Providers to ensure regulatory requirements are met and adequate to meet members needs.			Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
V.3	Provider Self Monitoring (Inter-Rater Reliability)	Quality Improvement	FY 2020-2021	Increase Provider's participation in Self Monitoring from the previous year by 10%.			Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Responsible Department	Timeframe for Each Activity's Completion	Monitoring of Previously Identified Issues	Evaluation	Outcomes	Oversight of QI Activities by Committee
V.4	Autism Services	Quality Improvement and Children's Initiatives	FY 2020-2021	Achieve greater efficiency in processing denials and appeals.			Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
V.5	Enhancement of Critical/Sentinel Event Modules (MH_WIN) and Reporting	Quality Improvement and Information Technology	FY 2020-2021	Improve and update the Critical Sentinel Event Modules for better reporting.			Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
V.6	Behavior Treatment Plan Oversight	Quality Improvement and Medical Director	FY 2020-2021	Meet performance measure on required BTPRCs requirements set by MDHHS. Threshold 95%. Review quarterly data on BTPRC outcomes submitted to ensure BTP restrictions are appropriately used and time limited.			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 2020-2021	Focused on follow up after hospitalization within 7 or 30 days. This measure has the potential to improve the health of members with mental illness and reduce readmissions through increasing appropriate follow up care.			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 2020-2021	Improve members with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.			Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.
V.7c	Antidepressant Medication Management for People with a New Episode of Major Depression	Integrated Health Care and Quality Improvement	FY 2020-2021	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).			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 2020-2021	Increase Diabetes Screening for people with Schizophrenia and/or Bipolar Disorder measures for percentage of patients 18-64 years of age.			Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Responsible Department	Timeframe for Each Activity's Completion	Monitoring of Previously Identified Issues	Evaluation	Outcomes	Oversight of QI Activities by Committee
V.7e	Coordination of Care	Integrated Health Care, Utilization Management and Quality Improvement	FY 2020-2021	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.			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 2020-2021	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.			Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.
V.7g	Increasing Hepatitis A Vaccination	Integrated Health Care	FY 2020-2021	DWIHN was asked in June 2018 by the State of Michigan Department of Health and Human Services (MDHHS) to make available a prevention initiative for opioid treatment programs (OTP) that would help the State of Michigan reach the goal of 80% of the population vaccinated for Hep A.			Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.
V.7h	PHQ-9 Implementation	Clinical Practice Improvement	FY 2020-2021	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			Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.
V.7i	PHQ-A Implementation	Children's Imitative	FY 2020-2021	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.			Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Responsible Department	Timeframe for Each Activity's Completion	Monitoring of Previously Identified Issues	Evaluation	Outcomes	Oversight of QI Activities by Committee
V.7j	Wellness/myStrength	Clinical Practice Improvement	FY 2020-2021	Increase MyStrength members encompassing all enrollment codes. DWIHN focus will be to increase the number of members enrolled using the following three codes: DWIHNc, DWIHNcares and DWINHN Wellplace.			Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.
V.7k	Improve ACT Fidelity w/ACT Step-Down	Clinical Practice Improvement	FY 2020-2021	Improve medication adherence for adults and children who have challenges taking their medications in the prescribed manner.			Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.
V.7l	Decreasing Wait for Autism Services	Children's initiative	FY 2020-2021	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			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 2020-2021	Ensure full compliance in the network with the Home and Community Based Settings requirements by March 2023. Outcome: FY18/19 aggregate score (34%) Goal: FY 19/20 (60%)			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**						
VII.1	MDHHS Certification	QI, MCO, CS, ORR, Finance, Workforce, Credentialing, IHC and Administration	FY 2020-2021	Achieve 95% compliance for all standards of Annual MDHHS Review.			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 2020-2021	Achieve full 3-Year Re-accreditation for all standards of NCQA Review.			Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Responsible Department	Timeframe for Each Activity's Completion	Monitoring of Previously Identified Issues	Evaluation	Outcomes	Oversight of QI Activities by Committee
VII.3	Health Services Advisory Group (HSAG)	QI, MCO, CS, ORR, Finance, Workforce, Credentialing and IHC	FY 2020-2021	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.			Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
VII.4	Annual Needs Assessment	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.			Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.

Detroit Wayne Integrated Health Network

(DWIHN)

Quality Assurance Performance Improvement Plan

Annual Evaluation FY 2020

Submitted by:

April L. Siebert - Director of Quality Improvement

Approved:

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

Table of Contents

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 serves to emphasize the accomplishments and effectiveness of DWIHN's Quality Program as well as identify barriers and opportunities for improvement within the process.

Executive Summary

This QAPIP evaluation provides a description of completed and ongoing quality improvement activities that address quality, safety of clinical care and quality of services. The goals and objectives from the 2019 QAPIP Work Plan were evaluated and are included in the QAPIP evaluation for FY20. 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.

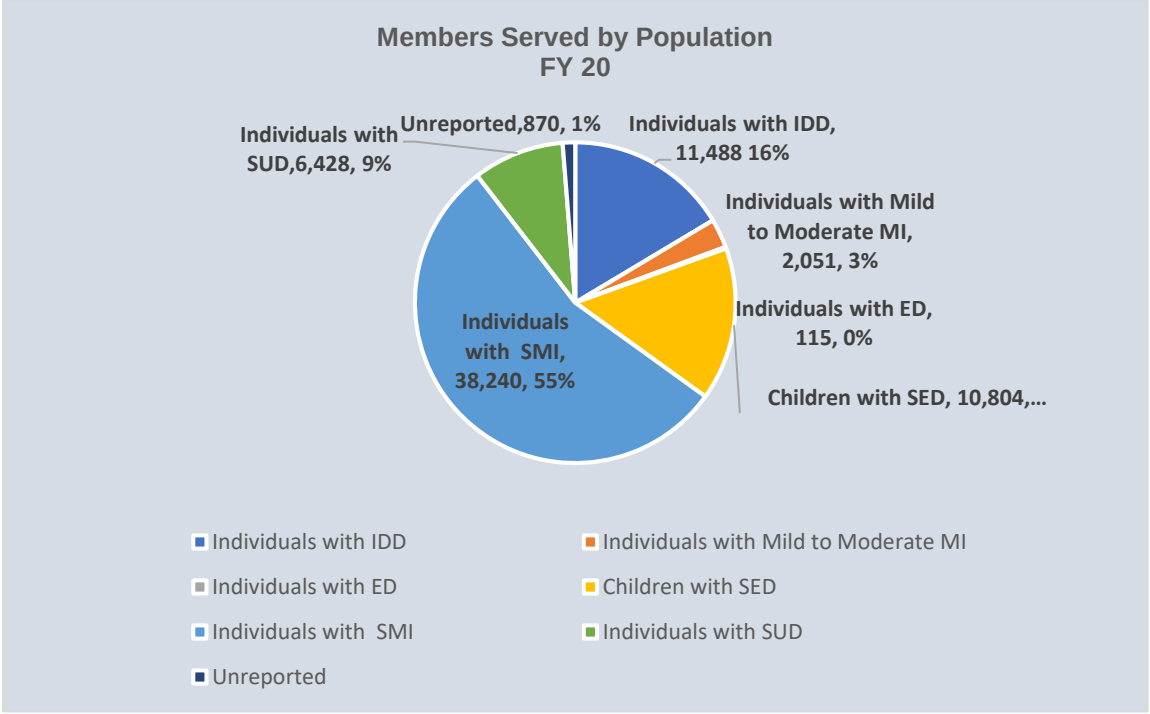
Description of Service Area

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 70,030 members during FY20, which is a decrease of 3,399 *(9.5%)* from FY19 (73,429). Of those served 45,200 *(52.09%)* received services through Medicaid funding, 16,812 *(19.37%)* received services through Healthy Michigan Plan funding, 8,940 *(10.30%)* received services through General Fund, 7,977 *(9.19%)* through SUD Block Grant, 5,267 *(6.07%)* through MI Health Link, 1,671 *(1.92%)* through State Disability Assistance (SDA), 902 *(1.03%)* through Habilitation Supports Waiver. The percent of adults who reported having a SMI in FY20 (38,240), demonstrated a decrease of *(5.48%)* from the previous year (40,460). Followed by 10,804 *(15.43%)* (SED), 11,488 *(16.40%)* (IDD), 6,428 *(9.18%)* (SUD), 2,051 *(2.92%)* (MI), 3,846 (*4.97%)* Co-Occurring, and 870 *(1.24%)* unreported. Of those served 38,612 *(55.15%)* were of African American decent. This reflect a decrease of 2,761 *(6.7%)* from FY19. The Caucasian count was 22,251 *(31.78%).* The remaining *(15%)* 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 30,652 *(43.78%),* demonstrating a decrease of 2,149 *(7.01%)* from FY19. Followed by the age group of 51-64 years-old,15,238 *(21.76%)* and the age group of 0-17 years-old, 15,073 *(21.52%).* The growth of persons served 65 and over increased by *(4.3%)* from the previous year.



Customer Pillar

Experience of Care and Health Outcomes (ECHO) Survey

Activity Description

DWIHN conducted the ECHO survey to receive feedback from members who accessed behavioral health services in the past 12 months. This survey is to obtain information about experience with behavioral health care services and the health plan. As with other member experience data, DWIHN's member experience manager along with a cross-departmental member experience workgroup 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 other member feedback received directly from customer service.

Quantitative Analysis and Trending of Measures

ECHO survey results for both the overall rating questions and the composite questions. The overall rating questions assessed overall experience with counseling or treatment, and overall experience with the behavioral health care services for counseling or treatment. Response options range from 0-10, with 0 being lowest and 10 being highest. Ratings of 8, 9 or 10 are considered achievements and the achievement score is presented as the proportion of members whose response was an achievement. In the ECHO survey for adults in 2017, DWIHN members reported scores below the goal in the overall rating for "Rating of counseling or treatment" and the composite scores for "Office wait and access". DWIHN members also reported scores below the goal in the composite score for "Getting treatment quickly". DWIHN provided a randomly selected list of 5,999 members, out of the approximately 77,000 adults receiving services, 966 DWIHN members responded to the survey. 752 members reported receiving services in the past year. In FY20, DWIHN scored well on several of the ECHO reporting measures, notably members reporting receiving information on patient rights *(91%)* and confidence in the privacy of their information *(91%).* There were three measures with scores of less than *(50%):* Perceived improvement *(31%);* Office wait *(36%);* and Getting treatment quickly *(43%).* Compared to 2017, more members reported treatment helped "a lot" and more rated their overall treatment a "9" or "10", with10 being the highest rating. The difference between the Global Rating in FY20 *(51%),* compared to 2017 *(46%)* was found to be statistically significant. The chart below illustrates the composite scores for FY20 and FY17, in which the scores were <50% for the 2017 reporting period. The reporting measures listed below were identified in the 2018-2019 Work Plan. There were no ECHO Surveys administered during FY 2018-2019. The domains include: Treatment after benefits are used up, Counseling and Treatment, Getting Treatment Quickly, Office Wait and Perceived Improvement. The identified areas improved with an overall percentage increase of *(10%).*

ECHO Reporting Measures, Comparison Across Years

Composite Measures and Global Rating	2020	2017
Treatment after benefits are used up	55%	48%
Global Rating: Treatment (Overall rating of counseling and treatment)	51%	46%
Getting treatment quickly	43%	37%
Office wait	36%	33%
Perceived improvement	31%	29%

The ECHO Survey for Children was administered for the first time by DWIHN during FY20. DWIHN scored well on several 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%).* There were four measures with scores of less than *(50%)*: Perceived Improvement *(25%)*; Getting Treatment Quickly *(42%)*; Overall rating of counseling and treatment *(49%);* and Amount helped *(49%).*

There were statistically significant differences in the responses of those with children whose primary disability designation was IDD and those with SED. Members with IDD were less likely to indicate delays in treatment and there were no identified problems while waiting for approval *37%* of members with a disability designation of IDD, compared to *68%* of members with a disability designation of SED. Parents/Guardians with children with a disability designation of IDD were less likely to indicate they felt they could refuse a specific type of medicine or treatment (*85%* compared to *90%*). Respondents with children with a disability designation of IDD were more likely to report that their children had been helped a lot by the treatment (*54%* compared to *46%*).

Respondents with children receiving autism services were less likely to report delays in treatment were not a problem while waiting for approval (*38%* for those receiving autism services), compared to *61%* for those not receiving autism services); getting needed help was not a problem when calling customer service (*48%*, compared to *65%* for those not receiving autism services); their child always had someone to talk to for counseling or treatment when troubled (*51%* compared to *59%*); and they felt they could refuse a specific type of medicine or treatment (*84%* compared to *89%*). However, respondents with children receiving autism services were more likely to report that their children had been helped a lot by the treatment (*56%* compared to *47%*).

DWIHN randomly selected 7,087 members to receive the survey, out of approximately 17,000 members younger than 18 receiving services. Overall, 1,532 *(21%)* responded to the survey out of the 7,087 selected. Out of the 1,532 responses, 1,123 reported their children had received counseling, treatment, or medicine in the last 12 months. 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 FY20. There was variation in the overall rating for "Perceived improvement" (*25%* compared to *31%*); How Well Clinicians Communicate" (*72%* compared to *68%*); and rating of counseling and treatment (*49%* compared to *51%*).

ECHO Reporting measures, Child Comparison to Adult Results FY20

Composite Measures and Global Rating	Children	Adult
Getting treatment quickly	42%	43%
How well clinicians communicate	72%	68%
Getting treatment and information from the plan or MBHO	55%	57%
Perceived improvement	25%	31%
rating of counseling and treatment)	49%	51%

DWIHN will continue to address recommendations from appropriate committees regarding treatment and access in relation to behavioral health services. The ECHO survey results are shared across cross functional teams both internally and externally to identify opportunities for improvement and how DWIHN can improve behavioral health care services. As with other member experience data, DWIHN reviews the data and develops improvement activities and interventions to improve member experience.

Evaluation of Effectiveness

DWIHN has worked on strategies to increase response rates to better understand DWIHN population that accesses behavioral health services. DWIHN administered the ECHO Survey using Wayne State Center for Urban Studies (WSCUS) as its vendor. The survey was administered via three modes: The Center mailed the members a paper survey, link to the web version was included with the mailed invitation and one week after the paper survey was sent, staff from the Center's Computer Aided Telephone Interviewing (CATI) lab began calling members and asking them to complete the survey over the phone. The three modes of surveys administered demonstrated that the CATI method was proven to be more effective at (49.6%), Mail (47.1%) and Web (3.3%). Respondents received a $5-dollar CVS gift card and a chance to be randomly selected to receive one of three visa cards ($100, $250 and $500) WSCUS offers a mailed survey as well as an online version. WSCUS also offers improved reporting and dashboards. WSCUS also conducts follow-up calls to members encouraging completion of the survey. This vendor provides detailed reports that allows DWIHN to complete a more thorough analysis of results year over year. The survey response rate did increase from 2017 with DWIHN members, well over the 600 targeted for FY20.

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.

Barrier Analysis

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.

Opportunities for Improvement

DWIHN will continue to focus on access to care for behavioral health services based on the 2020 Adult ECHO survey results. Intervention strategies that will be implemented include the following:

- 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.

The ECHO Survey for Children results will be shared both internally and externally to identify opportunities for improvement and how DWIHN can improve behavioral health care services. DWIHN has identified the following as opportunities for improvement.

- 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

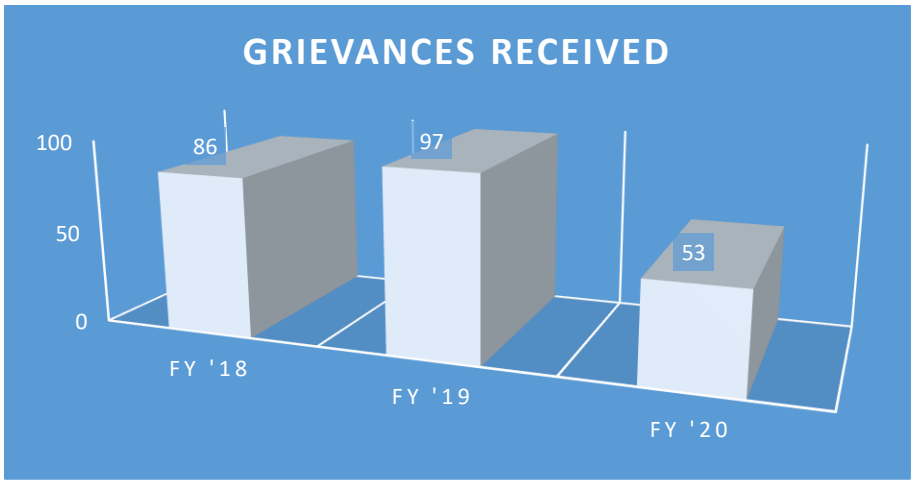
Activity Description

The grievance system is an important element in identifying how providers function in various areas. The grievance data is reviewed daily, monthly, and quarterly. It is also shared quarterly with the Quality Improvement Steering Committee (QISC) and monthly with DWIHN's Constitutes Voice Member Experience Workgroup. The appeals and grievances data are divided into five categories: quality of care, access, attitude and services, billing and financial issues, and quality of practitioner office site. DWIHN's goal is to reduce the number of appeals and grievances relating to access to care. DWIHN focused on improving member experience scores in order to remain above the national average for getting needed care and getting care quickly. DWIHN also worked to improve ECHO scores in order to obtain the threshold for getting treatment quickly and getting treatment and information from the plan.

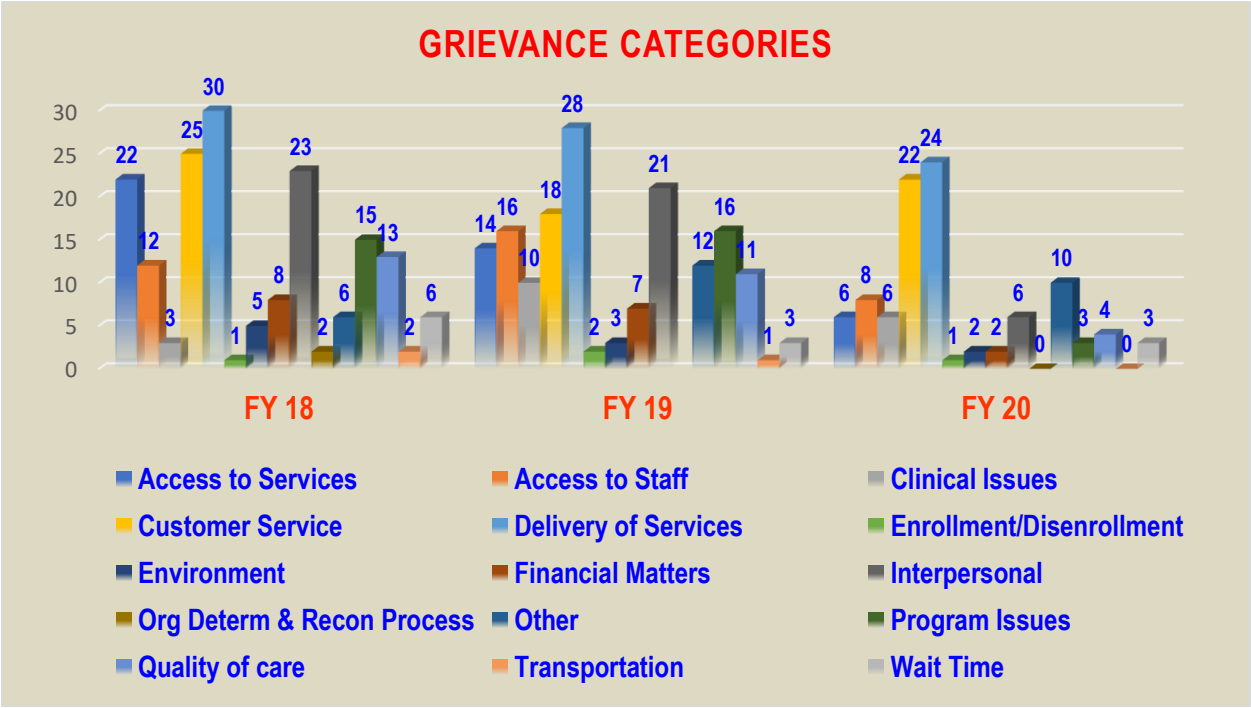
During FY20, DWIHN completed an analysis of member experience trends and occurrences through review of Grievances, Appeals, Recipient Rights and Sentinel Events data. DWIHN uses this data and other initiatives to determine priority actions and improvements to better engage members and stakeholders. Outcomes 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.

Quantitative Analysis and Trending of Measures

There was a total of 236 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 during FY19 and the second highest number being in FY18. There was a significant decline in the number of grievances reported in FY20 compared to FY19. Between April 1st, 2019 and September 30th, 2019, there were 40 grievances received compared to 19 grievances during the same time frame in 2020. The difference in the two years represents a *(52%)* decrease in the number of grievances reported for this period in 2020. It is believed this could be attributed to the COVID-19 pandemic during which time there was a "stay at home order" that was effective as of March 23rd, 2020 and yet to be completely lifted.



A grievance may include more than one category. With that being stated, 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 FY18 there were 86 grievances reported in which 173 categories were identified; 162 categories within 97 grievances reported in FY19 and 97 categories within the 53 grievances reported in FY20. Delivery of Service and Customer Services were consistently high over each of the three years. There was a decline in the number of grievances in the following categories in FY '20. 1.) Access to Services; 2.) Interpersonal and 3.) Quality of Care.



The data collection of these grievances, provided no reliable way to determine if any of them consisted of any cultural, racial, ethnic or linguistic concerns. DWIHN recognizes that this information is needed to identify the nature and extent of disparities, to target quality improvement efforts, and to monitor progress. Tracking the racial and ethnic composition and changing health care needs of different populations is vital if our health care system is to fulfill its essential functions. Measurement, reporting, and benchmarking are critical to improving care.

Evaluation of Effectiveness

DWIHN's Customer Service unit completed a total of 28 appeals for FY20. An estimated *(17%)* decrease from the previous FY19 where 34 appeals were completed. There was a total of 10 State Fair Hearings completed, a *(23%)* decrease from FY19. Thirteen (13) State Fair Hearings were completed. There were 53,073 Advance and Adequate Adverse Benefit Determination Letters sent in FY19 and 32,278 Advance and Adequate Adverse Benefit Determination Letters sent for FY20, approximately *(39%)* less than the previous year.

Overall, of the 432 grievance categories reported over the last three fiscal years, 331 or *(77%)* 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 40 *(9%)* 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. Thirteen (13) or *(3%)* 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. 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 38 days during FY18. The average timeframe for resolution of a grievance was 22 days in FY19 and 37 days in FY20.

Barrier Analysis

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. There were 236 grievances reported over the last three fiscal years (FY18, FY19 and FY20). 163 or *(69%)* of those grievances were resolved to the satisfaction of the grievant. Nineteen *(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.

Opportunities for Improvement

Overall, DWIHN's 2020 grievance data showed improvement; however, DWIHN is continuously striving to improve the health and safety of members through innovative services and partnerships. DWIHN identified a number of key areas of focus.

- 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.

Complex Case Management (CCM)

Activity Description

The overall goal of Complex Case Management (CCM) is to help members move towards optimum health, improved functional capability, and a better quality of life by focusing on their own health goals. The member selects the health goals that they wish to address, and DWIHN coordinator will help facilitate the identification of steps needed and the community support available to meet the member-centered goals. Complex Case Management is available to members who have a variety of co-morbid behavioral health, physical conditions, and needs. Complex Case Management offers DWIHN members the opportunity to talk with a Registered Nurse to assess physical and behavioral health needs; establish member-centered goals to address needs; identify barriers and solutions to help achieve goals and identify additional available community resources. The purpose of Complex Case Management is to help organize and coordinate services for members with complex physical and behavioral health conditions.

Quantitative Analysis and Trending of Measures

Members participating in Complex Case Management (CCM) services demonstrated overall improvement in their PHQ scores, and the improvement increased the longer that the members participated in CCM services. Average PHQ scores improved *(7%)* from baseline at 30 days, *(25%)* at 60 days and *(46%)* at 90 days of receiving CCM services. Members PHQ baseline scores ranged from 5 to 22, with an average score of *(11.8).* Members participating in Complex Case Management 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 did not show improvement from baseline to 30 days of receiving CCM services. Average WHO-DAS scores improved *(13%)* from baseline at 60 days and *(32%)* at 90 days of participating in 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 *(25%)* reduction in Emergency Department utilization and average *(69%)* reduction in Hospital Admissions from 90 days prior to 90 days after starting CCM services. No members experienced an increase in Hospital Admissions from 90 days prior to receiving CCM services to 90 days after starting CCM services.

Evaluation of Effectiveness

Four out of 35 (11%) members who actively received CCM services signed up to use the myStrength application during FY2020. One-member reports that she uses the application on a daily basis to assist with her symptoms of anxiety. PIHP Care Coordinators reported that additional members did not enroll in the myStrength due to not having access to, or choosing not to access, an electronic device to utilize the myStrength services.

DWIHN analyzed members claims data for out-patient behavioral health service utilization 90 days prior to participating in CCM services and 90 days after starting CCM services. The average number of out-patient behavioral health services during the 90 days prior to CCM services was 7.2 and the average number of out-patient services after starting CCM services was 10.5, which amounts to a *(46%)* increase in out-patient services utilization.

DWHIN also measured the number of members who attended two out-patient behavioral health services within 60 days of starting CCM services. Of the 31 members that were available to participate in 2 out-patient services after starting CCM services, 30 members *(97%)* attended two out-patient behavioral health services within 60 days of starting CCM services. Of the 36 CCM cases opened during FY2020, 25 members had Complex Case Management services closed during FY2020. 12 *(48%)* Satisfaction Surveys were completed and returned.
No members reported responses of 'Less than expected' to the Survey questions. One member provided a response of 'As expected' to one question. All other members provided responses of 'More than expected' and 'Consistently more than expected'. The majority of the responses were 'Consistently more than expected' for an overall satisfaction rate of *(100%)*. Six respondents also included positive comments in the Satisfaction Survey.
In addition to the comments included on the Satisfaction Surveys, a member's parent, and a provider also submitted highly positive comments regarding Complex Case Management services to the DWIHN CEO and to the Director of Integrated Care.

Barrier Analysis

PHQ and WHO-DAS scores were higher than PHQ and WHO-DAS scores at baseline, 30 days and 60 days after starting CCM services in FY2020 compared to the FY2019 and 2018 periodic reviews. This could be an issue of interrater reliability as a result of staff changes that occurred during FY2019. The two staff that provided CCM services during the 2018 and FY2019 timeframes transferred to other positions within the organization during FY2019. Due to the possible interrater reliability concern with the completion of the PHQ and WHO-DAS assessments, current Care Coordinator staff will be re-in serviced on the completion of the assessment tools.

Opportunities of Improvement

An area identified as an opportunity for improvement during FY2019 was Behavioral Health engagement. While the sample size of 11 was low, only *(73%)* of members attended two or more visits with a behavioral health provider within 60 days of starting CCM services. The intervention was for Care Coordinators to work at engaging members in outpatient treatment and identifying potential barriers to attending outpatient appointments. During FY2020, the Care Coordinators emphasized the importance of member attendance and participation at outpatient behavioral health appointments and assisted with addressing barriers of attending appointments, including arranging transportation, rescheduling appointments to accommodate member schedules, and connecting member to service providers of members preference. As a result of these efforts, *(97%)* of members who received CCM services for 60 days or more during FY2020 attended at least two outpatient behavioral health visits within 60 days of starting CCM services.

Two areas that DWIHN will focus on improving during FY2021 are in the areas of self-management tools. During FY2021, DWIHN will offer non-web-based self-management tools to all members, along with the myStrength application. DWIHN PIHP Care Coordinators will encourage members to utilize the self-management tools that are right for them. While responses to the CCM Satisfaction Surveys that were returned were overwhelmingly positive, DWIHN would like to increase the return rate. During FY2021, DWIHN will offer a $5 Visa Gift Card to all members who complete and return a CCM Satisfaction Survey. Lastly, continue to coordinate services for the highest risk members with members with complex conditions and help members access needed resources.

National Core Indicator Survey (NCI)

Activity Description

Another measure of member experience and health outcomes is the Michigan National Core Indicators Survey (NCI), which surveys adults with intellectual developmental disabilities. The NCI are measures used across states to access the outcomes of availability of services provided to individuals and families. The indicators address key concerns including employment, rights, service planning, community inclusion, choice, and health and safety.

Quantitative Analysis and Trending of Measures

In FY19, DWIHN delivered to MDHHS a total 164 interview consents and 149 pre-surveys to members, *(20%)* above the identified goals for members to participate in the survey. While the survey results are not DWIHN specific, DWIHN will use the results to identify and investigate areas of dissatisfaction and implement interventions for improvement. Once data is available and analyzed information will be presented to Quality Improvement Steering Committee (QISC) for development of interventions as needed. Interviews and surveys were not completed during FY19-20 due to the COVID-19 Pandemic. Interviews and surveys will reconvene in FY21.

Barrier Analysis

The survey is only conducted in English, Spanish, Vietnamese, Arabic and Chinese. DWIHN population is a very diverse population and members may not receive the survey in their primary language or do not read in English or their first language making it difficult to complete or answer the NCI questions. In addition, self-reported data is difficult to use as members may not fully understand the questions or the questions are not applicable to diversity and one's culture. Member evaluation of the services offered by DWIHN is critical to the identification of opportunities to improve all aspects of care to the people we serve.

Provider Practitioner Survey

Activity Description

In FY20, DWIHN administered the Provider Practitioner Surveys during the month of September related to service access, service provision, treatment experiences and outcomes.

Quantitative Analysis and Trending of Measures

A Comparison of FY19 and FY20 surveys, indicate that provider participation increased overall by *(25%)*; *(50%)* for provider organizations and *(21%)* for individual practitioners.

Evaluation of Effectiveness

DWIHN experienced a significant increase in the survey response rate from FY19. The response rate increased *(50%)* for provider organizations and *(21%)* for individual practitioners. The total number of actual respondents from provider organizations was 180 out of 354 and 572 respondents out of 1,500 individual practitioners. In total 753 surveys were returned out of approximately 3,000 emailed surveys with an overall percentage response rate of about *(25%).*

Barrier Analysis

DWIHN's targeted response rate of *50%-60%* was below the targeted benchmark of *50% -75%* participation. The length of survey questions (76) may dissuade provider organizations and practitioners to complete survey. "*As it was reported to have taken 30 minutes to complete"*. Based upon number of surveys that bounced back there is further need to clean up our email database to void invalid email addresses.

Opportunities for Improvement

The surveys have identified several opportunities for improvement. The Provider Survey Ad-Hoc Task Force will utilize the findings from FY19 and FY20 surveys, and develop a Corrective Action Plan for implementation. The ad-hoc group will be charged with tailoring the survey to best fit our contracted provider organizations and practitioners to achieve a higher response rate; as well as gain a better understanding of how we can support and maintain a strong provider network that will provide high quality supports and services to our members. Additionally, specific interventions for each of these opportunities for improvement should be developed, implemented and tracked through a collaborative effort. Those areas of focus are:

- To alert provider organization and practitioners of the issuance of the survey and promote the significance of completion via email.
- Post notifications in our MH-WIN System.
- Contract Managers to send reminders to provider organizations as well as encourage provider organizations to promote individual practitioner.
- Correct the email address database to avoid emails from bouncing back.

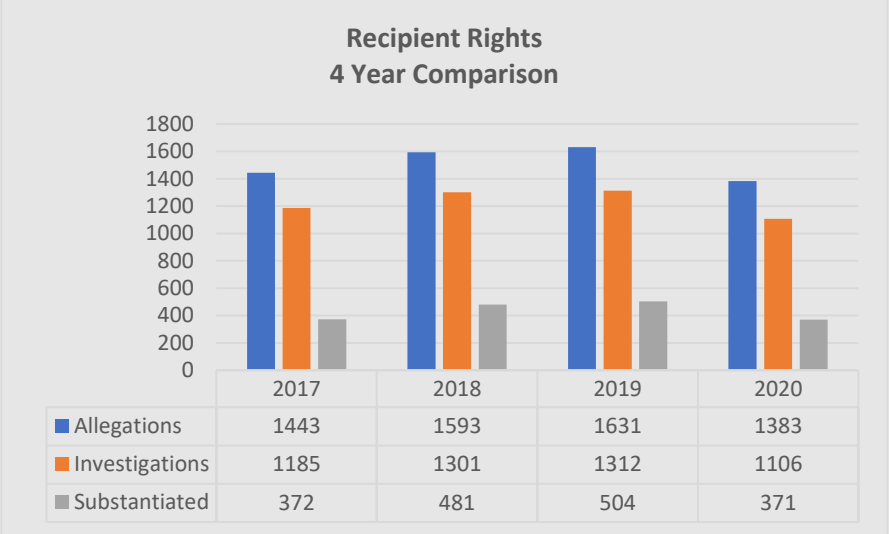
Office of Recipient Rights (ORR)

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

The chart below indicates the most allegations were reported during FY19 and the second highest number being in FY18. 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. In addition, ORR received allegations from 474 recipients and 376 employees which represents the highest number of individuals that filed complaints. 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.
- Ensure uniformly high standard of recipient rights protection across all service providers.

Cultural and Linguistic Needs

Activity Description

Racial and ethnic disparities in behavior health care have been well documented. Data analysis has demonstrated that racial and ethnic disparities contribute to lower HEDIS effectiveness of care scores. DWIHN seeks to improve the collection of race, ethnicity, and language data to improve the overall care of members by identifying the racial and ethnic composition of DWIHN members so that potential health care disparities can be identified.

Quantitative Analysis and Trending of Measures

In assessing the language needs of members, DWIHN explored the number of requests for interpreter services at the point of the initial request/screening for eligibility for service. The data was pulled from the screening information gathered by the Access Center at the initial request for service for Medicaid members who received services in FY17. Findings: Less than *(1%)* of the screenings request language interpreters.

Evaluation of Effectiveness

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.

To support access to cultural and linguistic diversity DWIHN have implemented the following:

- DWIHN have about 10 ethnic/culturally specific providers.
- Member has access to interpreters free of change.
- Member literature is routinely available in Spanish and Arabic.
- Diversity and Cultural competence as a mandatory training.
- Faith-based collaboration and programming is available.
- We have developed an improvement plan pursuant to the result of the CLAS assessment.
- Autism has a quality improve project.

Barrier Analysis

Currently DWIHN does not have data on the languages spoken by individual practitioners. This information is being gathered with the current credentialing/re-credentialing process through Medversant program. Full implementation of Medversant is expected in FY22. Baseline data analysis will be available for reporting in FY22.

Opportunities for Improvement

DWIHN has identified the following 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.

Access Pillar

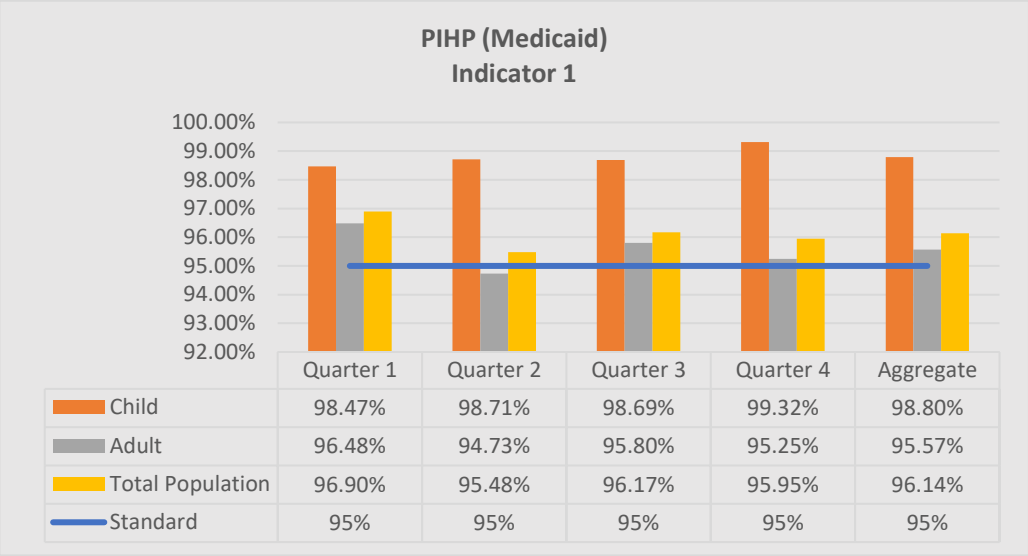
Michigan Mission Based Performance Indicators (MMBPI)

Activity Description

DWIHN monitors access to service using the Michigan Mission Based Performance Indicators (MMBPI). The indicators measure the performance of the PIHP for Medicaid beneficiaries served through the CMSP/SUD affiliates. The performance measure data are aimed at measuring access, quality of service, and to identify barriers to ensure appropriate access to behavioral healthcare and member services.

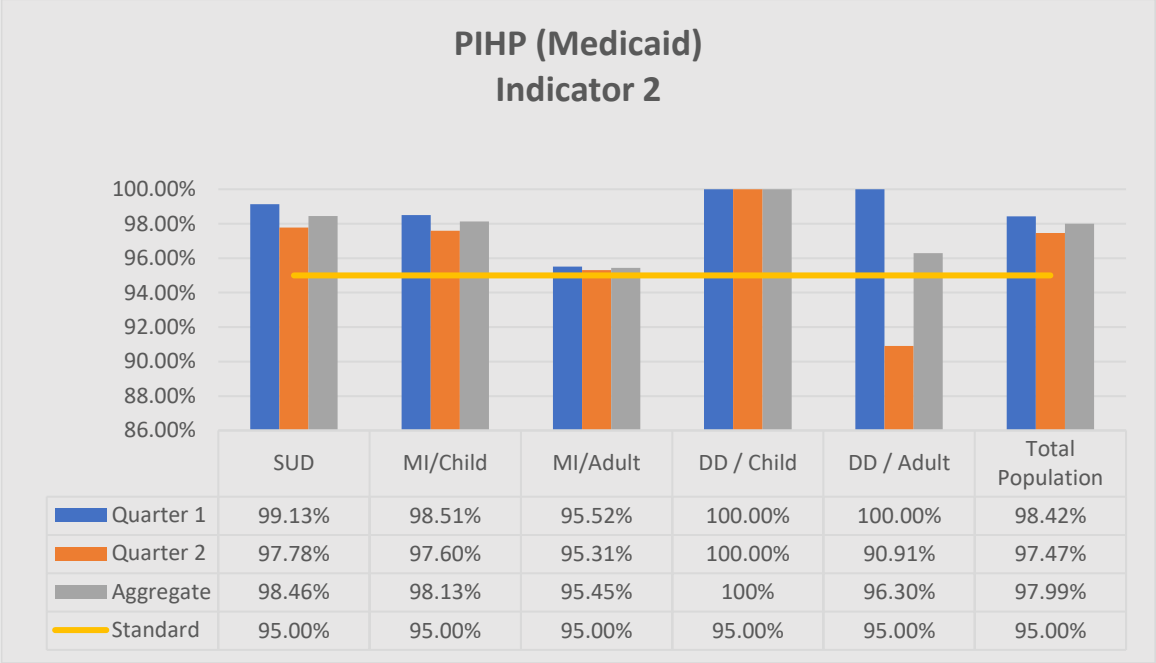
Quantitative Analysis and Trending of Measures

The percentage of persons during 2020 receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. **Target Goals**: To achieve the Michigan Department of Health and Human Services (MDHHS) established benchmark of *(95%)* for (4) quarters during FY 2020. **Results:** FY 2020 standard met for adult and children population for 4 quarters.



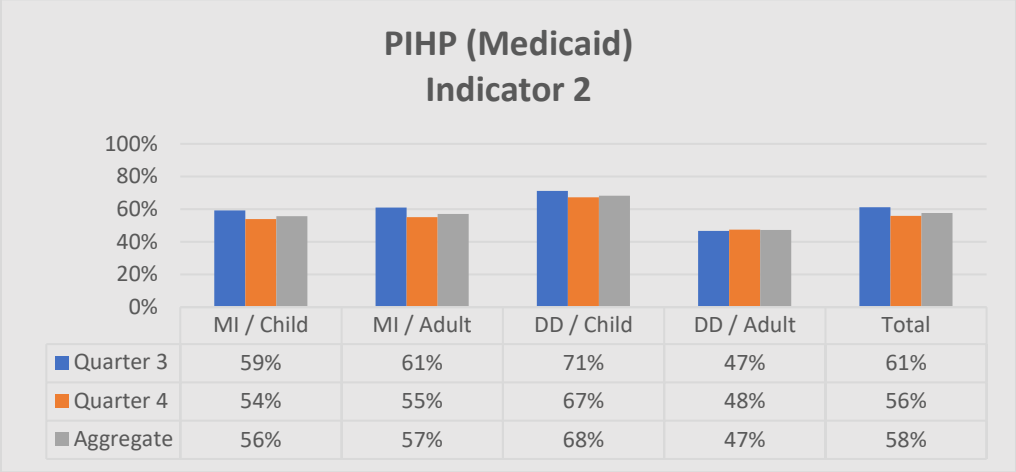
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Aggregate
Child	98.47%	98.71%	98.69%	99.32%	98.80%
Adult	96.48%	94.73%	95.80%	95.25%	95.57%
Total Population	96.90%	95.48%	96.17%	95.95%	96.14%
Standard	95%	95%	95%	95%	95%

The percentage of persons during FY 2020 receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service. **Target Goal**: To achieve MDHHS established benchmark of *(95%)* for (4) quarters during FY 2020. **Results**: FY 2020 standard met for all populations with the exception of Q2 DD/Adult *(90.91%).* DWIHN falls below the threshold for Q2 (DD/Adult). To address this area, 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.



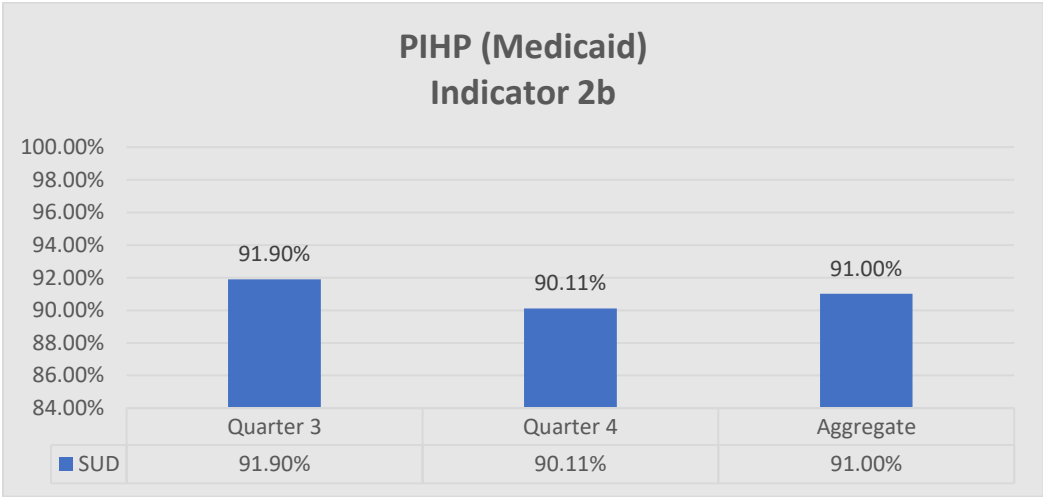
	SUD	MI/Child	MI/Adult	DD / Child	DD / Adult	Total Population
Quarter 1	99.13%	98.51%	95.52%	100.00%	100.00%	98.42%
Quarter 2	97.78%	97.60%	95.31%	100.00%	90.91%	97.47%
Aggregate	98.46%	98.13%	95.45%	100%	96.30%	97.99%
Standard	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%

Beginning Q3 of FY 2020, a separate indicator was developed for new persons receiving a completed Biopsychosocial Assessment within 14 calendar days of a non-emergency request for service. There are no exceptions for indicator 2. No standard/benchmark for first year of implementation has been set by MDHHS.



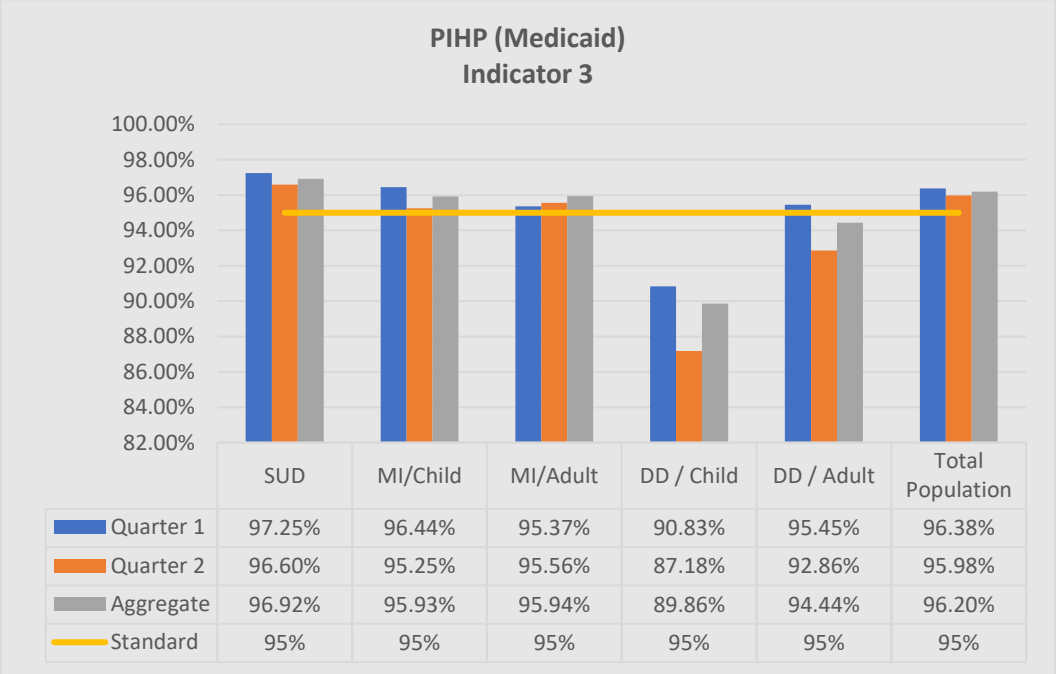
	MI / Child	MI / Adult	DD / Child	DD / Adult	Total
Quarter 3	59%	61%	71%	47%	61%
Quarter 4	54%	55%	67%	48%	56%
Aggregate	56%	57%	68%	47%	58%

Beginning Q3 of FY 2020, a separate indicator was developed for SUD for persons requesting a service who received treatment or supports within 14 days. There are no exceptions for indicator 2b. No standard/benchmark for first year of implementation has been set by MDHHS.



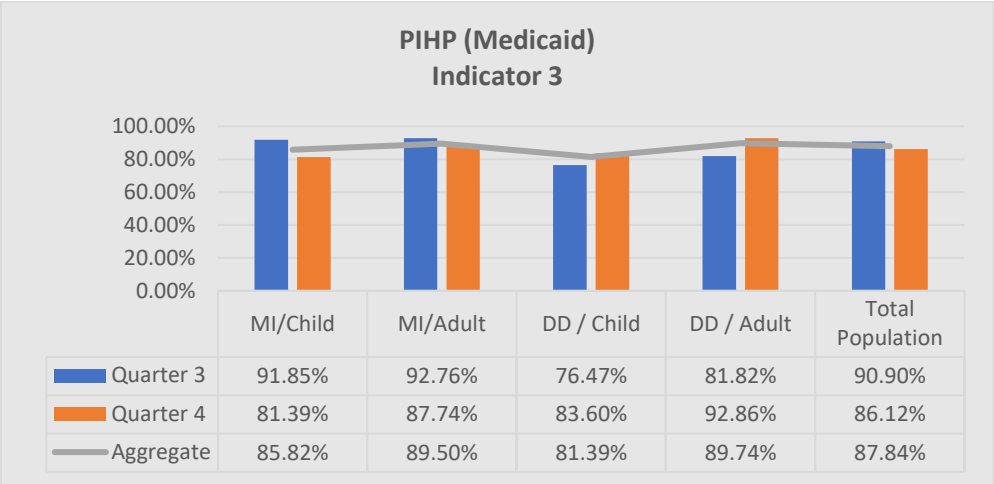
	Quarter 3	Quarter 4	Aggregate
SUD	91.90%	90.11%	91.00%

The percentage of persons during FY 2020 needed on-going service within 14 days of a non-emergency request for service. **Target Goal**: To achieve MDHHS established benchmark of *(95%)* for (4) quarters during FY 2020. **Results**: FY 2020 standard met for all populations with the exception of Q1 DD/Child *(90.83%),* Q2 DD/Child *(87.18%)* and Q2 DD/Adult *(92.86%).* DWIHN falls below the threshold for Q1, Q2 and Q3. To address these areas, 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.



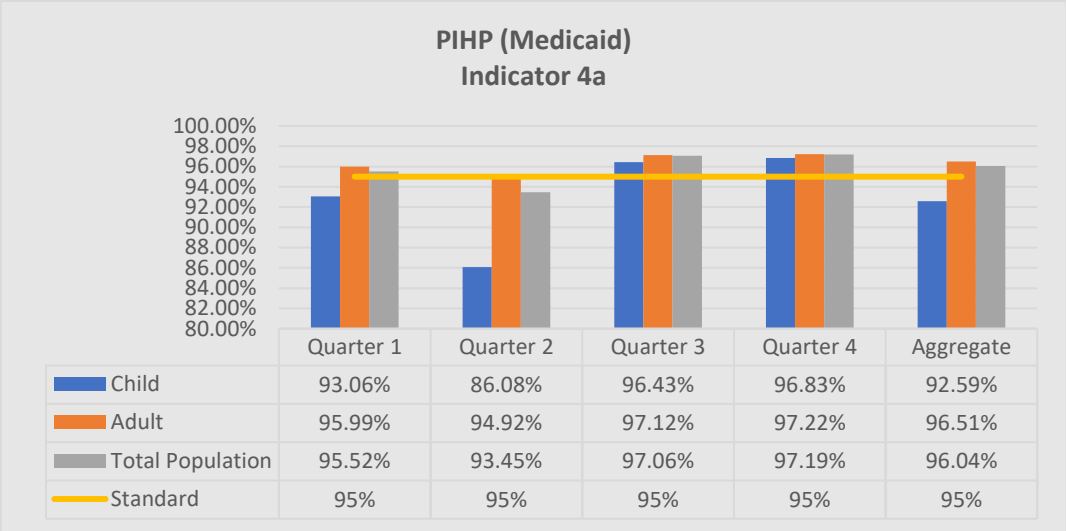
	SUD	MI/Child	MI/Adult	DD / Child	DD / Adult	Total Population
Quarter 1	97.25%	96.44%	95.37%	90.83%	95.45%	96.38%
Quarter 2	96.60%	95.25%	95.56%	87.18%	92.86%	95.98%
Aggregate	96.92%	95.93%	95.94%	89.86%	94.44%	96.20%
Standard	95%	95%	95%	95%	95%	95%

Beginning Q3 of FY 2020, a separate indicator was developed for new persons starting any medically necessary on-going covered service within 14 days of completing a non-emergent Biopsychosocial Assessment. There are no exceptions for indicator 3. No standard/benchmark for first year of implementation has been set by MDHHS.



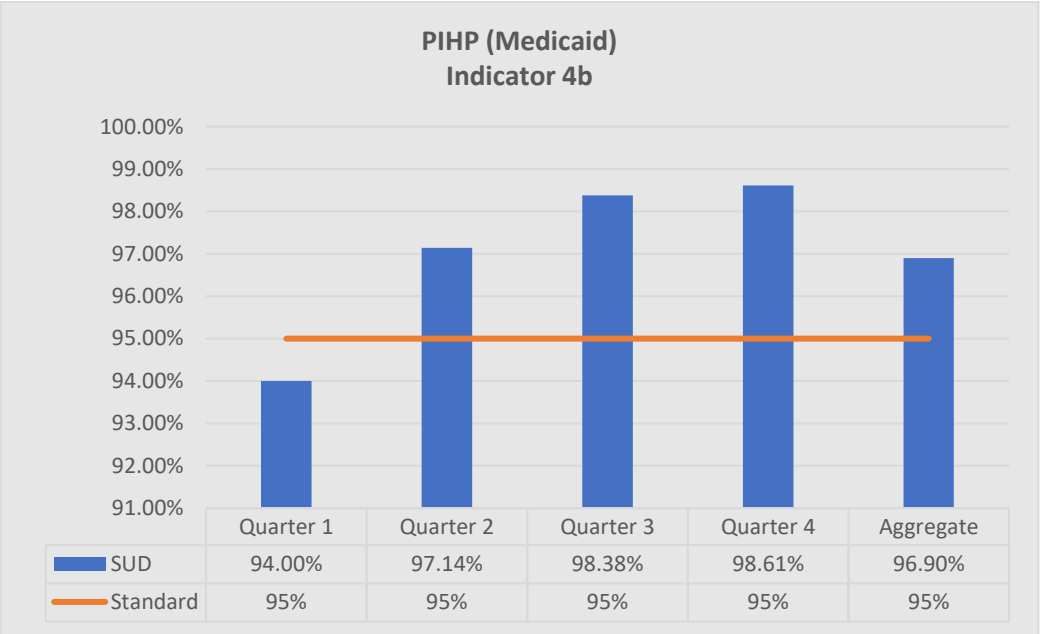
	MI/Child	MI/Adult	DD / Child	DD / Adult	Total Population
Quarter 3	91.85%	92.76%	76.47%	81.82%	90.90%
Quarter 4	81.39%	87.74%	83.60%	92.86%	86.12%
Aggregate	85.82%	89.50%	81.39%	89.74%	87.84%

The percentage of discharges from a psychiatric inpatient unit during FY 2020 who are seen for follow-up care within seven days. **Target Goal**: To achieve MDHHS established benchmark of *(95%)* for (4) quarters during FY 2020. **Results**: FY 2020 standard met for all populations with the exception of Q1 Child *(93.06%)*, Q2 Child *(86.08%)* and Q2 Adult *(94.92%).* DWIHN falls below the threshold for Q1, Q2 (Child) and Q2 (Adult). To address these areas, 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.



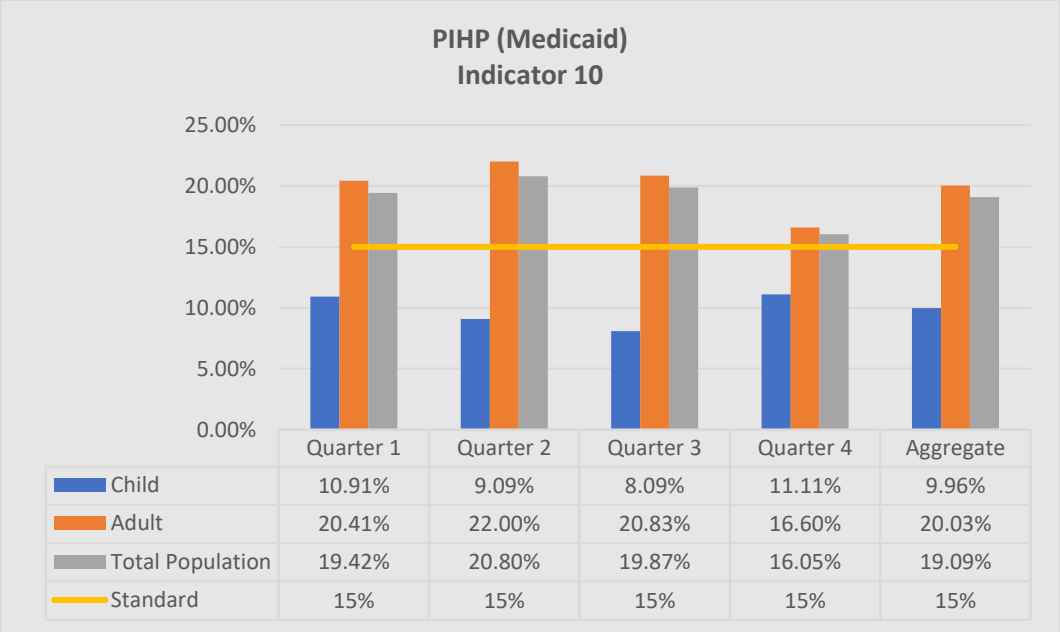
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Aggregate
Child	93.06%	86.08%	96.43%	96.83%	92.59%
Adult	95.99%	94.92%	97.12%	97.22%	96.51%
Total Population	95.52%	93.45%	97.06%	97.19%	96.04%
Standard	95%	95%	95%	95%	95%

The percentage of discharges during FY 2020 from a Substance Abuse Detox Unit who are seen for follow-up care within 7 days. **Target Goal**: To achieve MDHHS established benchmark of *(95%)* for (4) quarters during FY 2020. **Results**: FY 2020 standard met for all populations with the exception of Q1 *(94.0%).* DWIHN falls below the threshold for Q1. To address this area, 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.



	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Aggregate
SUD	94.00%	97.14%	98.38%	98.61%	96.90%
Standard	95%	95%	95%	95%	95%

The percentage of readmissions of children and adults during FY 2020 to an inpatient psychiatric unit within 30 calendar days of discharge from a psychiatric inpatient unit. **Target Goal**: To achieve MDHHS established benchmark of *(15%)* or less for (4) quarters during FY 2020. **Results:** FY 2020 standard met for the children population. The standard was not met for the adult population for all quarters. DWIHN falls below the threshold for adult population. To address this area, 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.



	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Aggregate
Child	10.91%	9.09%	8.09%	11.11%	9.96%
Adult	20.41%	22.00%	20.83%	16.60%	20.03%
Total Population	19.42%	20.80%	19.87%	16.05%	19.09%
Standard	15%	15%	15%	15%	15%

Evaluation of Effectiveness

During FY 2020, The state's overall benchmark of *(95%)* was met for each indicator for Quarters 1-2 with the exception of Indicators 4b (Q1) and 4a (Q2). During Q1, the score for indicator 4b was at *(94.0%).* On the contrary, during Q2, Indicator #4b increased 3.14 percentage points and was able to meet the state standard for the first time of FY 2020. During Q2, the score for Indicator #4a decreased by 2.07 percentage points and fell below the state standard to *(93.45%).* While our department does not want to ever see our numbers decrease, Q2 includes the timeframe when workplaces in the United States were transformed due to the COVID-19 Pandemic. Providers have reported some interruptions/delays with appointments in the middle/end of March 2020 due to closing of agencies and adjusting to telehealth services. Nonetheless, the performance improvements can be contributed to ongoing efforts which include educating our provider network. Ongoing efforts to include review of potential barriers for members that are not following through with their 7-day follow up appointments.

Barrier Analysis

DWIHN has failed to meet the threshold of *(15%)* or less for Indicator # 10 (Adult Recidivism) during the last four (4) quarters. Quarter 4 data has demonstrated an overall decrease in adult readmissions *(16.50%),* which is an average of *(4.6%)* less than the prior three quarters *(Q1 20.4%), (Q2 22%),* and *(Q3 21%).* This decrease is noted to ongoing efforts which include review of members that are recidivist. Indicator #10 increased by *(1.38)* percentage points in Q2 for adults readmitted within 30 days to *(22.0%),* the state standard is *(15%)* or less. There are several departments within DWIHN that continue to meet and complete work in an attempt to reduce the adult recidivism rates. This group continues to meet regularly and discuss action items. Network providers will be asked to complete a Plan of Correction again to ensure steps are taken to prevent numbers from increasing during Quarter 3. Efforts to decrease hospital admissions and readmissions continue to be a challenge for DWIHN. DWIHN Quality Improvement unit has established an internal workgroup to examine admission and readmission trends, conduct root cause analysis, identify opportunities for improvement and determine next steps.

The correlation between Indictor 4a (follow-up care within 7 days) and Indicator 10 (Recidivism) for Q3 identifies that 33 *(10%)* members are readmitted and have not been assigned to a Clinically Responsible Service Provider (CRSP). The correlation also shows, as illustrated below, 122 *(38%)* members did not make 7-day follow up appointment and were readmitted within 30 days. Q4 identifies that 38 *(9%)* members are readmitted and have not been assigned a CRSP, 132 *(31%)* members did not 7-day follow up appointment. Overall, when two or more indicators are missed, DWIHN implements a higher level of scrutiny, which requires the providers to submit monthly (and sometimes weekly) reports on their progress. DWIHN providers are required to submit the MMBPI tracking template monthly to ensure accuracy and outliers are being followed-up with on a timely basis. Quarterly data is compiled and sent to MDHHS on the last day of the 3rd month in each quarter.

Opportunities for Improvement

DWIHN has identified the following interventions and improvement efforts:

- Identification of members that are readmitted more than once during each quarter.
- Development of a Recidivism Workgroup which is a collaboration effort with Quality Improvement, Integrated Health, Access/Crisis and Clinical Practice Improvement Units to review if members that continue to be readmitted, or admitted more than once during a quarter are enrolled in the Complex Case Management Program (voluntary), ACT or assigned to a Clinical Responsible Service Provider (CRSP).
- Engagement of the CRSP's to conduct Interdisciplinary meetings for members that have multiple readmissions.
- Monitoring of the Quality Improvement Project (PIP) data for improving the attendance at Follow-up Appointments with a Mental Health Professional after a Psychiatric Inpatient Admission.
- Providing technical assistance and training to our provider network as required.
- Review and monitoring of the correlation between Indictor 4a (follow-up care within 7 days) and Indicator 10 (Recidivism).
- DWIHN has also increased the frequency of analysis data during the Quality Operations Technical Workgroup and Performance Indicator meetings and sharing best practices across the network. This process has helped identify trends early on. DWIHN has also developed dashboards in the MHWIN system, that allow providers to access and review their own cases that are approaching the end of the follow-up period.
- Continue to ensure providers are meeting regulatory and DWIHN standards.

Improving Access to Substance Use Disorder

Activity Description

DWIHN SUD continuum of care consists of prevention, treatment and recovery services. DWIHN prevention programs address reducing childhood and underage drinking, reducing prescription and over the counter drug abuse/misuse, reducing youth access to tobacco, and reducing illicit drug use.

Quantitative Analysis and Trending of Measures

There were 7,355 individuals that received SUD services for FY20. This is a *(18%)* decrease from FY 19 with 8,943 individuals served. Consistent with the decrease in individuals served, there were 14,885 admissions, a decrease of *(19%)* from FY18 with 17,724 admissions. 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 saw a reduction in three performance indicators (PI) in two fiscal years including the first quarter in 2020 that did not meet the threshold of *(95%)* compliance. Those indicators are # 2 Access 1st Request Timeliness, #3 Access/1st Services Timeliness and 4b SUD-Detox Discharges Follow -up. These PIs are being closely monitored by SUD and information technology staff. Previously DWIHN was looking only for residential admit within 7 days from detox discharge for compliance. Now DWIHN is looking for paid service units also in residential admits with service date within 7 days from detox discharge.

Evaluation of Effectiveness

DWIHN received a new indicator 3rd quarter of fiscal year 2020. The Percentage of Indicator #2e is always *(0.00%).* This is about the number of clients who were approved by DWIHNs access center for SUD Treatment but never received an admittance by any SUD Providers. The Michigan Department of Health and Human Services (MDHHS) asked the Pre-paid Inpatient Health Plans (PIHP) to give this number from 3rd quarter of FY2020.

Barrier Analysis

Withdrawal management services (WMS) previously detoxification, accounts for *(22%)* of admissions. If all levels of residential services are combined, it accounts for *(32%)* of admissions. Outpatient admits account for *(13%)* of admissions. Intensive Outpatient, IOP Level 1 through Level 4 account for *(8%)* of admissions. Admissions for Medication Assisted Treatment including methadone account for *(16%)* of admissions, followed by Recovery Services at *(9%).* (Note: some categories that are less than *(1%)* of whole, reflect *(0%)* even though there are admissions reflected in those categories). The percentage served in each category remains relatively consistent, and is correlated with the available capacity of the provider network. Even though number of members admitted was reduced overall, the level of care service mix remains consistent. Another barrier is that providers have neglected to input claims in residential admits after detox discharge. As a result, providers cannot enter service units in MHWIN without authorization approval. They are unable to mark this as an exception.

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, DWIHN believes prevention works, treatment is effective and recovery is real! Our actions will continue to improve health and achieve excellence in operations.

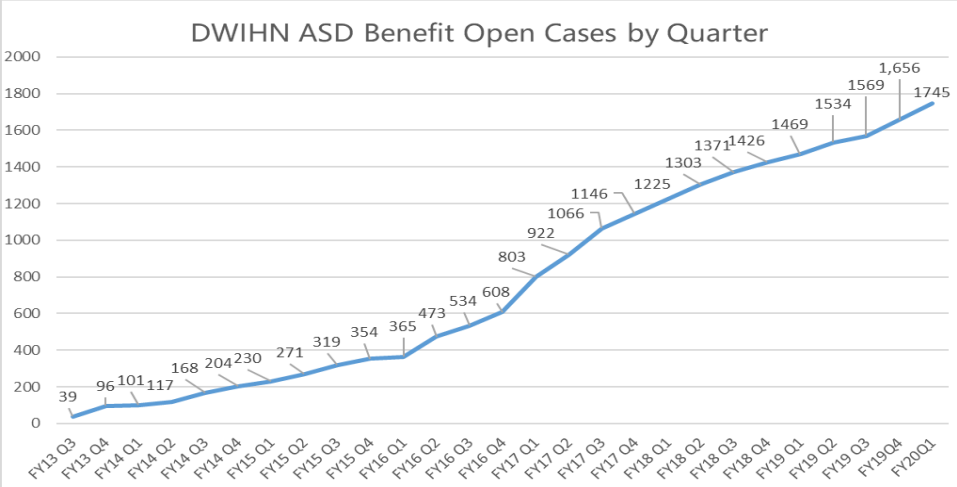
Improving Access to Autism

Activity Description

Another significant area in which DWIHN strive to improve is to increase the number of members who receive Applied Behavior Analysis (ABA) services from an ABA Behavior Technician within 90 days of the Michigan Department of Health and Human Services (MDHHS) approval.

Quantitative Analysis and Trending of Measures

FY20, there are currently 1,710 open cases of members receiving ABA services with the largest concentration of enrollees between the ages of two and seven compared to 1,659 in FY19. In FY20, referrals reduced by *(20%)* due to COVID-19. Timeliness of authorizations reached *(98%)* in FY 20. Overall, as illustrated below the numbers served over the past 8 years have increased substantially.



Evaluation of Effectiveness

DWIHN's ABA Benefit continues to grow each quarter for members enrolled in the ABA Benefit. DWIHN receives approximately 100 new referrals each month for the Benefit. DWIHN's ABA Provider Network continues to have an 8:1 or less ratio of staff to member. DWIHN added 2 new ABA providers during FY 20 for a total of 15 ABA providers throughout Wayne County. In addition, DWIHN hosted (2) two virtual trainings for the provider network on interpreting ABA Assessments, and Building Foundational Livings Skills. Each training highlighted a different focus area as well as provide the right tools and resources that providers can leverage to improve outcomes. The ABA providers are completing Authorization Approval documents in DWIHN's MHWIN system. This form details important information the Support Coordinators need in order to request authorizations in MHWIN for the ABA Benefit. This has increased communication between ABA Providers and Support Coordinators and decreased the return rate authorizations with errors. The ADOS-2 Worksheets and Behavior Assessment Worksheets have been added to MHWIN. Over the last fiscal year DWIHN has focused on improving data collection and analysis to enhance overall quality of care. Working in conjunction with the information technology department, authorizations are now automatically approved in accordance with the service utilization guidelines and providers are now capable of entering assessment data electronically.

Barrier Analysis

One of the major barriers is that 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 FY20.

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:

- Implemented systems process changes including: ASD Benefit Request Form, ADOS-2 Worksheet, Behavior Assessment Worksheet in MHWIN, and Auto-Authorization Approval Process.
- Added 2 additional ABA Providers to network.
- Provided 4 ASD specific trainings.
- Contracted with 2 Independent Evaluator Organizations to conduct initial ASD evaluations.
- Increase provider meetings to monthly to increase communication, education, and support for providers from DWIHN.
- Continue to meet with and contract with prospective providers to build provider network capacity.
- 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.
- Implemented Authorization Request for Form.

Habilitation Supports Waiver (HSW)

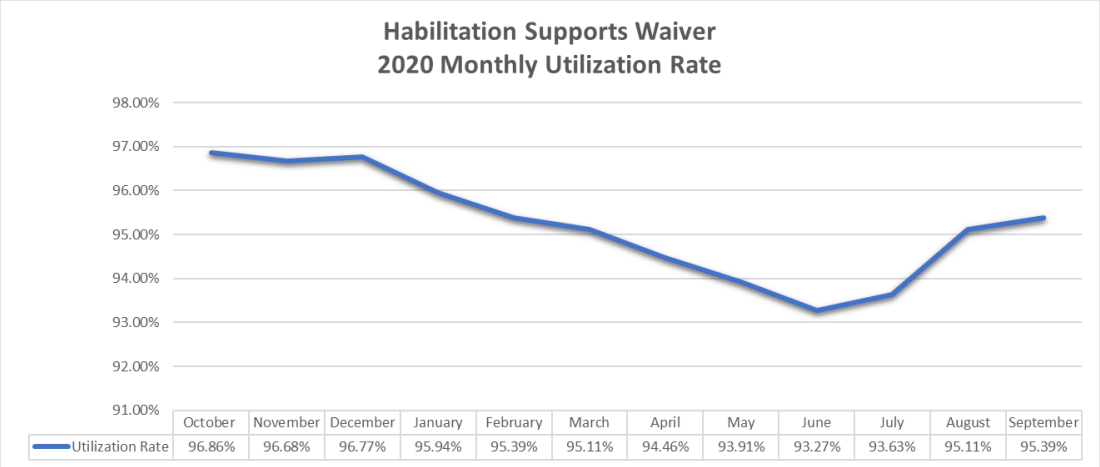
Activity Description

To improve service access to the Habilitation Supports Waiver (HSW) program, DWIHN took steps to modify the program's rate structure. In July of FY2020, an incentive program that provided a one-time payment of $1,000 per member was made available to contracted supports coordinator agencies. Additionally, these agencies began to receive an increased payment rate of *(7%)* for HSW billed services. Lastly, the HSW Program Coordinator performed Supports Coordinator Meetings and Technical Assistance Meetings throughout 2020. As a result of the incentives and meetings, DWIHN was able to change the HSW program membership downward trend that has been occurring over the last two years.

Quantitative Analysis and Trending of Measures

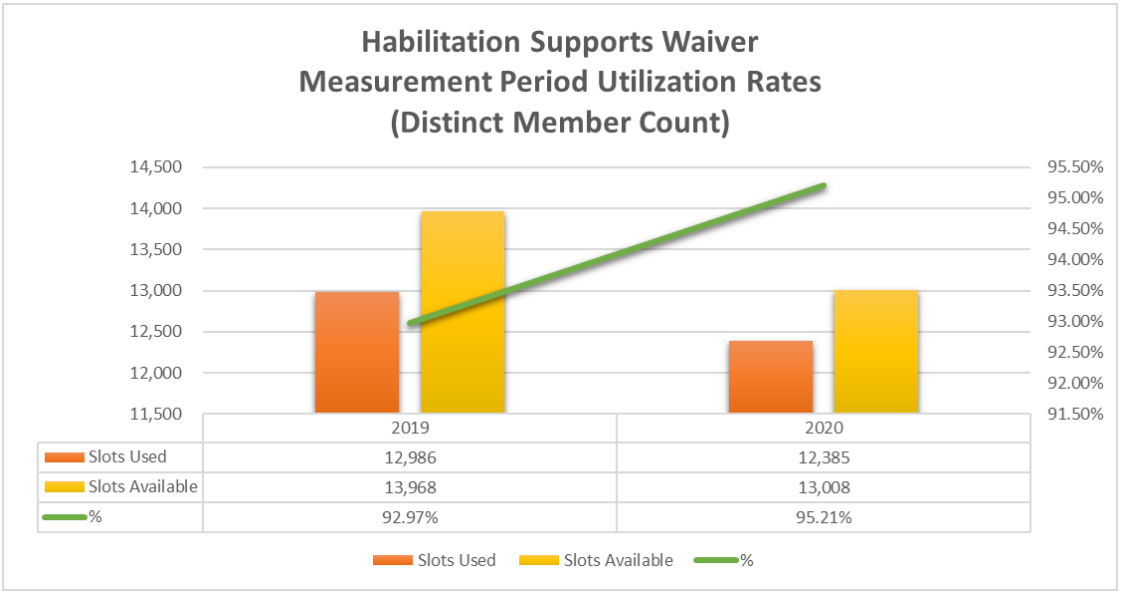
DWIHN's HSW program utilization rate and enrollment numbers have been decreasing the last three years. This struggle has led MDHHS to reducing DWIHN's number of allocated program slots in 2018 and 2020. At the beginning of the FY20, this reduction gave the illusion that the HSW program was running more successfully than it actually was. Table 1 shows the continuous decline in program enrollment from the months of October 2020 to June 2020. Key interventions (financial incentive and technical assistance meetings) were implemented in June 2020 and July 2020 and helped shift the downward trend. Table 2 shows how the overall utilization rate increased during FY2020 compared to FY19.

Table 1



	October	November	December	January	February	March	April	May	June	July	August	September
Utilization Rate	96.86%	96.68%	96.77%	95.94%	95.39%	95.11%	94.46%	93.91%	93.27%	93.63%	95.11%	95.39%

Table 2



	2019	2020
Slots Used	12,986	12,385
Slots Available	13,968	13,008
%	92.97%	95.21%

Evaluation of Effectiveness

During FY20, the Michigan Department of Health and Human Services (MDHHS) required a utilization rate goal of *(95%)* for all of its Prepaid Inpatient Health Plans' HSW Programs. DWIHN's HSW program utilization rate and enrollment numbers have been decreasing the last three years. This struggle has led MDHHS to reducing DWIHN's number of allocated program slots in 2018 and 2020.

DWIHN has been working on interventions to halt the declining HSW program members. The first half of FY20 continued the downward program membership trend. Key interventions, including the financial incentive program and technical assistance meetings that were discussed in the Activity Description section, were implemented in the second half of the year and changed the downward trajectory. They assisted DWIHN in finishing the year at a *(95.21%)* utilization rate for FY20. While FY20 had fewer slots available, DWIHN found it encouraging that the number of enrollees began to increase in the second half of the year. DWIHN will work to continue this trend in FY21.

Barrier Analysis

At the beginning of FY20, DWIHN had a number of barriers preventing the HSW program from meeting its *(95%)* goal. The first identified barriers included provider delays in application submissions; difficulties in completion of applications due to poor provider documentation; and low application numbers. DWIHN addressed this barrier by sending monthly reports to providers as well as implementing a Corrective Action Plan process.

A second set of barriers included lack of awareness among supports coordinators of the HSW program and its benefits; lack of knowledge and understanding of qualification criteria for the program; and lack of knowledge of the process for certification and recertification. Interventions to address these barriers included Supports Coordinators Trainings for providers as well as Technical Assistance Meetings at two providers who make up *(87.5%)* of DWIHN's HSW members.

The last set of barriers were providers' concerns regarding the additional cost associated with enrolling participants in the HSW program; supports coordinators vocalizing not having capacity to enroll members due to other duties; and HSW participants having more complex support and service needs. The intervention that was created to address these barriers was a financial incentive program.

Opportunities of Improvement

DWIHN has identified the following interventions and improvement efforts:

- Present this Quality Improvement Project to DWIHN's Improving Practices Leadership Team for any barrier ideas as well as for the project's approval.
- Explore pre-post tests and sign-in sheets at meetings with providers to ensure accurate attendance and learning.
- Send Corrective Action Plans to providers who are failing to meet deadlines or program requirements.
- Continue to facilitate trainings for new staff members as well as refresher trainings for experienced ones.
- Continue financial incentive program to assist providers with the additional costs of program enrollment and the complexity of members' service needs.

Children's Waiver Program

Activity Description

The Children's Waiver Program (CWP) makes it possible for Medicaid to fund home and community-based services for children with IDD who are under the age of 18 when they otherwise wouldn't qualify for Medicaid funded services.

Quantitative Analysis and Trending of Measures

During FY20, DWIHN had 36 children, youth and their families served by the different agencies on this waiver. On October 1, 2020, the Michigan Department of Health and Human Services (MDHHS) took steps to expand this waiver to an additional 50 children throughout the state increasing the available slots from 469 to 519, with an ultimate goal of 569 slots for the State of Michigan by the end of 2021.

Evaluation of Effectiveness

The School Success Initiative is offered by 11 Community Mental Health agencies in Wayne County and utilizes a three-tier universal health screening. Students that score in Tier 1 are eligible for stigma reduction services. Tier 2 students receive evidence based behavioral health supports and Tier 3 participants are linked to community mental health or private insurance for additional services. During FY20, 8,182 students received services at all 3 Tier Levels. A total of 16,792 services were delivered which included: case management, classroom observation, consultation, crisis intervention, family therapy, individual therapy, group therapy, psychoeducation, and others.

Additionally, funding for this project was given to Detroit Public Schools Community District (DPSCD) and the Goal Line. DPSCD provided services through social workers and nurses to students online or phone to general education students at Mason, Pershing, Dixon, Cody, Ronald Brown, and East English Village. They served 3,025 students in this project. Goal Line provided services to students in 14 schools and served 1,356 students with after school and busing activities. Ronald Brown, and East English Village. They served 3,025 students in this project. Goal Line provided services to students in 14 schools and served 1,356 students with after school and busing activities

Barrier Analysis

During FY20, four risk factors were identified to increase accessibility to children, youth and families. DWIHN staff collaborated with the Children's Community Mental Health (CMH) providers to enhance services to address the following identifiable risks:

- Depression and Anxiety*: 62%* of students experience symptoms of depression and *56%* experience anxiety.
- Bullying: *65%* have heard students called mean names and *71%* have heard rumors or lies being spread about others.
- Dating Violence: *33%* reported witnessing community or domestic violence*, 61%* have seen classmates get pushed, hit, or punched, *51%* heard others being threatened.
- Suicide: *31%* reported having thoughts of suicide or self-harm; *23%* reported having seriously thought about attempting suicide; one-third in grades 8-12 have considered suicide.

Children's Serious Emotional Disturbance Waiver (SEDW)

Activity Description

DWIHN is currently responsible for the assessment of potential SED waiver candidates. Wayne County currently has 5 SEDW providers providing this service; Black Family Development Inc., Development Centers, Southwest Counseling Solutions, The Children's Center and The Guidance Center. DWIHN is required to serve at a minimum 65 children and youth in this program. DWIHN exceed that number by providing services to 81 children, compared to 56 in FY19.

Evaluation of Effectiveness

In FY19, the waiver moved from a fee-for-service program to managed care payment. Additionally, the SEDW will be offered state wide, allowing young people to receive waiver services regardless of proximity within the State of Michigan. Two (2) new SEDW services will also be added to the array; Choice Voucher and Overnight Health and Safety Support. SEDW trainings were held throughout FY20 to both Department of Health and Human Services district offices as well as Wraparound providers within Wayne County. DWIHN trained 500 DHHS Specialist on the SEDW.

Crisis Services

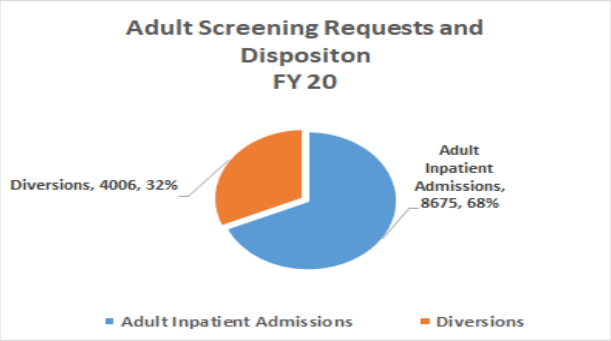
Activity Description

Access and Crisis Services works to ensure access to DWIHN's full array of services which includes the Crisis Continuum Service System. The department began working remotely in early March due to the COVID-19 pandemic. Access and crisis services across all programs decreased during the early months of the pandemic, however, volume began to consistently increase near the end of the 3rd quarter.

DWIHN has contracted with Community Outreach Psychiatric Services (COPE), a component of Hegira Programs to conduct Pre-Admission Reviews for Inpatient Hospitalization and Crisis Stabilization. The change in the pre-admission review process provided members to be screened within three hours of their request for crisis/urgent services upon entry into the emergency department/emergency room and DWIHN the ability to capture better data.

Quantitative Analysis and Trending of Measures

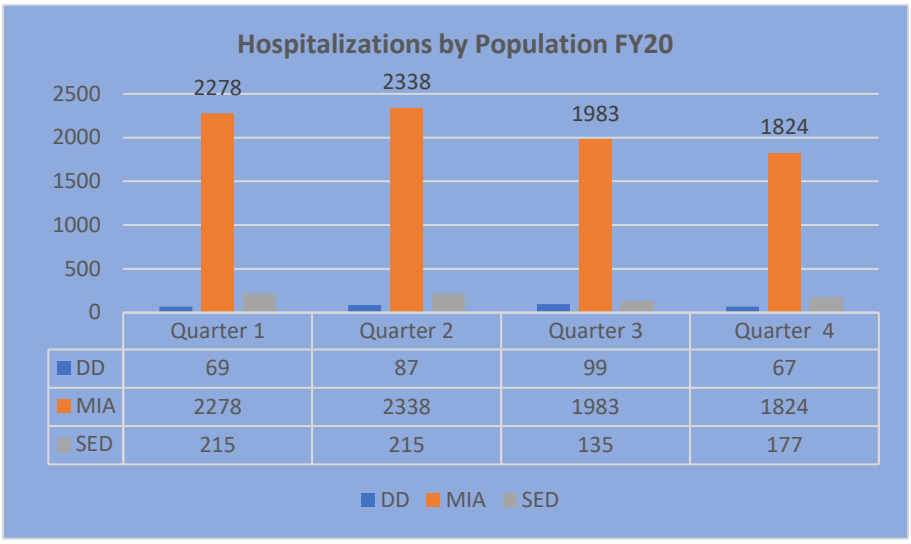
The following pie charts indicate the volume of requests for service received by COPE and the Children's Screening Entities. The screeners for children and adolescents are The Children's Center, The Guidance Center, and New Oakland Family Services. A preadmission review is conducted to determine need for hospitalization. Hospitalization is the most restrictive and expensive level of care. Diversions are not only cost effective but provide a less restrictive environment for consumers.



Evaluation of Effectiveness

The above chart shows that COPE screened 12,681 members. *(68%)* were hospitalized and the other *(32%)* diverted to the other levels of care which include outpatient, crisis residential, partial hospital, SUD residential, withdrawal management and other. The other referral categories may include home, health plan or other community resource. COPE also reported that 1277 (*10%* of members screened) had to wait more than 23 hours from time of request to time of placement. Additionally, 132 clients were admitted due lack of a crisis residential bed. This is reduced significantly from the previous year where 286 were admitted due to lack of a crisis residential bed in FY19. The data for Inpatient Hospitalizations indicates a decrease in number of admissions and unique members hospitalized during FY20 compared to FY19. This is consistent with decrease in overall members served this FY. When reviewing the percentage of Admissions per the number of members served for the past 3 fiscal years, the following emerges:

- FY18 DWIHN served 74,932 members and had 7860 members hospitalized for a percentage of *(10%).*
- FY19 DWIHN served 73,307 members and had 8757 members hospitalized for a percentage of *(12%).*
- FY20 DWIHN served 69,333 members and had 8149 members hospitalized for a percentage of *(8.5%).*



DWIHN continues to move forward in the planning and development of the Crisis Assessment Center. Plans for completion are scheduled for October 2022. DWIHN has worked with the Detroit Police Department (DPD) since FY19 to engage *(65%)* of the individuals in behavioral health services. Approximately of those individuals *(15%)* received long-term housing. COPE Leadership is a key contributor and has developed additional partnerships with the following law enforcement agencies: Canton, Grosse Pointe and Plymouth. Conversations are occurring with Romulus and Livonia to expand COPE services into those communities. In addition, documentation will assist in providing and Established "Crisis Alerts" in Member Records for identified recidivistic cases. The alerts assist crisis providers in coordinating services with the Clinically Responsible Service Provider (CRSP) for individuals experiencing crisis.

Barrier Analysis

Hospitalization is the most restrictive and expensive level of care. Diversions are not only cost effective but provide a less restrictive environment for member. As indicted above, Adults with Mental Illness account for *(89%)* of the 9487 hospital admissions. Children with Serious Emotional Disturbance account for *(8%)* of the hospital admissions, and individuals with developmental disabilities account for *(3%)* of the hospital admissions.

Opportunities of Improvement

DWIHN has identified the following interventions and improvement efforts:

- Collaborate with DWIHN's provider network to monitor members that present at the Emergency Department (ED).
- Providers must be notified in a real time of members seen in ED or admitted.
- Ensure members schedule a 7-day and 30-day follow-up appointment.
- Understand and educate providers to work members that are at greatest risk of hospital admissions and or readmissions.
- Continue the Med Drop program which provides education about specific medications and assists in identifying and implementing organizational strategies for members to take their prescribed medications. Members that participate have a 90% or better medication adherence rate, a reduction in psychiatric hospitalization usage and in crisis home usage.
- Identify members who are recidivist in MH-WIN with a banner alert, allowing the assigned CRSP the ability to review and update member crisis plans as needed.

Quality Pillar

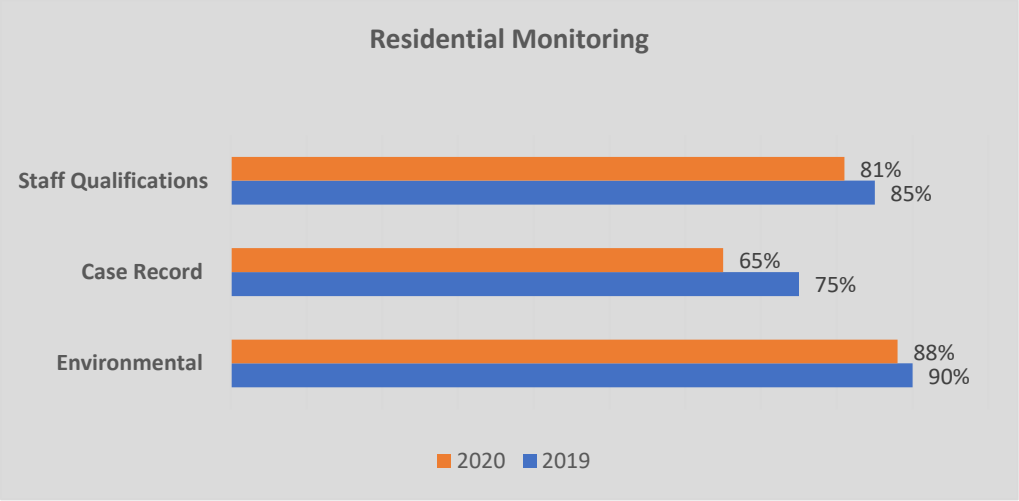
Monitoring and Oversight

Activity Description

Providers are monitored monthly, quarterly and as needed through the complaint threshold reporting for trends. The analysis allows DWIHN to determine if members have adequate access to care while ensuring compliance with state and federal statutes, the Michigan Department of Human and Health Services (MDHHS) contract, the Medicard Provider Manual, and NCQA requirements. DWIHN annually measures the provider network access across all programs against the established access standards. DWIHN collects and analyzes information using a sound data collection methodology that produces valid and reliable results.

Quantitative Analysis and Trending of Measures

During FY20, DWIHN staff conducted approximately *(65%)* of required reviews through virtual monitoring. Monitoring included SUD, CRSP and Residential providers. This is a substantial decrease from the previous fiscal year by *(15%)*. Scores for Residential Environmental Compliance ranged from (*77%-96%)*; with an average score of *(88%)*. Scores for Case Record reviews ranged from *9%* to *100%*; averaging *(65%).* Scores for Residential staff qualifications reviews ranged from (*39%-100%)*, with an average score of *(81%).* The chart below is an aggregate display of each area reviewed with a slight decrease from FY19.



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

Each year the performance monitoring staff conducts reviews of provider services and programs. However due to the COVID-19 pandemic, all on-site Performance Monitoring reviews were suspended on March 11, 2020. Performance Monitoring Reviews resumed remotely on July 6, 2020. Since this time the performance monitoring staff has conducted approximately *(65%)* of required reviews through virtual monitoring. Areas that require improvement for Residential reviews for environmental, case record and staff qualification include the following:

- Ensuring that member's food choices are honored as evidenced by documenting chosen substitutions on posted menus.
- Ensuring that members have full access to their home as evidenced by no signs restricting their access; ensuring that members can safely exit the home in the event of a fire, as evidenced by correctly documented Evacuation Scores.
- Posting of emergency contact information on the dashboard of vehicles used to transport members; working Carbon Monoxide detectors in the bedroom hallways.
- Heat detectors in the kitchen; single motion door handles and current Material Data sheets for chemical products in the home.
- Making certain the records contain guardianship papers.
- Signed consent forms; a copy of the current signed IPOS.
- Evidence that staff were trained on the member's IPOS.
- Completion of I-9 verification forms at date of hire to verify staff's eligibility to work in the state of MI.
- Monthly Office of Inspector General (OIG) checks to ensure staff's ongoing eligibility to be paid using Medicaid dollars.
- Ensuring that staff have an emergency contact listed in their Human Resources file.

Opportunities of Improvement

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. DWIHN's QI staff will continue to provide technical assistance during site reviews and make themselves available to help throughout the year as requested. Providers have access to DWIHN's Provider Notification Form to assist them with obtaining documentation from the Clinically Responsible Service Provider (CRSP).

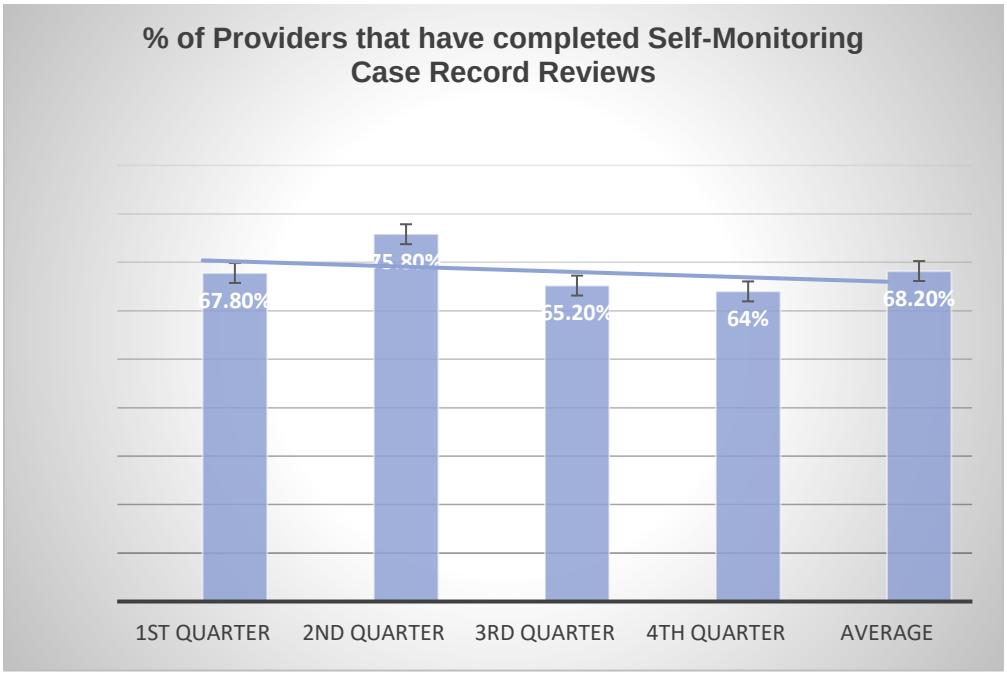
Performance Measurement Validation

Activity Description

As a component of the Continuous Quality Improvement (CQI) process, DWIHN implemented a provider self-monitoring plan. DWIHN developed and trained on a standardized monitoring tool to objectively assess the level of consistency within the Provider network. The provider self- monitoring review is a multilevel approach, which begins at the service provider level and cascades up to DWIHN's QI unit and other departments as needed.

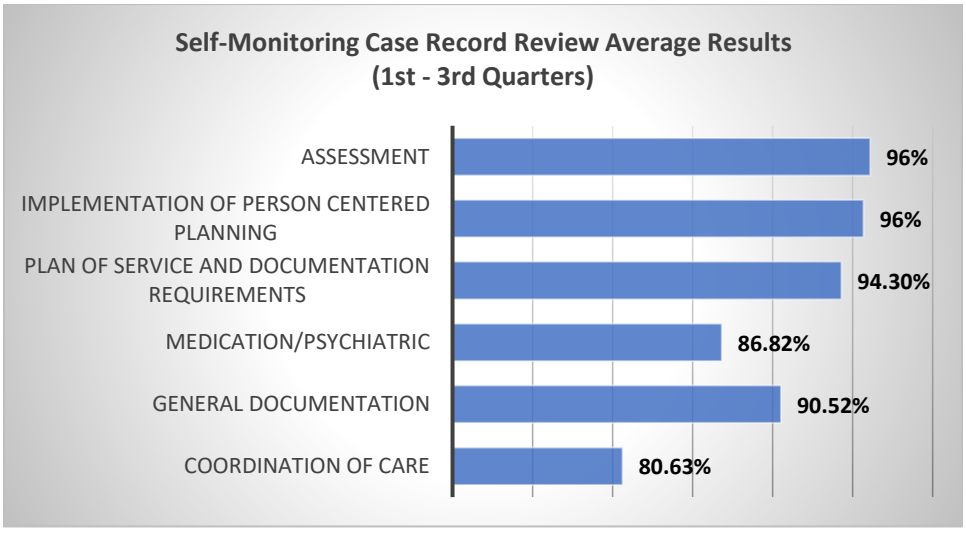
Quantitative Analysis and Trending of Measures

The chart below represents the percentage of providers that completed the quarterly case record reviews self-monitoring as required for FY20. The results demonstrate an increase in provider participation in Quarters 2 *(75.8%),* Q3 *(65.2%)* and Q4 *(64%)* The overall average increased from *(61.6%)* to *(68.2%).* This is a significant increase over previous years.



Evaluation of Effectiveness

The chart below represents the average compliance score for the selected areas for FY20, and received less than *(95%)* overall on Case Record Reviews. During FY20, compliance scores ranged from *(82%)* to *(100%),* which is a slight decrease from FY19. There was an increase in the Behavior Treatment Plan Score from previous year FY19, however the sample size is too small to draw an overarching conclusion. There was significant improvement in the areas of Wraparound and General Documentation while there was a decrease in Medication/Psychiatric and Coordination of Care. For FY20 the annual review findings focused on provider performance in the following areas; Person Centered Planning, Plan of Service Documentation, Medication/psychiatric, General Documentation and Coordination of Care.



Barrier Analysis

All providers were not completing the 35 case record reviews quarterly as required pursuant to the contract. In FY19, *(62%)* participated in the self-monitoring, compared to *(68%)* in FY20. QI will increase monitoring of provider's participation in the self-monitoring as part of the continuous quality improvement process (CQI).

Opportunities of Improvement

Quality Improvement staff will increase monitoring of provider's participation in the self-monitoring as part of the continuous quality improvement process (CQI). Quality Improvement staff will:

- Review a *(10%) sample* of the providers self-monitoring on a quarterly basis.
- Validate the self/monitoring activity submitted by the providers and identify patterns, trends and outcomes.
- Review the results with the provider, offer any needed technical assistance.
- Monitor for improved compliance as needed.
- Where there is ongoing inconsistencies and lack of improvements QI staff will collaborate between internal units to assist with improving outcomes.
- Compare provider self-monitoring results to the quality monitoring of the programs.
- Root Cause Analysis will be requested from providers scoring < *95%*.
- Develop a "Deemed Status" process that will allow for providers to submit their self-monitoring reviews to QI, thus not allowing for annual on-site reviews to occur each year if applicable.

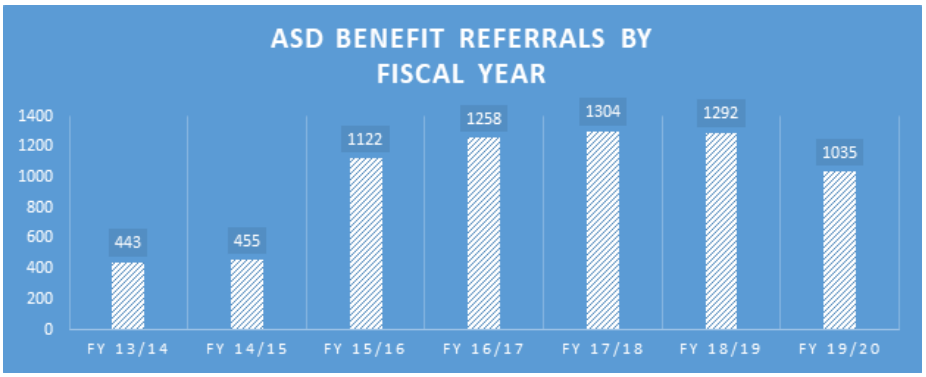
Autism Benefit

Activity Description

In FY20, DWIHN brought in review of medical necessity denials for Applied Behavior Analysis (ABA) services in order to 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.

Quantitative Analysis and Trending of Measures

The graph below indicates the number of referrals that DWIHN has in its provider network. There are currently 1,710 cases open in the ASD benefit. During FY20, *(98.4%)* of authorization reviews were completed in 14 days or less exceeding the NCQA standard timeliness disposition of *(90%).*



All referrals to the ASD benefit result in a member receiving direct services. A service of the benefit is completing evaluations to determine if a member meets criteria for the benefit. Members may be evaluated and found not eligible for the benefit or may meet criteria but decline services. As part of this system, electronic worksheets were developed to capture data from the evaluations and behavior assessments. Implementation of the electronic worksheets, has allowed DWIHN to resume responsibility in determining if a consumer meets medical necessity criteria for the ASD Benefit. Previously, DWIHN had delegated this responsibility to the service providers.

DWIHN QI staff conducted on-site and remote reviews of case records to ensure full compliance with the ASD regulatory requirements. Provider's compliance scores ranged from *(85%)* to *(100%),* compared to *(56%)* to *(82%)* for FY19. This is a substantial increase from the previous fiscal year.

Barrier Analysis

As is the case with many service areas, the ASD Benefit has been impacted by COVID-19. Historically, many of the service providers have only offered center-based treatment. At the onset of the pandemic in March 2020, many of the ASD Benefit services were initially not allowed to be provided via telehealth per MDHHS. After the onset of the pandemic, MDHHS quickly adjusted allowing nearly all ABA services to be administered via telehealth when clinically appropriate while also being more flexible on evaluation date requirements. While these changes were a tremendous help to the providers and consumers, some consumers opted to temporarily discontinue services until they felt they could safely receive services at the centers. Some consumers also chose to wait to pursue referrals into the ASD Benefit out of similar concerns. COVID-19 is likely a leading factor for the *(19.89%)* decrease in referrals from last year to this year.

Additionally, challenges remain in the following areas which had a combined score below the threshold of *(95%).*

- The annual consent for treatment is current, signed and dated.
- There is evidence the members Medicaid was active at the time of service delivery.
- The average hours of ABA services during a quarter were within the suggested range of service intensity *(+/-25%)*.
- There is evidence that the ABA assessment (ABLS, VB-MAPP, and AFLS) was uploaded to MHWIN within seven (7) calendar days of the completed assessment.
- When more than three appointments in one week were missed, inactivity was entered in the WSA and there was evidence of multiple attempts to keep the family engaged.

Opportunities of Improvement

To improve access availability the following interventions and strategies have been established.

- 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.

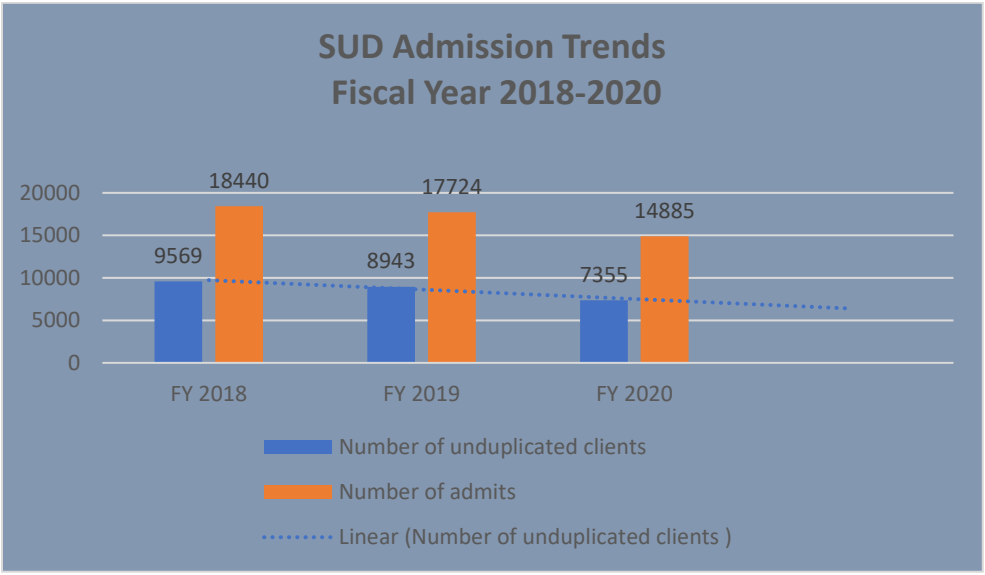
Substance Use Disorder (SUD)

Quantitative Analysis and Trending of Measures

In FY20, there were 7,355 members that received SUD services. This is a *(18%)* decrease from FY19 with 8,943 members served. Consistent with the decrease in members served, there were 14,885 admissions, a decrease of *(19%)* from FY18 with 17,724 admissions. This decrease can be attributed to COVID-19 which greatly reduced the capacity of many providers to serve consumers in both residential and outpatient settings. DWIHN QI staff completed annual reviews for *(100%)* of the SUD Treatment and Prevention providers for FY19 and FY20. The compliance scores range from *(86.0%)* to *(100%)* for FY20, compared to *(85%)* to *(100%)* for FY19 and *(90%)* to *(100%)* in FY18, which demonstrates a slight decrease from previous years. Each individual provider, obtain an overall aggregate score of *(96%)* for FY20, compared to *(97%)* for FY19, which met MDHHS established benchmark of *(95%).* Providers that have compliance scores of < *95%* are placed on Plans of Corrections (POC) in addition to requesting supporting documentation to support compliance. No CAPs were issued this year, due to no serious findings.

Evaluation of Effectiveness

The bar graph below shows the trend of admissions and the number of members served for the past 3 fiscal years. From FY18 to FY20, there has been a decrease in the number of individuals served. A large portion of the reduction in FY20 can be attributed to COVID. Each change in level of care is considered an admission. Some members receive more than one level of care, such as withdrawal management, followed by residential services and outpatient and/or recovery services.



The age distribution metric has remained relatively constant over the last several years. During FY 20, *(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.

Barrier Analysis

No barriers have been identified at this time.

Opportunities of Improvement

- 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 scores are less than *(95%).*

Critical/Sentinel Events Reporting

Activity Description

The processing of Critical/Sentinel Events is one element for identifying member safety and risks.

Quantitative Analysis and Trending of Measures

DWIHN processed a total 4,731 Critical/Sentinel Events in FY20, which is a decrease of *(49%)* in FY18. The change from FY19 reflected a *(19%)* decrease. With the highest category being Serious Challenging Behavior (815); the next top category is Physical Illness Requiring Emergency Room (634); and the lowest number of critical incidents is Medication Error (27).

Evaluation of Effectiveness

The reduced number of critical/sentinel events reporting can be attributed to member-specific, provider-specific and trend analysis and network trainings, which is required for access to utilize DWIHN's Critical Sentinel Event module. DWIHN has provided ongoing trainings and technical assistance to our provider network on reporting requirements as outlined in Critical/Sentinel Event Policy/Procedures.

The Critical/Sentinel Event training was provided for DWIHN's Clinically Responsible Provider (CRSP) Staff and Specialized Residential Providers. A total of 364 staff throughout the provider network participated in the training. Between October 1, 2019 through March 10, 2020 all trainings were held face-to-face; and beginning May 14, 2020 through September 30, 2020 trainings were conducted via the webinar platform.

The Training Manual was updated providing comprehensive instructions to the provider staff and guidance in the entry of critical/sentinel events. Technical assistance has been increased to ensure that all required reporting is complete, timely, and correct. Together the Quality Improvement unit has assisted in ensuring the updating/upgrading of all aspects of training and review in order to capture trends and patterns which ultimately impact the quality of services to our members.

Barrier Analysis

Per a recent Health Service Advisory Group (HSAG) External Quality Audit, it was determined that risk event analysis needs to be conducted on a more frequent basis. Also, Critical incidents are being reported to MDHHS for Emergency Medical Treatment outside of the 60 days window time frame required. A process has been established to begin collecting this information during FY 2021.

Opportunities of Improvement

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

- DWIHN has designated an assigned staff to monitor and review the five (5) reportable MDHHS required events on a daily basis to ensure the reporting is completed within the required timeframe.
- Conduct an in-depth review of providers who consistently report minimal or no critical incidents, sentinel events, or risk events.
- Review events related to substance use disorder (SUD) providers and members receiving SUD services.
- The Medical Director will review case findings and determine if a same and similar specialty review is required. (Consult an external expert in the specialty of medicine needed for the review).
- The Medical Director will also review case findings and determine if actions/review is needed.

Behavior Treatment Advisory Committee (BTAC)

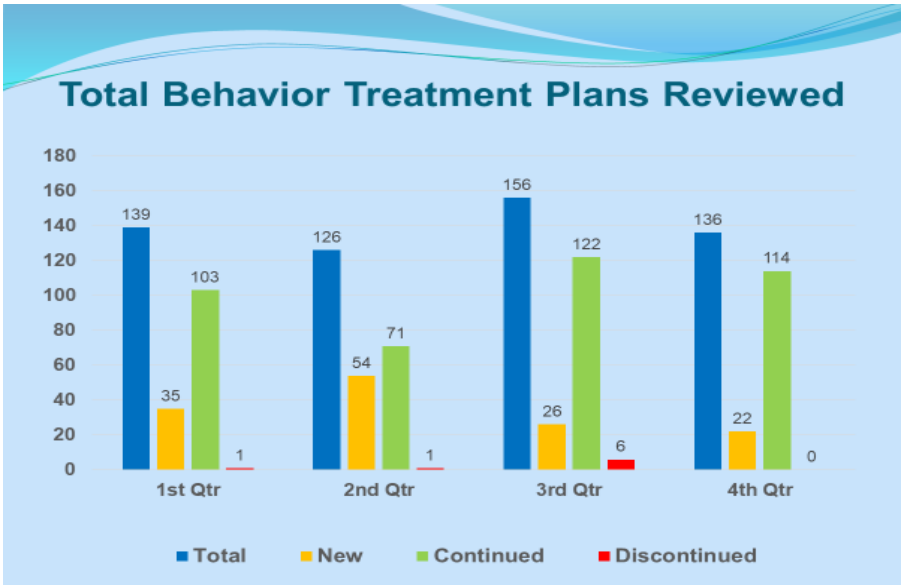
Activity Description

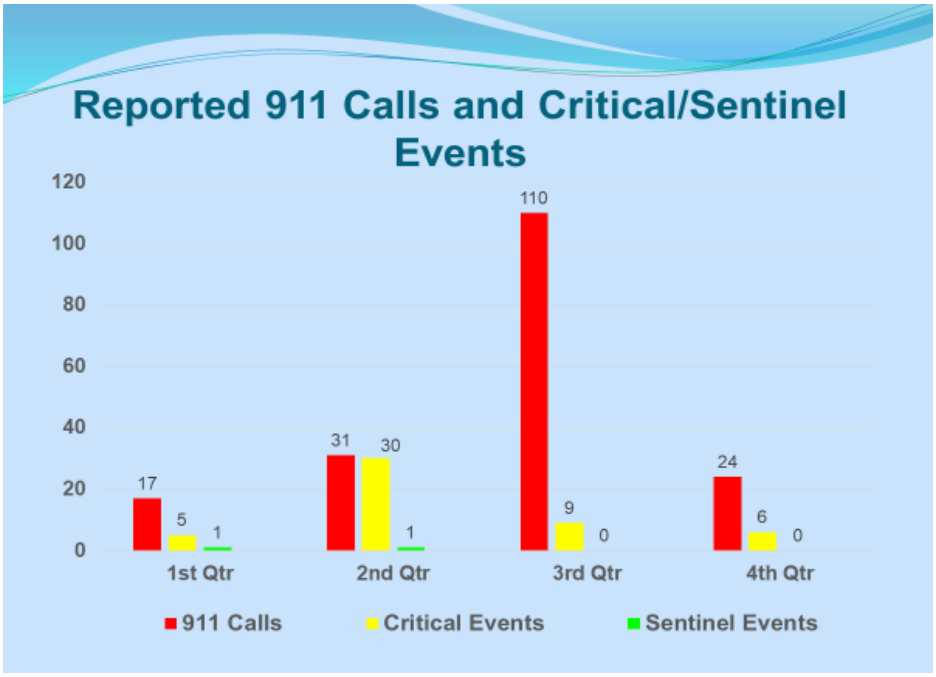
The QAPIP quarterly reviews analyses of data from the Behavior Treatment Review Committee (BTRC) where intrusive or restrictive techniques have been approved for use with members and where physical management has been used in an emergency. The data track and analyze the length of time of each intervention. 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.

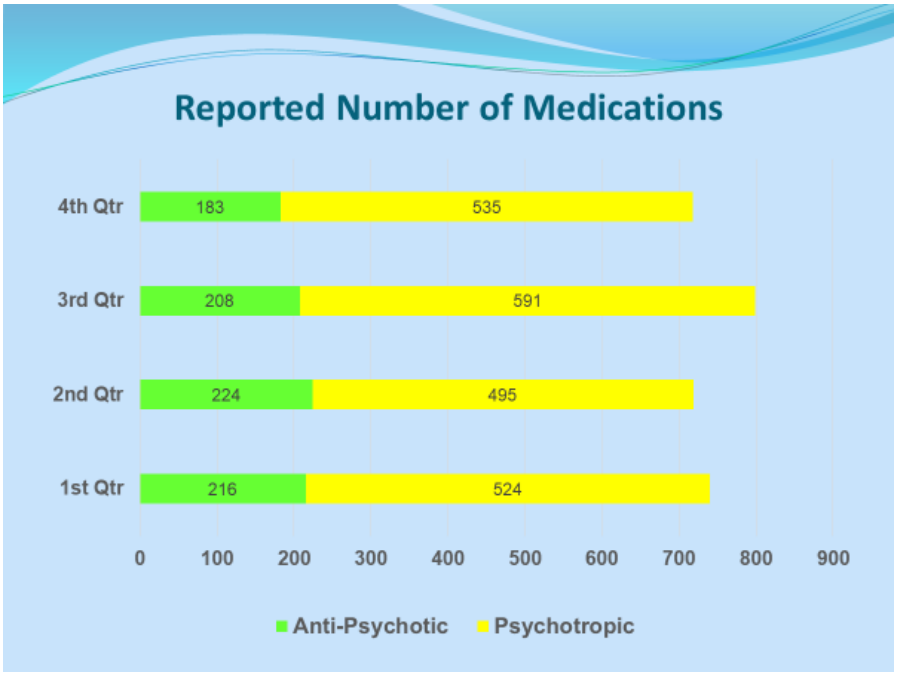
Quantitative Analysis and Trending of Measures

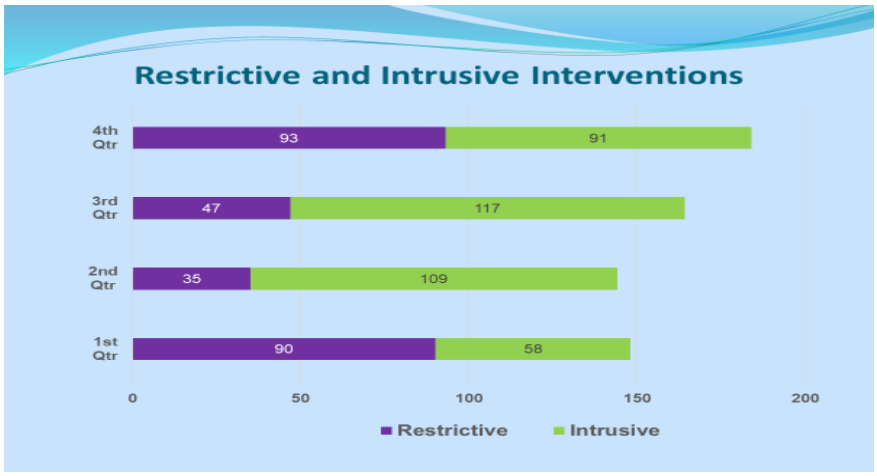
During FY20, DWIHN hosted the largest in-house Behavior Treatment training with MDHHS attended by 112 participants. As a step towards improving the monitoring of case records, a notification banner for each member on a Behavior Treatment Plan has been added to DWIHN's Mental Health Wellness Information Network (MH-WIN). During the pandemic of COVID 19, DWIHN issued HIPPA safe remote review and approval guidelines to network BTPRCs to ensure the continuation of the Behavior Treatment Review process.

In FY20, DWIHN BTPRC reviewed 557 members on Behavior Treatment Plans which is an increase of 24 *(4.3%)* 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 FY20.




Reported 911 Calls and Critical/Sentinel Events
120
100
80
60
40
20
0
17
5
1
31
30
1
110
9
0
24
6
0
1st Qtr
2nd Qtr
3rd Qtr
4th Qtr
911 Calls
Critical Events
Sentinel Events


Reported Number of Medications
4th Qtr
183
535
3rd Qtr
208
591
2nd Qtr
224
495
1st Qtr
216
524
0
100
200
300
400
500
600
700
800
900
Anti-Psychotic
Psychotropic



Evaluation of Effectiveness

DWIHN's Behavior Treatment Advisory Committee (BTAC) ensures that each Mental Health Clinically Responsible Service Provider (CRSP) submit BTRC data via the BTPRC Data Spreadsheet quarterly. This information is reviewed quarterly during BTAC meetings, and selected cases on the appropriateness of interventions are selected for BTAC review. As a step towards the continuous improvement of Behavior Treatment Review services, DWIHN issued a HIPPA compliant remote review and approval guidelines to the network BTPRC to ensure the continuation of the Behavior Treatment review services. As a step towards improving the monitoring of case records, a notification banner for each member on the Behavior Treatment Plan has been added to DWIHN's Mental Health Wellness Information Network (MH-WIN) to reflect any paid authorization of H2000 services within past 365 days. The Behavior Treatment Category is now available in MH-WIN Critical and Sentinel Reporting Module to improve the systemic under-reporting of 911 Calls, Deaths, Emergency Treatment, and Use of Physical Management, for the members on Behavior Treatment Plans.

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. A process has been established to begin collecting this information from the Clinically Responsible Service Providers (CRSP) during FY 2021.

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.
- To ensure the BTPRC requirements are included in the CRSP written contract for FY21

Workforce Pillar

Activity Description

To ensure a network of qualified practitioners, DWIHN utilizes Detroit Wayne Connect (DWC) for ongoing training requirements. Those trained included professional healthcare staff comprised of social workers, psychologist, physicians, nurses and counselors. The continuing education credits associated with these trainings accounted for: Child Mental Health Professionals (CMHP), Qualified Mental Health Professionals (QMHP), and Qualified Intellectual Disability (QIDP), and Substance Use Professionals (MCBAP).

Quantitative Analysis and Trending of Measures

In FY20, there were 65,460 individuals that actively utilize DWC with 56,633 completing the required online courses and 38,755 taking optional online courses. The total number of individuals trained demonstrates an increase of 10,602 *(23%)* compared to FY 2019. In the fiscal year of 2020, a total of 1,980 calls were made/received between October 1, 2019 and September 30, 2020. Call volumes decreased from the previous fiscal year. As a result of COVID-19, the monthly call volume decreased significantly beginning in March 2020. The March call volume (167 total calls) decreased by 165 calls compared to February 2020 (332 total calls). Beginning March 13, 2020, DWIHN ordered all employees to work from home. Many organizations utilizing Detroit Wayne Connect temporarily closed as well, decreasing the number of inquiries received by the helpdesk. The DWC helpdesk remained functional, and efficiently worked to resolve user issues.

Evaluation of Effectiveness

DWIHN's Naloxone Imitative program has saved 660 lives since its inception, which demonstrates additional 183 lives saved in FY20. DWIHN only reports those saves that we have documentation to support this initiative. Core Competency trainings continued to be held at the provider level throughout the year with the help of certified trainers who provide training to all Community Mental Health (CMH) children's clinical staff. This year 179 staff received training on 7 foundational components: CAFAS and PECFAS, Crisis and Safety Plans, Family Service Plans, Measurable Goals/Objectives, Strength-Based Assessment, Supervision and Systems of Care 101.

DWIHN's partnering provider network are working very closely with law enforcement to ensure individuals are assessed and reengaged with community behavioral treatment services. There has been much discussion around court-diversion services, thus, connecting the MHJN with Mental Health Court Dockets ensuring in-reach and out-reach continues for those with behavioral health challenges. Treatment outcomes have been successful, at least *(60%)* remain connected with their community behavioral health provider, and have not returned to the Wayne County Jail during the period of October 2019 – September 2020.

Last fiscal year the division supported over 89 events that had a cumulative number of 4,470 attendees. Pre-COVID, from October 1, 2019 through beginning March 9, 2020, prior to the shutdown, we impacted 1,351 individuals via training. After going virtual via BlueJeans, we impacted nearly 3 quarters more through September 30, 2020, with a cumulative number of over 3,119 attendees at events for this period. This number excludes internal events such as board meetings, HR trainings, etc.

In FY20, the use of the BlueJeans teleconference application has increased substantially. DWIHN began transitioning its in-person activities to remote/virtual activities. The Bluejeans platform has been an invaluable component in helping the department achieve its goal to maintain a high level of productivity in this new work environment. It has become the primary means for hosting DWIHN Board & committee meetings and public-facing meetings. For example, in the 5 months prior to COVID19, fewer than 50 meetings/trainings were conducted using Bluejeans. In the 8 months since, 20,606 individuals have participated in 2,411 meetings/training from 20,400 different endpoints. This accounts for nearly 1,018,000 minutes spent in those meetings. Further, 355 meetings have been recorded and viewed 611 times and 12 shared throughout the network. Over 8,000 individuals were reached through the social media Adolescent Engagement sessions. The activities and webinars aim to get adolescents engaged during the COVID-19 pandemic. As a result, a weekly web series was created to get adolescents engaged.

DWIHN established a Racial Equality Committee of DWIHN employees to discuss racial equality in the workplace. Staff Developed and implemented first adult focused Transgender affirmative care conference. Delivery of affirming care for individuals that identify as transgender, lesbian, gay, bisexual, queer, intersex, asexual, two-spirited, plus additional identities not included in current discourse. An emphasis on clinical care with transgender identified individuals was provided to practitioners to ensure that services are delivered in a respectful and safe manner within our system of care.

Barrier Analysis

Fentanyl remains the driving force in the drug overdose deaths. COVID 19 impacted the outcomes of our data. The DWIHN Naloxone Initiative program has saved 660 lives since its inception, this number is based on documentation up to September 30, 2020.

Opportunities for Improvement

DWIHN has identified the following as opportunities for improvement:

- Conduct training of Network Staff on how the practice will use social needs data to improve member health.
- Deliver Stage Wise Treatment Education.
- Expand the NAMI relationship to provider community-based education and training.
- Increase Integrated Care Competencies of the network practitioners.
- Increase Quality Improvement competencies of the network practitioners.
- Increase self-care for Caregivers / MyStrength implementation.
- Increase the competencies around Self-Determination, Shared Decision Making and Person-Centered Planning.
- Revamp training portal to cover the holistic care for the member.

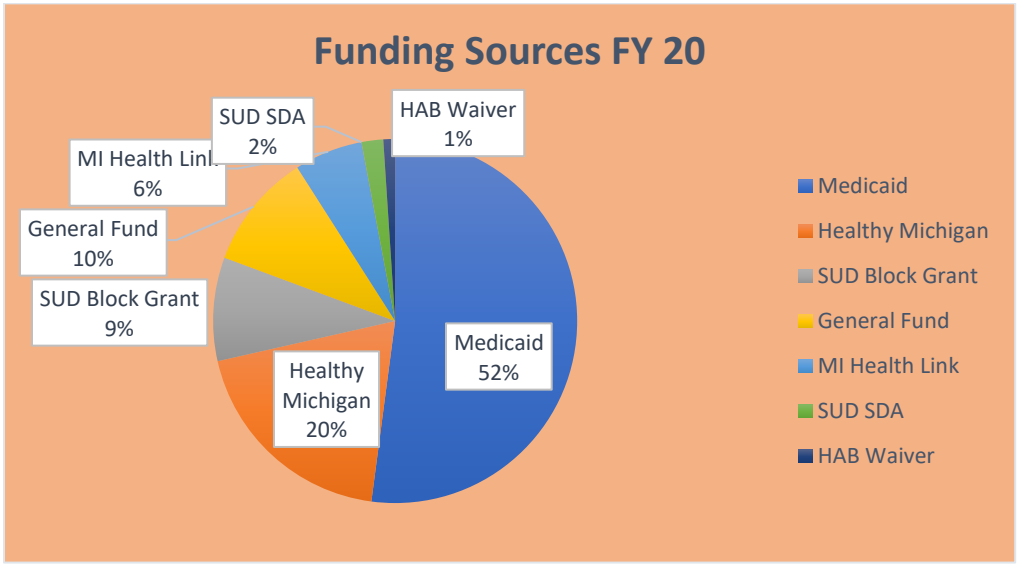
Finance Pillar

Activity Description

Commitment to financial stewardship and to the optimal prioritized allocation of scarce resources across a plethora of growing and competing needs to best fulfil its mission, vision and values.

Quantitative Analysis and Trending of Measures

The chart below indicates funding sources utilized to pay for an individual's service in FY 20. It combines general Medicaid, Healthy Michigan, Habilitation Waiver and other waiver programs which are all Medicaid, accounting for *(73%)* 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 *(11%);* decreased from *(18%)* last fiscal year. General Fund is reflected at *(10%)* (changed from *9%*) and MI Health Link is at *(6%)* (a change from *5%*). The funding source mix is very similar to last year. Further analysis is required to determine if funding source impacts overall utilization.



During FY20, DWIHN Quality Improvement staff completed compliance reviews of utilization data to identify potential under and over utilization issues due to the hybrid funding model. As a result, recoupment occurred for identified providers. It is also the department's goal to share the over and under-utilization of codes and services within the next fiscal year.

During FY20, the UM department approved 4,014 General Fund Exception authorization requests for a range of outpatient services for SMI, SED and IDD consumers. There was an additional unknown number of requests that were *not* approved because of eligibility or inadequate information or over usage issues. An additional unknown number of automated General Fund Exception approvals were generated through HIE at the time of the IPOS, beginning in August 2020.

The General Fund requests approved during FY20 represents a *(71%)* increase from the 2,346 approvals during FY19. That number was a marked increase from FY18, when 827 approvals were processed. Each of these increases are a result of the introduction of General Fund authorization requests that are submitted via MH-WIN, beginning October 2018.

Opportunities of Improvement

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

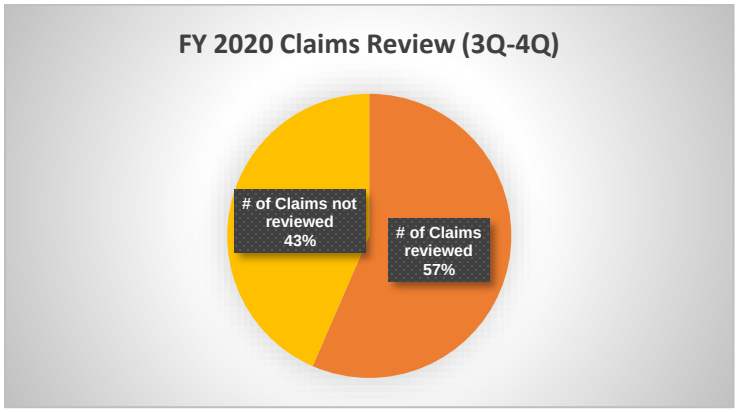
Medicaid Claims Service Verification

Activity Description

DWIHN is required to perform annual Medicaid Claims Service Verification audit to access the validity of claims and encounters submitted by Network Providers. Rat-Stat Variable Sample Size Determination, and Unrestricted Probe Sample module is used to determine the sample size.

Quantitative Analysis and Trending of Measures

In FY20, DWIHN conducted two (2) separate Medicaid Claims Verification audits. DWIHN reviewed a total of 923 claims through the Medicaid Claims Verification Review process, compared to 1,204 for FY19, which demonstrates a significant decline from the previous year. Of those159 were not validated due to the lack of evidence to support the claim, compared to 253 in FY19. For Quarters 3-4, it was decided that the focus of the reviews would include providers that had not been reviewed during the 1st and 2nd Quarters of FY20. This left a total number of 92 claims for review, of which 40 *(43%)* were not validated as illustrated below.



Evaluation of Effectiveness

As part of the audit, DWIHN staff pulled from the claim sample those providers who were on plans of correction from 2018/2019 fiscal year to assess current performance. There was a total of 38 providers and 159 claims in this group. There was six (6) providers of the 38 still on plans of correction during FY20. A further quantitative analysis for FY 2020, for Quarter 1-2, of the randomly selected providers, *(89%)* scored *(95%)* or better, *(10%)* were non-compliant scoring less than *(95%),* and *(1%)* failed to submit required documentation which will result in full recoupment of funds related to the claim. As for Quarters 3-4, 21% of the providers reviewed were non-compliant or failed to submit required documentation to support claim.

Barrier Analysis

The Medicaid Claims review process was impacted by the COVID 19 pandemic. DWIHN staff had to alter the site review process to virtual reviews and desk audits from home. Providers were responsible for displaying documentation virtually, by secured mail or electronic submission in MHWIN. Due to the pandemic there were providers that were closed for an extended period of time, and some providers for the entire duration of the review period.

Performance Improvement Projects

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 measure 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 from the previous FY18 of *(35.78%)* with a goal of *(45%)* for the 7 Day Follow – Up Appointment with a Mental Health Professional. For the 30-Day Follow – Up Appointment with a Mental Health Professional there is an increase of *(31.9%)* from the previous year. 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
1/1/2018-12/31/2018	Measurement 7 day	3348	9357	35.78%	45%	Below 2.33 percentage point decrease
1/1/2018-12/31/2018	Measurement 30 day	5886	9357	62.90%	75%	Below 10.11 percentage decrease
1/1/2019-12/31/2019	Re-Measurement 7 days	2144	8353	25.67%	45%	Below 10.11 percentage point decrease
1/1/2019-12/31/2019	Re-measurement 30 days	4207	8353	50.37%	75%	Below 12.53 percentage point decrease

Evaluation of Effectiveness

Despite the decrease, the interventions initiated that are felt to be strong interventions and had significant outcomes and will continue are the following:

- November 2017 and ongoing: Process developed to have 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 2018 12,005 7-day follow-up appointments were scheduled through the Access Center and in 2019 10,330 appointments were scheduled.
- 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: In 2018 10,160 members agreed to being sent a text reminder. Of those 10,160 members, *(82.21%)* acknowledged the text and of those members *(45.27%)* kept their appointment. In 2019 8040 members were texted appointment reminders and of those *(77.73%)* of the members kept their appointment. For the first two quarters of 2020, 3877 members were texted reminders and *(62.22%)* kept their appointments. This is a definite improvement from 2017 when *(40%)* of the members who had scheduled appointments kept them.
- Starting in 2019, DWIHN staff began making calls to members at least forty-eight hours prior to their appointment that were not in the texting program to remind them of their appointments and to discuss any barriers to them keeping the appointment. In 2019, 336 members were contacted and of those *(47%)* kept their scheduled appointment. In 2020, 525 members were contacted and of those *(58%)* kept their appointment.

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 started 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.

Adherence to Antipsychotic Medications for Individuals with Schizophrenia

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 2017 baseline data for Improving Adherence to Antipsychotic Medications for Individuals with Schizophrenia in the first re-measurement period of 2018, showed an increase in this measure from baseline from *(40.42%)* to *(69%)*. This is a *(28.58)* percentage point increase. The *(45%)* goal was achieved. Comparing 2018 to 2019 for Improving Adherence to Antipsychotic Medications for Individuals with Schizophrenia showed a decrease in this measure as the 2019 result was *(53%).* The chart below represents the baseline and results of the HEDIS measurements rates over a six-year period.

Time Period	Measurement	Numerator	Denominator	Rate	Goal	Comparison to goal
1/1/2017-12/31/2017	Baseline	2958	7319	40.42%	40%	Above
1/1/2018—12/31/2018	Remeasurement 1	3306	4762	69%	45%	Above Increase 28.58 percentage points
1/1/2019-12/31/2019	Remeasurement 2	2398	4510	53%	70%	Below Decrease 16 percentage points

DWIHN is performing below both the Medicaid health plan NCQA average and the Michigan health plan average for the HEDIS measures as well as below their goal. 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

Despite the decrease, the interventions that are felt to be strong interventions are the following:

- FY18, educational information posted on DWIHN website on customers site. Educational material that address the importance of medication adherence.
- FY19, several of Detroit Wayne Integrated Health Network providers started providing text messages, to members that agree, medication reminders and refill reminders.
- FY19, 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 *(81.4%)* in 2018 to *(76.9%)* in 2019 (the first remeasurement period. This is a *(4.5)* percentage point decrease. The table below illustrates the baseline and results of the HEDIS measurements rates over a six-year period.

Time period	**Measurement**	Numerator	Denominator	**Rate**	**Goal**	**Comparison to Goal and Statistical Significance**
1/1-12/31 2017#	Baseline	4,076*	5,277*	77.24%	80.10%	Below Increase 0.66 percentage points
1/1/- 12/31/ 2018	Re-measurement 1	2589	3179	81.44%	85.0%	Above Increase 4.2 percentage points
1/1/2019- 12/31/2019	Re-measurement 2	2380	3094	76.92%	85.0%	Below Decrease 4.52 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

- Continue to educate providers annually and post clinical practice guidelines on the DWHN website for Improving Diabetes Monitoring for People with Schizophrenia and Bipolar Disorder.
- Continued 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 in 2017. 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 us 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 monitors and continues to analyze the results of NCQA HEDIS measure requirements which include the following:

- Follow-up After Hospitalization for Mental Illness.
- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment.
- Follow-up Care for Children Prescribed ADHD Medication. (Continuation and Maintenance)
- Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults. (MHWIN Data)
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia.
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are using Antipsychotic Medications.
- Plan All-Cause Readmissions.

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

Coordination of Care is the cornerstone of many healthcare redesign efforts, including primary and behavioral healthcare integration. DWIHN's goal of care coordination is to meet member needs and preferences in the delivery of high-quality, high-value care. It involves bringing together various providers (physical health, SUD, community supports, etc.) to help achieve the goals of treatment. Data shows that care coordination increases efficiency and improves clinical outcomes and member satisfaction with care.

Quantitative Analysis and Trending of Measures

Through the provider self-monitoring for Coordination of Care providers continuously score, >95% with linking and coordinating with the Primary Care Physician (PCP), Natural and other Community Supports scored *(84%*), which is a slight increase from the previous FY in which scores ranged from (*95%) and (83%*). This slight increase is attributed to the improve efforts of the Behavioral Health 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 70%, 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

Care coordination is a core function of the MI Health Link program. MI Health Link requires coordination of services for all individuals to ensure effective integration and coordination between providers of medical services and supplies, behavioral health, substance use disorder (SUD) and intellectual/developmental disabilities (I/DD), pharmacy, and long term supports and services (LTSS). This requires coordination between the Integrated Care Organization (ICO) and the Pre-paid Inpatient Health Plan (PIHP) or the LTSS entities, where applicable.

DWIHN worked with the following health plans in FY20: AmeriHealth, Aetna, Michigan Complete, Molina and HAP Midwest. The Agency Profile within I-Dashboards indicates 5,271 MI Health Link members were enrolled with DWIHN in FY20, compared to the 5,010 members reported as enrolled last fiscal year. MI Health Link enrollees are a significantly small subset of DWIHN members *(6%)*. There were 616 MI Health Link (MHL) members hospitalized during FY20. During FY19, DWIHN managed 560 community hospital admissions of MI-Health Link members. 92 MHL members were readmitted in FY19 and in FY20, there were 58 members who were readmitted within 30 days of discharge. The number of readmissions decreased by (*45%)* in FY20. Molina saw the highest number of admissions during FY20 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.

Opportunities for Improvement

DWIHN has identified the following as opportunities for improvement:

- Continue to monitor and take action as necessary to improve continuity and coordination of care within DWIHN health care network.
- Continue to collaborate with behavioral healthcare practitioners to monitor and improve coordination between medical care and behavioral healthcare.
- 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.

Advocacy Pillar

Home Community-Based Services (HCBS)

Activity Description

The HCBS provide opportunities for Medicaid Beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. DWIHN is committed to working with the provider network toward full compliance with Home and Community Based Services by March, 2023. Activities include, but are not limited to, completing survey process, review of data collected from survey, notifying providers of corrective action, collecting corrective action, approving corrective action and resurveying to assure both initial and ongoing compliance. DWIHN will allow providers a reasonable length of time to remediate identified issues as specified in their corrective action plan as long as the provider is making progress and provides regular updates to DWIHN's Quality Improvement unit. These programs serve a variety of targeted populations, such as people with intellectual or development disability, physical disabilities, and /or mental illnesses. Additionally, the rule is designed to ensure that Medicaid's HCBS programs provide full access to the benefits of community living and offer services in the most integrated settings.

Quantitative Analysis and Trending of Measures

Currently, 65 out of 118 non-residential sites and 133 out of 471 residential sites in the region have been assessed by DWIHN's Quality Improvement (QI) unit as compliant with the HCBS final rule requirements. DWIHN will continue to provide providers a reasonable length of time to remediate identified issues as specified in their CAP as long as the provider is making progress to come into full compliance with the HCBS rule.

Evaluation of Effectiveness

The compliance reviews regarding the HCBS Rules under Medicaid are ongoing. DWIHN has created a residential provider report card that offers an overall view of performance and tracks compliance with standards, policies and procedures regarding the final rule. In addition, DWIHN's Quality Improvement unit maintains a directory of all contracted service providers that are HCBS compliant within the network. This information can be found on DWIHN's website under the Providers/Provider Resources tab. DWIHN has developed a Home and Community Based Services policy for our provider network that will be implement before the next contracting period. DWIHN will continue its efforts towards compliance in all services that fall under HCBS.

Barrier Analysis

To address the HCBS barriers:

- 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

DWIHN remains steadfast in its commitment to continue to provide technical assistance to the providers to identify implementation approaches that ensure provision of Medicaid Services in a manner consistent with program requirements through the following initiatives:

- 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

Most activities were canceled due to COVID but there were several new opportunities to get the word out about DWIHN and its resources. The DWIHN Access to Care 30-minute special aired on Fox 2 in September. DWIHN sponsored a “Community Day of Hope” and a back-to-school supply giveaway. DWIHN was also involved in creating a Wayne County "Walk a Mile in My Shoes Rally" that was shown during the virtual walk in September.

DWIHN Website

During FY20, the 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 Assessment Performance Improvement Program (QAPIP)
  - QAPIP Description Plan FY 2019-2021
  - QAPIP Description Plan FY 2021-2023
- Annual Evaluations
  - QAPIP Annual Evaluation FY 2017
  - QAPIP Annual Evaluation FY 2018
  - QAPIP Annual Evaluation FY 2019
  - QAPIP Annual Evaluation FY 2020

Compliance with Applicable Accreditation, Legislative Federal/State

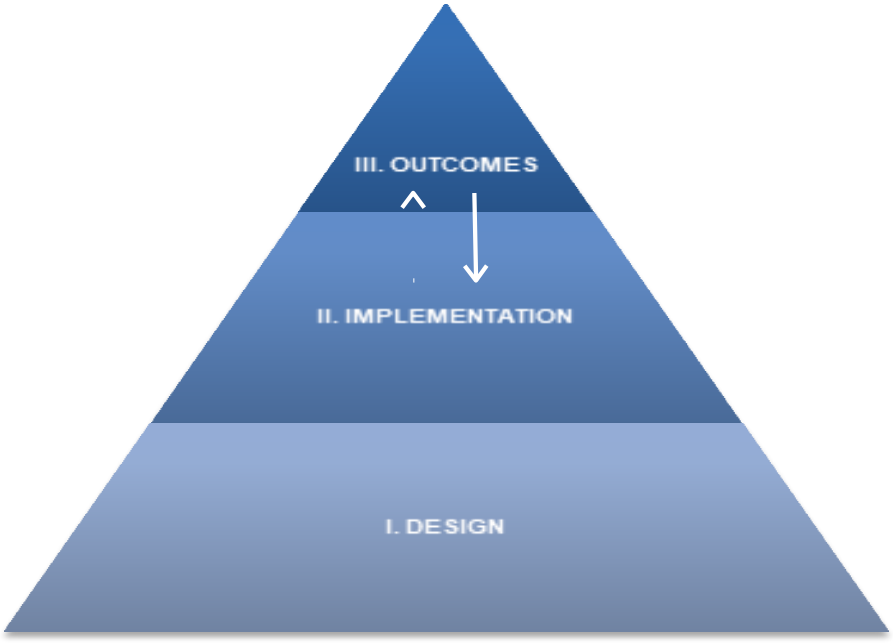
Health Services Advisory Group (HSAG)

Activity Description

HSAG completes three separate reviews as required by MDHHS: Performance Improvement Project (PIP), Performance Measure Validation (PMV) and the Compliance Monitoring review.

Quantitative Analysis and Trending of Measures

The goal of this PIP is to increase Diabetes Screening for members with Schizophrenia or Bipolar Disorder who are dispensed Atypical Antipsychotic Medications. Individuals with a mental health illness are at increased risk for developing diabetes. Diabetes left untreated can result in serious health complications such as blindness, kidney disease, and amputations. This PIP topic represents a key area of focus for improvement by DWIHN. This PIP also aligns with the HEDIS measure. To implement successful improvement strategies, a methodologically sound study design is necessary as illustrated below.



Evaluation of Effectiveness

The table below displays the validation results for DWIHN's PIP evaluated during 2019–2020. The table illustrates the DWIHN's overall application of the PIP process and success in implementing the PIP. Each step is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in the table show the percentage of applicable evaluation elements that received each score by step. Additionally, HSAG calculated a score for each stage and an overall score across all step.

Performance Improvement Project Validation Results for Detroit Wayne Mental Health Authority

Stage	Step		Percentage of Applicable Elements*		
			Met	*Partially Met*	*Not Met*
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	0% (0/1)	100% (1/1)	0% (0/1)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**88% (7/8)**	**13% (1/8)**	**0% (0/8)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (3/3)	0% (0/3)	0% (0/3)
	VIII.	Appropriate Improvement Strategies	100% (6/6)	0% (0/6)	0% (0/6)
Implementation Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Outcomes	IX.	Real Improvement Achieved	33% (1/3)	0% (0/3)	67% (2/3)
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			**33% (1/3)**	**0% (0/3)**	**67% (2/3)**
Percentage Score of Applicable Evaluation Elements *Met*			**85% (17/20)**		

Barrier Analysis

Overall, *(85)* percent of all applicable evaluation elements received a score of *Met*. However, The identification and prioritization of barriers through causal/barrier analysis and the selection of appropriate active interventions to address these barriers are necessary steps to improve outcomes. DWIHN's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the DWIHN's overall success in achieving the desired outcomes for the PIP.
The three areas in which DWIHN received a Partially Met and/or Not Met include the following:

- DWIHN failed to describe the eligible population in the denominator description rather than listing the exclusion criteria *(Partially Met).*
- DWIHN failed to demonstrated improvement in the study indicator result *(Not Met).*
- The study indicator did not achieve statistically significant improvement over the baseline *(Not Met)*.

DWIHN's causal/barrier analysis process involved the use of an Ishikawa Fishbone diagram in collaboration with providers and conducted data and literature reviews. DWIHN will use the Plan-Do-Study-Act (PDSA) to assess the identified barriers and determine appropriate interventions. DWIHN's Improving Practice Leadership Team (IPLT) used team discussions to assign priority rankings for each identified barrier. From these tools, DWIHN determined the following barriers:

- Lack of knowledge among providers to recommend diabetes screening for members with schizophrenia and bipolar disorder.
- Physicians' belief that diabetes prevalence is low in their practice.
- Lack of follow through by enrollees/members to have labs drawn when ordered.

The Michigan Department of Health and Human Services (MDHHS) 2018 Aggregate Report for Michigan Medicaid showing the average for all reporting health plans to be *(84.31%).* DWIHN's baseline is reported at *(78.6%)* for FY 2019. The re-measurement 1 period will be calculated in March of 2020, with a goal of *(80.0%).*

Opportunities for Improvement

To address these barriers, DWIHN initiated the following interventions:

- DWIHN will monitor compliance with diabetes screening through clinical treatment chart audits. Findings from the chart audits will be provided to providers through the Quality Operations Workgroup meetings and the Quality Improvement Steering Committee.
- DWIHN will measure and monitor compliance with having labs ordered and drawn no less than quarterly through review of the HEDIS-like data in Relias ProAct. Findings will be provided to providers through the Quality Operations Workgroup meetings and the Quality Improvement Steering Committee.
- Enrollees/members will be educated on the importance of having labs completed through community outreach initiatives and training and reinforced in a pilot program through face-to-face medication delivery and monitoring with members transitioning from an Aggressive Community Treatment program.
- DWIHN will provide education on the Clinical Guidelines Procedures to service providers, practitioners, and DWIHN staff members through the Quality Operations Workgroup, Quality Improvement Steering Committee, and Improvement Practices Leadership meetings.

- DWIHN will educate the provider network through community outreach initiatives and training on the importance of diabetes screening.
- DWIHN will 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 Measure Validation (PMV)

Activity Description

HSAG validated a set of performance indicators that were developed and selected by MDHHS for validation. The reporting cycle and measurement period was for the first quarter of SFY 2020 (October 1, 2019 through December 31, 2019).

Quantitative Analysis and Trending of Measures

The previous year's data was used along with the current reports to assess trending patterns and rate. The measurement period for Indicators #1, #4a, #4b, #5, #6 and 10 is Quarter 1 FY 2020 (October 1, 2019-December 31, 2019). The measurement period for Indicators #8, #9, #13 and 14 is FY 2019 (October 1, 2018-September 30, 2019).

Effective of Evaluation

DWIHN met all required reportable areas during the HSAG Performance Measure Validation (PMV) review for FY20, with the exception of BH-TEDS Data Elements (*Disability Designation) during the HSAG Annual Review Validating that DWIHN's systems and processes successfully captured critical data elements needed to calculate performance indicators in alignment with MDHHS' expectations and codebook. In FY19, DWIHN implemented several quality improvement initiatives to address challenges and improve indicator rates. In June 2019, DWIHN initiated a Performance Indicator Provider and Internal Workgroup to review past performance, address challenges to improving rates, and define quality improvement initiatives. This workgroup meets quarterly and includes both DWIHN staff members and members of its provider network. Additionally, we worked with PCE to enhance the reporting module within MH-WIN that allows the provider to review the performance indicator data prior to submission to the PIHP. This system and process change was designed to address data quality issues and address the completeness and accuracy of information impacting performance. Finally, DWIHN develop a Recidivism Workgroup to review and implement interventions targeted at addressing non-compliance with Indicator #10.

Opportunities for Improvement

Overall, during the HSAG review, DWIHN systems and processes successfully captured critical data elements needed to calculate performance indicators in alignment with MDHHS' expectations and codebook. However, although no material bias was identified during the audit, to further improve the accuracy and completeness of its performance indicator data, DWIHN identified the following improvement efforts:

- 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.
- Review the BH-TEDS to ensure that all required elements are not only collected and reported, but that the logical relationships between fields are correct. Although only one discrepancy was noted in the BH-TEDS data reviewed by HSAG, DWIHN will evaluate the cause for the discrepancy to determine whether data entry systems or validation procedures should be updated to prevent inaccuracy in its submissions.

Compliance Review

Activity Description

To improve performance in the quality and timeliness of and access to care, the Michigan Department of Health and Human Services (MDHHS) has contracted with Health Services Advisory Group, Inc. (HSAG) to comprehensively assess the performance of PIHPs in providing quality, timely, and accessible healthcare services to members.

Quantitative Analysis and Trending of Measures

For FY 2020, the reporting period was the second year of the three-year compliance review cycle. HSAG reviewed approximately *(50)* percent of federally mandated standards and their associated State-specific requirements, when applicable.

Effective of Evaluation

DWIHN received a total compliance score of *(79)* percent across all standards reviewed during the 2018–2019 compliance monitoring review, which was equal to the statewide average. DWIHN scored above *(90%)* indicating strong performance in the following areas: QAPIP Plan and Structure, Members' Rights and Protections, and Coordination of Care standards. DWIHN scored *(75)* percent, *(75)* percent, *(67)* percent, *(81)* percent, *(56)* percent, and *(50)* percent respectively in the Quality Measurement and Improvement, Practice Guidelines, Staff Qualifications and Training, Utilization Management, Credentialing, and Confidentiality of Health Information standards, indicating that additional focus is needed in these areas. DWIHN's performance measure rates were above the MDHHS established MPS for one of the two reportable indicators, indicating strengths in this area. DWIHN's MPS related to timely preadmission screening for psychiatric inpatient care for new Medicaid members for children was not met, indicating opportunities for improvement in this area.

Additionally, Detroit Wayne Integrated Health Network's rates were deemed Not Reported for 17 of the 19 measure indicators related to timely assessment for new Medicaid members, starting ongoing services for new Medicaid members timely, timely follow-up care after discharge from a psychiatric inpatient unit, timely follow-up after discharge from a substance abuse detox unit, and readmissions to an inpatient psychiatric unit, indicating opportunities for improvement in most measures.

Opportunities for Improvement

To address the areas requiring improvement, DWIHN will prioritize areas of low performance. The strategy will include data trends and root cause analyses with actionable and measurable goals, benchmarks, and interventions, addressing development and implementation of mechanisms for sustaining and spreading improvement in health outcomes, member satisfaction, and other focus areas. DWIHN will also develop a comprehensive and effective plan of action to mitigate any deficiencies identified during the 2018–2019 compliance monitoring review. In addition, DWIHN will take proactive steps to ensure a successful PIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers timely.

Utilization Management

The Annual Utilization Management (UM) Program Executive Summary is under a separate cover for FY 2020. 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	50%
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	20%
Director of Customer Service	Customer Service	70%
Director of Integrated Health Care	Integrated Health Care	50%
Director of Managed Care Operations	Managed Care Operations	20%
Strategic Planning Manager	Compliance	80%
Information Technology	Information Technology	20%
Practitioner Participation	Provider Network	100%

Overall Effectiveness

The 2019-2020 QI Work Plan was implemented in accordance with the plan. The performance 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, vision and values. Overall, most activities planned in the 2019-2020 Work Plan were Partially Met *(50%).* Activities and outcomes that scored Partially Met may be attributed to the ongoing Covid-19 pandemic. The activities that were Partially Met and or Not Met will be considered for continuation in 2021. Planned activities for review on the QAPIP 2019-2020 Work Plan are attached to the FY20 QAPIP Evaluation. (Attachment A). 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 will move to use Vital Data in 2021 to run our HEDIS data. This move will allow us to have more detailed reporting which will allow us to drill down to the member level as well as the ability to share data with our providers.

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.
- Research Advisory Committee. (RAC)

DWIHN believes there are adequate practitioner involvement and consultation to meet the objectives of the Quality Program. No changes are anticipated for FY 2021.

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 objective, changes are anticipated for FY 2021 which include the implementation of the Research Advisory Committee (RSC).

Practitioner Participation

DWIHN's partnership with the service provider network encourages practitioner participation and leadership involvement in the QI program. The practitioners actively participate in DWIHN's QISC committee which involves process improvement, program planning, implementation and program evaluation, through data collection and analysis. 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 FY 2021.

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, 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 with the exception of adding the Research Advisory Committee (RSC).

DWIHN's commitment to continuous improvement is integral to achieving excellent health outcomes and an excellent overall member experience. In 2021, DWIHN will continue to address identified opportunities for improvement to ensure optimal member experience.

2021 Work Plan Goals and Objectives

The Quality Improvement Unit will continue to monitor the 2020 goals and quality initiatives. Additional priorities identified for 2021 that will be added to the goals include the following:

- Maintain and Achieve NCQA accreditation.
- Improve Member Engagement and Satisfaction of Services.
- Continue focus on maintaining and improving member behavioral health outcomes through Performance Improvement Projects.
- Continuously improve the quality, appropriateness, availability, accessibility, coordination and continuity of health care services to members across the continuum of care.
- Identify and implement strategies to address social factors and health disparities to improve overall health and health outcomes of our members.
- Define, demonstrate and communicate the organization-wide commitment to improving the quality of patient safety.
- Ensure a high-quality network through credentialing, peer review and contracting processes.
- Collaborate with providers to share ideas and implement strategies to improve care coordination and quality.
- Ensure compliance with MDHHS standards as well as state and federal regulatory requirements and accreditation standards.

Attachment A

QAPIP Work Plan
FY 2019-2020

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Responsible Department	Timeframe for Each Activity's Completion	Monitoring of Previously Identified Issues	Evaluation	Outcomes	Oversight of QI Activities by Committee
	Customer Pillar						
Goal I	**Enhance the quality of services based on member feedback**						
I.1	ECHO Adult Satisfaction Survey	Customer Service	FY 2019-2020	Increase response rates and improve member access to behavioral health services for the 5 reporting measures scoring < 50% 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.	The identified areas improved with an overall percentage increase of (10%) from the previous surveys administered in FY2018.	**Partially Met**; Goal will be continued in FY2020-2021.	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 2019-2020	Identify areas for system enhancement 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.	Interviews and surveys were not completed during FY19-20 due to the COVID-19 Pandemic. Interviews and surveys will reconvene in FY21.	**Not Met**; Goal will be continued in FY2020-2021.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
I.3	Provider Survey	Customer Service	FY 2019-2020	Increase response rates and improve service access, service provision, treatment experiences and outcomes in the network.	A Comparison of FY19 and FY20 surveys, indicate that provider participation increased overall by (25%); (50%) for provider organizations and (21%) for individual practitioners. DWIHN's targeted response rate of 50%-60% was below the targeted benchmark of 50% -75% participation. The length of survey questions (76) may dissuade provider organizations and practitioners to complete survey. "As it was reported to have taken 30 minutes to complete". Based upon number of surveys that bounced back there is further need to clean up our email database to void invalid email	**Partially Met; Goal will be continued in FY2020-2021.**	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
I.4	Grievance/Appeals	Customer Service	FY 2019-2020	Improve outcomes and member experience for the top five (5) grievances identified for FY 18/19. (1). Delivery of Service, (2). Interpersonal, (3) Program Issues, (4) Access to Staff, (5) Customer Service.	During FY18 there were 86 grievances reported in which 173 categories were identified; 162 categories within 97 grievances reported in FY19 and 97 categories within the 53 grievances reported in FY20. Delivery of Service and Customer Services were consistently high over each of the three years. There was a decline in the number of grievances in the following categories in FY '20. 1.) Access to Services; 2.) Interpersonal and 3.) Quality of Care.	**Partially Met**; Goal will be continued in FY2020-2021.	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 2019-2020	Meet performance set by the state for timely UM decisions making, timeframes and notification. Threshold 90% .	All of the delegated entities met the 90% threshold for timeliness of urgent preservice UM decision making during FY 20. The urgent concurrent category improved from 85% in FY 19 to 91.1% in FY 20. This improvement has led to SUD meeting the 90% threshold for the urgent concurrent category.	**Met**; Goal will be continued and monitored to improve outcomes during FY2020-2021.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.

Attachment A

QAPIP Work Plan
FY 2019-2020

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Responsible Department	Timeframe for Each Activity's Completion	Monitoring of Previously Identified Issues	Evaluation	Outcomes	Oversight of QI Activities by Committee
I.6	Cultural and Linguistic Needs	Customer Service, Managed Care Operations, Quality Improvement and Information Technology	FY 2019-2020	To advance health equity, improve quality, and help eliminate health care disparities by implementing culturally and linguistically appropriate services.	In assessing the language needs of members, DWIHN explored the number of requests for interpreter services at the point of the initial request/screening for eligibility for service. The data was pulled from the screening information gathered by the Access Center at the initial request for service for Medicaid members who received services in FY17. Findings: Less than *(1%)* of the screenings request language interpreters. Currently DWIHN does not have data on the languages spoken by individual practitioners. This information is being gathered with the current credentialing/re-credentialing process	**Partially Met**; Goal will be continued in FY2020-2021.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
	Access Pillar						
Goal II.	**Assess Needs and Manage Demand, Implement Holistic Care Model**						
	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 2019-2020	Meet performance on required state performance indicators. Outcome: FY 18/19 standard met for all populations for all quarters. Threshold 95% for each quarter.	FY 2020 standard met for adult and children population for 4 quarters.	**Met;** Goal will be continued in FY2020-2021.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
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 2019-2020	Meet performance on required state performance indicators. Outcome: FY 18/19 standard met for all populations for all quarters. Threshold 95% for each quarter.	FY 2020 standard met for all populations with the exception of Q2 DD/Adult (90.91%). DWIHN falls below the threshold for Q2 (DD/Adult).	**Partially Met**; To address this area, 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 Goal will be continued in FY2020-2021.	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 2019-2020	Meet performance on required state performance indicators. Outcome: FY 18/19 standard met for all populations for all Quarters except for Quarter 3 (88%). Threshold 95% for each quarter.	FY 2020 standard met for all populations with the exception of Q1 DD/Child (90.83%), Q2 DD/Child (87.18%) and Q2 DD/Adult (92.86%). DWIHN falls below the threshold for Q1, Q2 and Q3.	**Partially Met**; To address this area, 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 Goal will be continued in FY2020-2021.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.

Attachment A

QAPIP Work Plan
FY 2019-2020

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Responsible Department	Timeframe for Each Activity's Completion	Monitoring of Previously Identified Issues	Evaluation	Outcomes	Oversight of QI Activities by Committee
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 2019-2020	Meet performance on required state performance indicators. Outcome: FY 18/19 Quarter 1 (57%), Quarter 2 (88%) did not meet the standard; Standard met for Quarter 3 (96%) and Quarter 4 (95%). Threshold 95% for each quarter.	FY 2020 standard met for all populations with the exception of Q1 Child *(93.06%)* , Q2 Child *(86.08%)* and Q2 Adult *(94.92%)*. DWIHN falls below the threshold for Q1, Q2 (Child) and Q2 (Adult).	**Partially Met**; To address this area, 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 Goal will be continued in the FY2020-2021 Workplan.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
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 2019-2020	Meet performance on required state performance indicators. Outcome: FY 18/19 Quarter 1 (57%), Quarter 2 (88%) did not meet the standard; Standard met for Quarter 3 (96%) and Quarter 4 (95%). Threshold 95% for each quarter.	FY 2020 standard met for all populations with the exception of Q1 (94.0%). DWIHN falls below the threshold for Q1.	**Partially Met**; To address this area, 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 Goal will be continued in FY2020-2021.	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 2019-2020	Meet performance on required state performance indicators. Outcome: FY 18/19 Standard not met for Adults for Quarter 2 (17%), Quarter 3 (17%) and Quarter 4 (20%). Outcome: FY 18/19 Standard met for Children for all quarters with the exception of Quarter 4 (16%). Aggregate score for Children and Adults for FY 18/19 (17%). Threshold 15% for each quarter.	FY 2020 standard met for the children population with the exception of Q4. The standard was not met for the adult population for all quarters.	**Not Met**; To address this area, 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 Goal will be continued in FY2020-2021.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
II.7	Complex Case Management	Integrated Health Care	FY 2019-2020	Ensure members are move towards optimum health, improved functional capability, and a better quality of life by focusing on their own health goals. CCM will be measured against the following benchmark for participating members.	Members participating in Complex Case Management (CCM) services demonstrated overall improvement in their PHQ scores, and the improvement increased the longer that the members participated in CCM services. Average PHQ scores improved *(7%)* from baseline at 30 days, *(25%)* at 60 days and *(46%)* at 90 days of receiving CCM services. Members PHQ baseline scores ranged from 5 to 22, with an average score of *(11.8)*.	**Met**; Goal will be continued in FY2020-2021 .	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.

Attachment A

QAPIP Work Plan
FY 2019-2020

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Responsible Department	Timeframe for Each Activity's Completion	Monitoring of Previously Identified Issues	Evaluation	Outcomes	Oversight of QI Activities by Committee
II.8	Crisis Intervention	Utilization Management	FY 2019-2020	Decrease number of re-hospitalization within 30 days of discharge to 15% or lower. Baseline FY 18/19 (17%).	The state benchmark of 15% or less was not met for adults during FY 20. Quarters 1, 2 and 3 for FY 20, resulted in rates of recidivism over 20%, while quarter 4 decreased to 16.6%, notably lower but still higher than the 15% state requirement for adults. The number of children admitted within 30 days of discharge, remained below the 15% threshold for the entire fiscal year. The first quarter of FY 19 resulted in 15.70% and 8.12% rates of recidivism for adults and children compared to 20.41% and 10.91% for the first quarter of FY 20. The rates for the fourth quarter of FY 19 were 19.27% and 16.33% and 16.60% and 11.11% for FY 20 for adults and children, respectively. *Recidivism data for FY 20 is inclusive of the MI Health Link population. *	**Not Met**: Goal will be continued in FY2020-2021.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
	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 2019-2020	Increase the capacity of staff and providers to work effectively with diverse cultural and linguistic populations (expand cultural competency trainings as well as develop additional practice policies).	In FY20, there were 65,460 individuals that actively utilize DWC with 56,633 completing the required online courses and 38,755 taking optional online courses. The total number of individuals trained demonstrates an increase of 10,602 *(23%)* compared to FY 2019. In the fiscal year of 2020, a total of 1,980 calls were made/received between October 1, 2019 and September 30, 2020. Call volumes decreased from the previous fiscal year. As a result of COVID-19, the monthly call volume decreased significantly beginning in March 2020. The March call volume (167 total calls) decreased by 165 calls compared to February 2020 (332 total calls). Beginning March 13, 2020, DWIHN ordered all employees to work from home. Many organizations utilizing Detroit Wayne Connect temporarily closed as well, decreasing the number of inquiries received by the helpdesk. The DWC helpdesk remained functional, and efficiently worked to resolve user issues.	**Met**: Goal will be continued in FY2020-2021.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
	Finance Pillar						
Goal IV	**Maximize Efficiencies and Control Costs**						

Attachment A

QAPIP Work Plan
FY 2019-2020

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Responsible Department	Timeframe for Each Activity's Completion	Monitoring of Previously Identified Issues	Evaluation	Outcomes	Oversight of QI Activities by Committee
IV.1	Claims and Compliance Monitoring	Quality Improvement, Compliance and Finance	FY 2019-2020	Eliminate Fraud, Waste and Abuse in the network by identifying patterns and trends of behavioral health service utilization by funding source and by monitoring over and underutilization of services.	Incorporated several processes to match the utilization with Standardized IPOS travelling over Health Information exchange in a electronic real time format and create trends to ensure there is balance in what is medically necessity vs claims payment. Detecting fraud and abuse several measures have been implemented in partnership with Quality and Compliance teams: Quarterly checks in the system have been implemented to look for scenarios that would point to such activities. Standardized IPOS implementation will ensure nothing authorized is outside of Plan HIE implementation of IPOS will ensure all plans/addendums and authorizations reside in MHWIN which will ensure all services are authorized can only be billed Over and under utilization rules was developed in conjunction with DWIHN UM team to ensure such activities can be monitored and followed through.	**Met**: Goal will be continued in FY2020-2021.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
	Quality Pillar						
Goal V.	**Improve Quality Performance, Member Safety and Member Rights system-wide**						
V.1	Performance Monitoring - Clinically Responsible Service Provider (CRSP)	Quality Improvement	FY 2019-2020	Ensure providers are meeting regulatory and DWIHN's access standards and adequate to meet members needs. Measurement will include the number of providers reviewed during FY19 with reported outcomes.	During FY20, DWIHN staff conducted approximately (65%) of required reviews through virtual monitoring. Monitoring included SUD, CRSP and Residential providers. This is a substantial decrease from the previous fiscal year by (15%). Scores for Residential Environmental Compliance ranged from (77%-96%); with an average score of (88%). Scores for Case Record reviews ranged from 9% to 100%; averaging (65%). Scores for Residential staff qualifications reviews ranged from (39%-100%), with an average score of (81%). The chart below is an aggregate display of each area reviewed with a slight decrease from FY19.	**Partially Met**: Goal will be continued in FY2020-2021.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
V.2	Specialized Residential Settings	Quality Improvement	FY 2019-2020	Targeted goal is to review 60% of the Specialized Residential Providers to ensure regulatory requirements are met and adequate to meet members needs.	During FY20, DWIHN staff conducted approximately *(65%)* of required reviews through virtual monitoring. Monitoring included SUD, CRSP and Residential providers. This is a substantial decrease from the previous fiscal year by *(15%)*. Scores for Residential Environmental Compliance ranged from (*77%-96%)*; with an average score of *(88%)*. Scores for Case Record reviews ranged from *9%* to *100%*; averaging *(65%)*. Scores for Residential staff qualifications reviews ranged from (*39%-100%)*, with an average score of *(81%)*. The chart below is an aggregate display of each area reviewed with a slight decrease from FY19.	**Partially Met**: Goal will be continued in FY2020-2021.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.

Attachment A

QAPIP Work Plan
FY 2019-2020

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Responsible Department	Timeframe for Each Activity's Completion	Monitoring of Previously Identified Issues	Evaluation	Outcomes	Oversight of QI Activities by Committee
V.3	Provider Self Monitoring (Inter-Rater Reliability)	Quality Improvement	FY 2019-2020	Increase Provider's participation in Self Monitoring from the previous year by 10%.	The results demonstrated a slight increase in the percentage of provider's participation from the previous year of 70%, compared to 73%, 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.	**Partially Met**: Goal will be continued and monitored to improve outcomes in FY2020-2021.	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 2019-2020	Achieve greater efficiency in processing denials and appeals.	During FY20, (98.4%) of authorization reviews were completed in 14 days or less exceeding the NCQA standard timeliness disposition of (90%).	**Met**: Goal will be continued in FY2020-2021.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
V.5	Enhancement of Critical/Sentinel Event Modules (MH_WIN) and Reporting	Quality Improvement and Information Technology	FY 2019-2020	Improve and update the Critical Sentinel Event Modules for better reporting.	Several enhancements were made to the module to consolidate the various functions required to streamline Critical and Sentinel events.	**Met**: Goal will be continued in FY2020-2021.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
V.6	Behavior Treatment Plan Oversight	Quality Improvement and Medical Director	FY 2019-2020	Meet performance on required BTPRCs requirements set by MDHHS. Threshold 95%.	During MDHHS audit, DWIHN lack evidence of functioning BTPRC for all CMHSP's under DWIHN.	**Partially Met**: Goal will be continued and monitored in FY2020-2021.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.
	Quality Improvement Projects (QIP's)						

Attachment A

QAPIP Work Plan
FY 2019-2020

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Responsible Department	Timeframe for Each Activity's Completion	Monitoring of Previously Identified Issues	Evaluation	Outcomes	Oversight of QI Activities by Committee
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 2019-2020	DWIHN has focused on follow up after hospitalization within 7 or 30 days. This measure has the potential to improve the health of members with mental illness and reduce readmissions through increasing appropriate follow up care.	In 2017 which is DWIHN's baseline year, 38.11% of clients followed up after hospitalization within seven days and 66.02% within thirty days. According to the NCQA 2016 State of Health Care Quality which was the version available in January 2018, 45.5 % of the HMO Medicaid health plans members had completed a follow-up appointment at 7 days post-discharge and 63.8% had completed a follow-up appointment at 30 days post discharge. DWIHN was not only below the national health plan averages as published by NCQA for the seven-day measure, but we were only performing in the HEDIS 25th percentile for the 7 day follow-up and in the HEDIS 50th percentile for the 30 day follow-up rates. DWIHN's ultimate long-term goal is to be in the HEDIS 90th percentile for both	**Not Met**: Goal will be continued in FY2020-2021.	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 2019-2020	Improve members with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.	For FY20, DWIHN performed below both the Medicaid health plan NCQA average and the Michigan health plan average for the HEDIS measures as well as below their goal.	**Not Met**: Goal will be continued in FY2020-2021.	Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.
V.7c	Antidepressant Medication Management for People with a New Episode of Major Depression	Integrated Health Care and Quality Improvement	FY 2019-2020	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).	For FY20, DWIHN performed below both the Medicaid health plan NCQA average and the Michigan health plan average for the HEDIS measures as well as below their goal.	**Not Met**: Goal will be continued in FY2020-2021.	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 2019-2020	Increase Diabetes Screening for people with Schizophrenia and/or Bipolar Disorder measures for percentage of patients 18-64 years of age.	For FY20, DWIHN performed below both the Medicaid health plan NCQA average and the Michigan health plan average for the HEDIS measures as well as below their goal.	**Not Met**: Goal will be continued in FY2020-2021.	Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.
V.7e	Coordination of Care	Integrated Health Care, Utilization Management and Quality Improvement	FY 2019-2020	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.	Enhance the care management and incorporating effective Targeted Case Management , Complex Case management and delivery of best clinical practices , we are presently evaluating a population management solution as part of HEDIS measures and will roll that out to entire CRSP network to ensure effective outcome based clinical strategies are implemented in both operationalizing the care as well as clinical protocols Implementing a pilot implementation with a Health Plan to provide a care coordination platform with our Integrated care team and health plan partners. The goal is to take this pilot live 1/1/2021. HIE implementation of IPOS ensured all plans/addendums and authorizations reside in MHWIN which ensured all services are authorized can only be billed	**Partially Met:** Goal will be continued in the FY2020-2021 Work Plan.	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 2019-2020	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.	DWIHN HEDIS measures outcomes declined. DWIHN implemented several programs and strategies to address the identified barriers.	**Partially Met:** Goal will be continued and monitored to improve outcomes during FY2020-2021.	Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.

Attachment A

QAPIP Work Plan
FY 2019-2020

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Responsible Department	Timeframe for Each Activity's Completion	Monitoring of Previously Identified Issues	Evaluation	Outcomes	Oversight of QI Activities by Committee
V.7g	Increasing Hepatitis A Vaccination	Integrated Health Care	FY 2019-2020	DWIHN was asked in June 2018 by the State of Michigan Department of Health and Human Services (MDHHS) to make available a prevention initiative for opioid treatment programs (OTP) that would help the State of Michigan reach the goal of 80% of the population vaccinated for Hep A.	There were opportunity's for improvement with this activity. DWIHN found it difficult scheduling vaccination clinics at the provider sites. Some DWIHN providers were not able to determine how many clients would be at their agency in a given day. DWIHN developed the strategy of attending the clients group therapy educational session to education clients regarding Hep A and offered the vaccine on the same day.	**Not Met**: Goal will be continued and monitored to improve outcomes during FY2020-2021.	Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.
V.7h	PHQ-9 Implementation	Clinical Practice Improvement	FY 2019-2020	DWIHN's goal to 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	There have been some slight improvements in the number of members receiving an initial PHQ9 screening at intake as indicated by the 2018 baseline data query as compared to FY2020 data.	**Met**: Goal will be continued in FY2020-2021.	Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.
V.7i	PHQ-A Implementation	Children's Imitative	FY 2019-2020	To 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.	There have been some slight improvements in the number of members receiving an initial PHQA screening at intake as indicated by the 2018 baseline data query as compared to FY2020 data.	**Met**: Goal will be continued in FY2020-2021.	Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.
V.7j	Improve ACT Fidelity w/ACT Step-Down	Clinical Practice Improvement	FY 2019-2020	Improve medication adherence for adults and children who have challenges taking their medications in the prescribed manner.	Those who participate have a 90% or better medication adherence rate, a reduction in psychiatric hospitalization usage and in crisis home usage. Established a pilot program called ACT Step down (ACT-SD) involving 3 providers; ACT-SD served 10 members all of which have not had any inpatient hospital admissions since being connected to the program.	**Met**; Goal will be continued in FY2020-2021.	Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.
V.7k	Decreasing Wait for Autism Services	Children's initiative	FY 2019-2020	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	Timeliness of authorizations reached (98%) in FY 20. 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.	**Partially Met**; Goal will be continued in FY2020-2021.	Continue to collect and analyze data, and report to QISC and PCC no less quarterly on the reporting measure.

Attachment A

QAPIP Work Plan
FY 2019-2020

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Responsible Department	Timeframe for Each Activity's Completion	Monitoring of Previously Identified Issues	Evaluation	Outcomes	Oversight of QI Activities by Committee
	Advocacy Pillar						
Goal VI.	**Increase Community Inclusion and Integration**						
VI.1	Home and Community Based Services (HCBS)	Quality Improvement	FY 2019-2020	Ensure full compliance in the network with the Home and Community Based Settings requirements by March 2023. Outcome: FY18/19 aggregate score (34%) Goal: FY 19/20 (60%)	Currently, 65 out of 118 non-residential sites and 133 out of 471 residential sites in the region have been assessed by DWIHN's Quality Improvement (QI) unit as compliant with the HCBS final rule requirements. DWIHN will continue to provide providers a reasonable length of time to remediate identified issues as specified in their CAP as long as the provider is making progress to come into full compliance with the HCBS rule.	**Partially Met**; Goal will be continued in FY2020-2021.	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**						
VII.1	MDHHS Certification	QI, MCO, CS, ORR, Finance, Workforce, Credentialing, IHC and Administration	FY 2019-2020	Achieve 95% compliance for all standards of Annual MDHHS Review.	DWIHN is required to submit to MDHHS a CAP for all elements scored Not Met. For each component that requires correction, DWIHN must identify the planned interventions to achieve compliance with the requirement(s), the individual(s) responsible for each intervention, and the timeline, including scheduled dates of completion for each intervention.	**Partially Met**; Goal will be continued in FY2020-2021.	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 2019-2020	Achieve full 3-Year Re-accreditation for all standards of NCQA Review.	Look back period for 2021 Accreditation has started effective February 1, 2019.	Goal will be continued in FY2020-2021.	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 2019-2020	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.	85% of all applicable evaluation elements received a score of Met for the Performance Improvement Project (PIP). However, The identification and prioritization of barriers through causal/barrier analysis and the selection of appropriate active interventions to address these barriers are necessary steps to improve outcomes. Detroit Wayne Integrated Health Network demonstrated strong performance in the Compliance Review, scoring 90 percent or above in three standards, with two of those standards achieving full compliance. These areas of strength include QAPIP Plan and Structure, Members' Rights and Protections, and Coordination of Care. Lastly, DWIHN demonstrated full compliance with PMV, with the exception of BH-TEDS Data Elements (Disability Designation). The standard is 95% and DWIHN scored 87.65%. We will continue to strive for Continuous Quality Improvement.	**Partially Met**; Goal will be continued in FY2020-2021.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.

Attachment A

QAPIP Work Plan
FY 2019-2020

QAPIP Goals/Pillars	Yearly Planned QI Activities/Objectives Measure of Service	Responsible Department	Timeframe for Each Activity's Completion	Monitoring of Previously Identified Issues	Evaluation	Outcomes	Oversight of QI Activities by Committee
VII.4	Annual Needs Assessment	QI, MCO, CS, ORR, Finance, Workforce, Credentialing and IHC	FY 2019-2020	DWIHN targeted and prioritized planned actions through meaningful feedback that was ascertained from providers meetings, focus groups and members.	Annual Needs Assessment submitted to MDHHS on March 28, 2019. Ongoing work in the areas of planning, policy, process monitoring and program evaluation.	**Partially Met**; Goal will be continued in FY2020-2021.	Report to QISC no less than quarterly; Submit monthly reports to PCC on reporting measure.

Detroit Wayne Integrated Health Network (DWIHN)

Utilization Management Department
Annual Evaluation FY 2020

Submitted by:

John Pascaretti – Director, Utilization Management

Presented to QISC 1/12/2021

Presented to PCC 1/13/2021

Presented to Full Board of Directors 1/20/2021

Revisions Presented to QISC 2/9/2021

Revisions Presented to PCC 2/10/2021

TABLE OF CONTENTS

Purpose

Utilization Management (UM) functions are driven by Detroit Wayne Integrated Health Network (DWIHN) Board's commitment to the provision of effective, consistent and equitable behavioral health services that produce functional outcomes, as articulated in the Strategic Plan. The Utilization Management Program Description reflects the expectations and standards of the Michigan Department of Health and Human Services (MDHHS) and the Center for Medicare and Medicaid Services (CMS). The Medical Director, previously referred to as the Chief Medical Officer (CMO) has substantial involvement in the development, implementation, supervision and evaluation of the UM program as evidenced by participation in the Utilization Management Committee (UMC) and Quality Improvement Steering Committee (QISC). The Medical Director on an annual basis also reviews and approves all UM policies and procedures within the policy management system as well as providing oversight of key UM documents. In FY 20, case conferences were initiated with the medical director to review cases with lengths of stays exceeding 14 days. The case conferences addressed clinical challenges and recommendations for discharge planning. The Medical Director supervises physician consultants conducting UM denials and appeals. The Board of Directors has the ultimate responsibility for ensuring overall quality of the behavioral healthcare services delivered to Wayne County residents, including oversight of UM functions.

As part of continuous quality improvement process and on an annual basis, the UM Program is evaluated and incorporated into the annual Quality Assurance Performance Improvement Plan (QAPIP). This report is submitted to the DWIHN Utilization Management Committee (UMC), to the Quality Improvement Steering Committee (QISC) and the DWIHN Board of Directors for approval.

Fiscal year 2020, the UM Department continued to dedicate tremendous time to activities surrounding Systems Transformation, moving from a funder of care to a manager of care and removing administrative layers when possible to ensure more efficient and effective person-centered services while working closely with providers. The Department consists of 33 staff with responsibility for review and medical necessity determinations for the following Benefit programs and Levels of Care: Inpatient, Outpatient, HAB Waiver, ASD Benefit, General Fund, Partial Hospital, Crisis Residential, Substance Use Disorder Services, Autism, MI Health Link population, and the processing of denials and appeals associated with service requests.

In FY 2020, a new UM Director, and Clinical Specialist was promoted to the UM Administrator position. The Clinical Specialist vacancy was filled, and another Clinical Specialist hired to address hospital reviews. As one of the efficiencies, Autism adverse determinations were brought in house. Physicians and PhD clinical psychologists continue to be the only staff credentialled to deny medical necessity. UM Director will continue to assess staffing needs and impact on volume for both the appeals and denial coordinator, physician/psychologist reviewers, and departmental staffing. There were no additional staffing needs addressed in FY 20. Like many of the positions within UM, the Appeals and Denial Coordinator has staff cross trained to assume this time sensitive

function in his/her absence. In addition to the auto-approval process with Service Utilization Guidelines addressed later in this report, an electronic worksheet was implemented and developed for Autism providers to submit documentation.

Adequacy of Utilization Management Resources

The following chart is a summary of the positions currently in the UM department, and outside departmental staff with the percentage of their time allocated to UM activities:

Title	Department	Percent of Time allocated to UM
UM Director	UM	100
UM Administrator	UM	100
22 UM Clinical Specialist	UM	100
4 UM SUD Mental Health Technicians	UM	100
UM Administrative Support	UM	100
UM Grievance Coordinator	UM	100
Provider Network Prog Admin - IDD (Self Determination)	UM	100
Utilization Manager	UM	100
COFR Coordinator	UM	100
UM Coordinator	UM	100
Chief Clinical Officer	Admin	.15
Provider Network Clinical Officer	Clinical Practice Improvement	.15

UM Director will continue assessing departmental needs including interdepartmental involvement.

Utilization Management Committee

As described in the Utilization Management Program Description, the Utilization Management Committee (UMC) meets monthly. The Medical Director is the chairperson and the UM Director is the co-chair. Membership includes staff from UM, Customer Service, Children's Initiatives, Managed Care Operations, Finance, Quality, Substance Use Disorder, and Peer Support Specialist. Other staff or entities are invited on an as needed basis. The committee routinely addresses the following topics and many are included here in this report for annual trending/reporting purposes:

- Appeals and Denials
- Waiver Reports
- Autism Reports

- General Fund exception Reports
- Substance Use Disorder
- Authorizations (Preservice, Concurrent, Retrospective)
- Timeliness Reports
- Benefit Grid/Benefit Clarification
- Hospitalization Reports/MI Health Link Data
- Over and Under Utilization
- IT or Technology Assessments/Project Enhancements
- Millman Care Guideline (MCG) issues
- Medical Necessity
- Inter-rater Reliability Testing Results
- Policy and Procedure Development and Review

The following HEDIS results and analysis are reviewed by the UMC annually:

- Follow-up within 7 and 30 days after a behavioral health hospitalization
- State measurement of readmission data

Review and analysis of the above reports, dashboards, and measures in relation to UM are addressed within the UMC with interventions to address opportunities for improvement. Utilization Management leadership or staff also participate in a number of routine and ongoing collaborative committees or meetings with the provider network, consumers, heath plans, and departmental meetings which address and improve issues related to utilization management and are critical to the success of the UM department. Some of these are as follows: Provider Network meetings, Managed Care Operations meetings, Integrated Care Organization(ICO) meetings, Utilization Management Committee, COFR, Recidivism Work Group, Habilitation Waiver work group, Quality Improvement Steering Committee, Improving Practice Leadership Committee, Substance Use Disorder Bi-monthly Provider meeting, Michigan Consortium for Excellence bi-monthly meetings, Procedure Code Work Group meetings, Hospital Liaison meetings, COPE Crisis Huddle bi-weekly meetings, Children's Crisis Huddle bi-weekly meetings, Collaborative meetings, Behavioral Health Learning Collaborative and Assertive Community Team (ACT) monthly forums,

The second triennial survey by the National Committee on Quality Assurance Accreditation (NCQA) survey is scheduled for 2021. In preparation, the Utilization Management Department continues to review policy and procedures, maintain oversite of the delegates (Crisis Screening Entities, Well Place and Independent Review Organization), and continuously monitors service utilization and quality of care for populations served. All UM policies and procedures were reviewed, approved and or acknowledged by all UM staff and designated leadership within the policy software, Policy Stat, this fiscal year.

The FY 20 annual Utilization Management Program Plan Evaluation report includes the following elements:

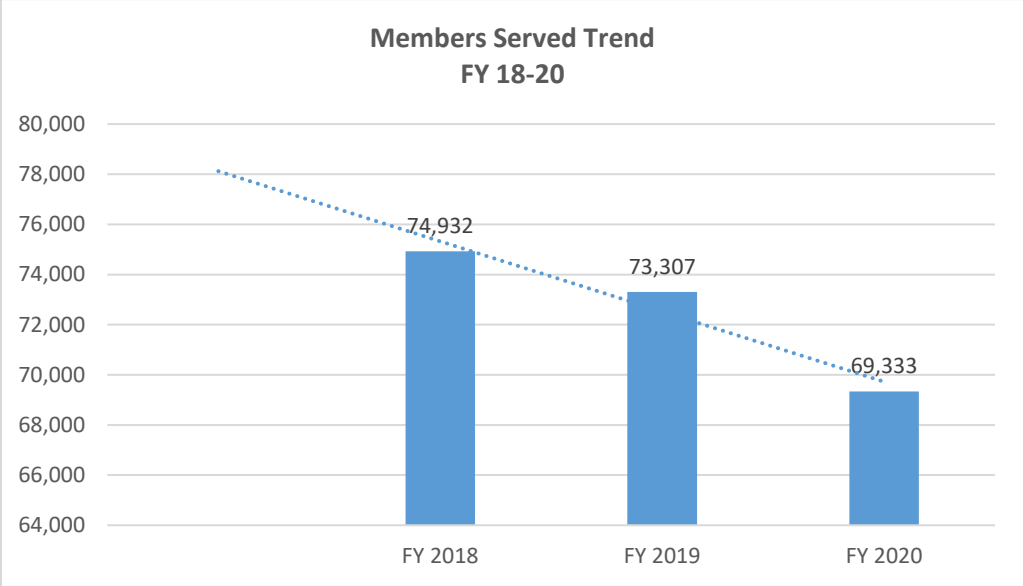
I. Populations Served

II. Status of Utilization Management Program Strategic Plan Goals

III. Status of UM Department Technology Recommendations/Initiatives

I. Population Served

The chart below indicates the trend of unique members served based on the past three (3) Fiscal Years (FY). As can be seen from the chart, there has been a decrease in the number of unique individuals served since FY 18 in both FY 19 and FY 20. Further investigation is necessary to determine potential contributing factors for the decrease in members served. There was a 5.4% decrease from FY 19 to FY 20, which can partly be attributed to the COVID-19 pandemic.

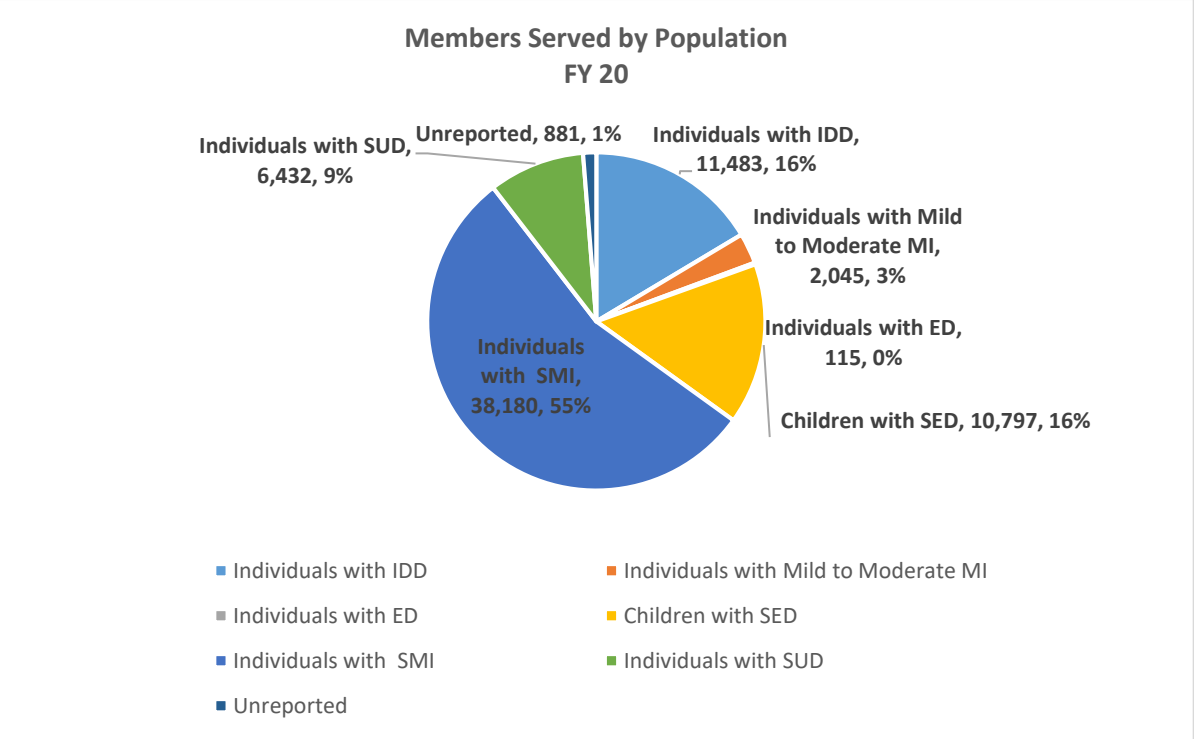


Source: Agency Profile Dashboard 11/23/2020

Population-Disability Designation

The pie chart below details members served by population and disability designation. DWIHN oversees and monitors services that are provided to Individuals with Serious Mental Illness (SMI), Children with Serious Emotional Disturbances (SED), Individuals with Substance Use Disorders (SUD), and Individuals with Intellectual and Developmental Disabilities (IDD). With the federal demonstration program, MI Health Link, DWIHN also serves individuals with Mild to Moderate Mental Illness (MI). Individuals with Substance Use Disorders may also be reflected in categories listed above due to co-occurring

diagnoses. The unreported disability designation is either due to consumers being admitted to the system in unconventional pathways (not via the Access Center) or consumers that do not have an updated disability designation.

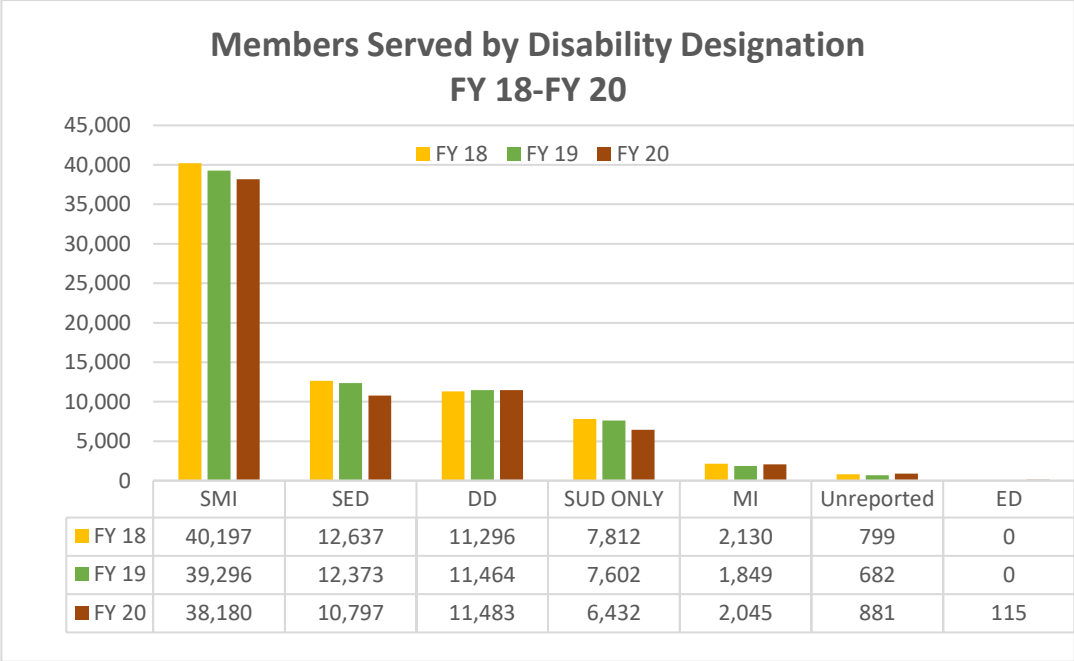


Source: Agency Profile Dashboard 11/23/2020

Population Trend

As previously noted, the amount of members served this fiscal year decreased by 5.4%. The graph below indicates the change in populations served over the last 3 fiscal years. Several categories showed an increase. Individuals with mild to moderate mental illness showed an increase of 11%. Unreported members also increased by 30%. Emotionally Disturbed not previously reported, shows 115 consumers. DD showed a small increase of less than 1%. Individuals with SMI decreased by 3% and individuals with SED decreased by 13%. Members served for SUD decreased by 15% in FY 20 from FY 19. (Note: Consumers with co-occurring substance use disorder are included in other disability designations. Unique members served for SUD referenced later in this report includes individuals with co-occurring disorders and is higher than what is reflected here in the SUD only category). The "unreported" category should be reviewed to determine if this category can be improved. In relation to those populations with decreases, it will be important to continue to track impact of COVID into the next Fiscal Year.

Source: Agency Profile Dashboard 11/23/20



	SMI	SED	DD	SUD ONLY	MI	Unreported	ED
FY 18	40,197	12,637	11,296	7,812	2,130	799	0
FY 19	39,296	12,373	11,464	7,602	1,849	682	0
FY 20	38,180	10,797	11,483	6,432	2,045	881	115

The UM evaluation is based on six (6) pillars that are identified in DWIHN's Strategic Plan. The UM evaluation reflects ongoing activities throughout the year and addresses areas of timeliness, accessibility, quality and safety of clinical care, quality of services, performance monitoring, member satisfaction and performance improvement projects. The data collected analyzes and evaluates the year to year trends of the overall effectiveness of the UM program, indicating progress for decision making to improve services and the quality of care for members served.

The Program Compliance Committee is responsible for oversight of DWIHN's UM Program Evaluation. The UM Program Evaluation is reviewed and approved annually by DWIHN's governing body. Through this process, the governing body gives authority for implementation of the plan and all of its components. The UM Program Evaluation report is submitted to the Program Compliance Committee for review and approval annually.

II. Status of Utilization Management Program Strategic Plan Goals

Customer Pillar– Maintaining a mutually respectful relationship with members and providers.

Goal I - Utilizing Provider and Practitioner Satisfaction Surveys related to service access and Utilization Management, make recommendations for improvement regarding service provision, treatment experiences and outcomes.

Goal Status: Partially Met

Enrollee/Member Satisfaction Survey

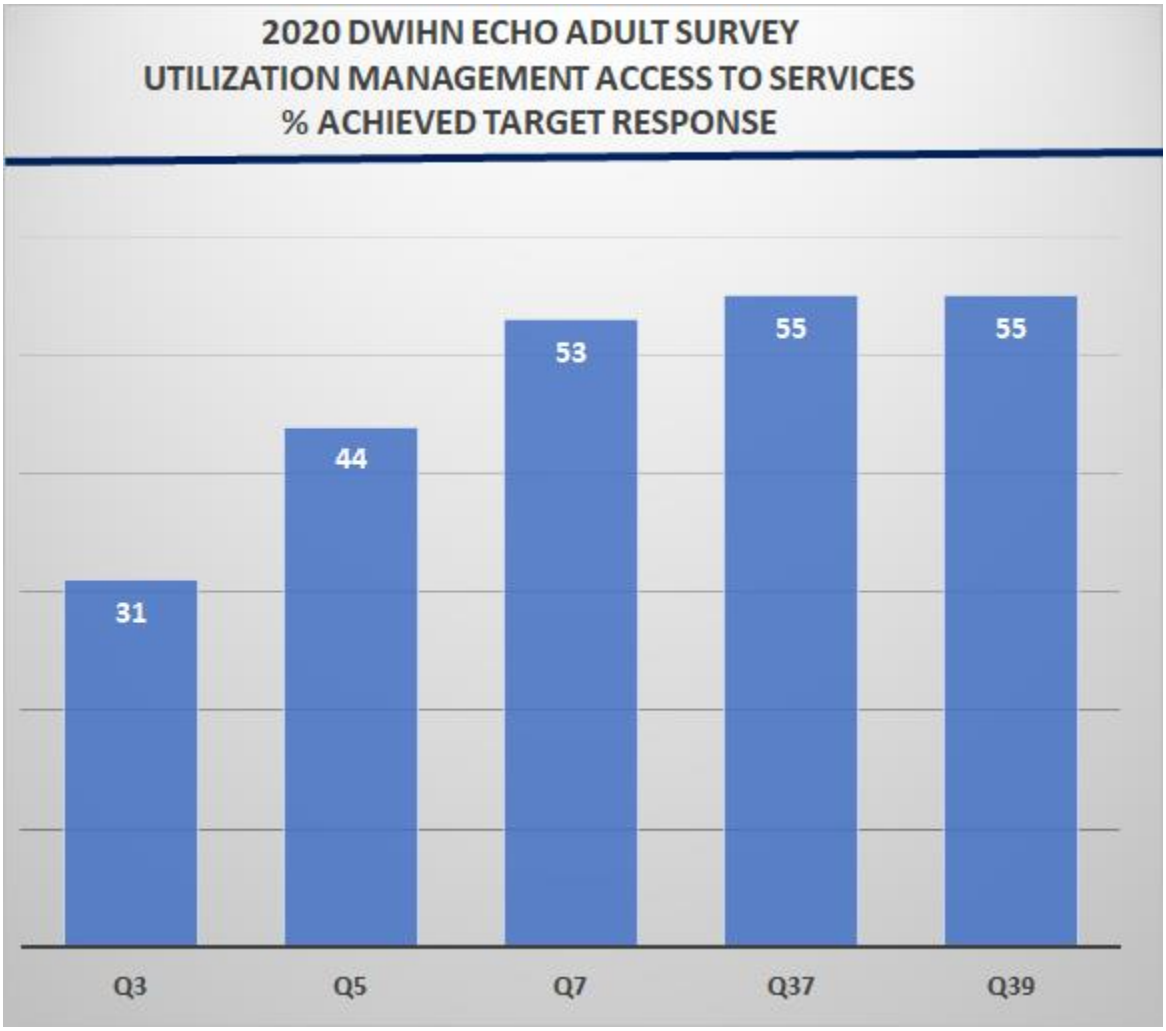
COPE conducted the “Perception of Care” survey for consumers and their natural supports. Consumers receiving COPE services are in the midst of experiencing a psychiatric crisis and often decline to complete the survey. However, during FY 20, a total of 360 surveys were completed. Due to COVID, this was a 67% reduction in volume from surveys completed in FY 19. The overall satisfaction rate, based on “Strongly Agree” and “Agree” ratings was 98%, which is the same as the previous fiscal year. COPE also collects surveys on Intervention (239 responded) and Stabilization (121 responded) services throughout the FY. Perception of care rates ranged from 96% to 99%.

DWIHN Member Satisfaction Survey

For FY 20, the Customer Service Department engaged the Wayne Center for Urban Studies to conduct the Experience of Care and Health Outcomes (ECHO) survey for adults and children. Parents and guardians’ of 1532 children completed the survey as well as 966 adults. The survey findings were shared during the Managed Care Operation Provider (MCO) meeting, as well as the Customer Service Quarterly Provider Meeting. The findings will be shared with the Constituents’ Voice member advisory group in January or February of 2021. Each department including UM, reviews findings to determine if there are opportunities for improvement.

A. FINDINGS

There were 5 questions related to access to services. None achieved the 85% target threshold. The chart below depicts the percent of achievement of the targeted score for each question:



Specifically, there are three domains the five questions fall into and they are as follows:

Domain I: Getting Treatment Quickly

The composite score is the percentage of respondents who answered "Always." The composite score is: 2020: 43%; 2017: 37%. This composite measure is based on the following questions.

Q3 in the last 12 months, how often did you get the professional counseling you needed on the phone?

Never
Sometimes
Usually
Always = 31%

Q5 in the last 12 months, when you needed counseling or treatment right away, how often did you see someone as soon as you wanted?

Never

Sometimes
Usually
Always = 44%

Q7 in the last 12 months, not counting times you needed counseling or treatment right away, how often did you get an appointment for counseling or treatment as soon as you wanted?
Never
Sometimes
Usually
Always = 53%

Domain II: Treatment after benefits are used up
Plan provides information about how to get treatment after benefits are used up:
Q37 Were you told about other ways to get counseling, treatment, or medicine? Score is the percentage of respondents who answered "Yes."
Yes
2020: 55%: 2017: 48%
No

Domain III: Getting Treatment and Information from the Plan or MBHO Getting Treatment and Information: Score is the percentage of respondents who answered "Not a problem" to **Q39**: In the last 12 months, how much of a problem, if any, were delays in counseling or treatment while you waited for approval?
A big problem
A small problem
Not a problem = 55%

A comparison for the 2017 DWIHN ECHO scores and the 2020 scores shows some improvement was made from 2017 to 2020, but the 85% threshold was not met during either survey period. The comparative scores are shown in the chart below:

B. 2021 OPPORTUNITIES FOR IMPROVEMENT

The Customer Service ECHO report states, "Opportunities Considering the findings from the survey, DWIHN has several potential areas to pursue for improvement, including working with 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."

The 2021 UM interventions to improve access to services during 2021 include the following:

- UM will continue Interdepartmental collaboration
- UM will continue to respond to authorization request in a timely manner
- UM will ensure that consumers are receiving services at the appropriate level of care.

DWIHN Report on Practitioner Network Satisfaction Survey

During FY 18, FY 19 and FY 20, the DWIHN Customer Service division collected survey data to determine network experiences with DWIHN. The report analyzes practitioner satisfaction with Utilization Management during the past three fiscal years. Questions pertaining directly to Utilization Management functions include the following: satisfaction with ease of obtaining initial and ongoing authorizations; satisfaction with MH-WIN authorization functions; procedure and timeliness for obtaining precertification/referral/authorization information; satisfaction with ease of placement in a suitable setting; satisfaction with provider appeal process for denials, and access to knowledgeable DWIHN UM staff. The 80% performance

standard was not met during any of the fiscal years studied. The detailed report is listed as Attachment A in this document.

The interventions during 2020 to address some of the concerns identified in the 2018 and 2019 provider experience with UM included:

- Develop dashboard reporting to monitor timeliness of the UM authorization process – *The UM department now has several reports that monitor timeliness.*
- Collaborate with Leadership Team to provide timely notification of process and requirement changes – *The UM department now has a daily "mail-merge" via MHWIN that captures this data. Additionally, for the Integrated Care Organizations in the MiHealth Link contract, and for other funding sources, a report was developed for analysis of the monthly "universes" or data runs from the claims database that demonstrates the timeliness of the authorization process. The UM Department uses this data to track the time of receipt and response of authorization requests.*

- *Create A*uthorization Training Schedule – I*n July 2020, a memorandum was sent to the Provider Network discussing the implementation of the Service Utilization Guidelines (SUGs) and scheduled trainings. There were 2 webinars held in August 2020 on the Blue Jeans platform which covered the following topics of discussion: submitting authorization requests including those for Outpatient Services, the Autism Spectrum Disorder benefit, General Fund and Self-Determination, implementation of assessments, individual plans of service and how the goals, objectives and time frames outlined within the plan support the service requests, the Denial and Appeal process and accessing the SUGs. Technical guidance was also provided by DWIHN's IT department during the webinars. Additionally, the PowerPoint presentation and frequently asked questions were compiled from the webinars, answered and distributed to the Provider Network as a resource tool. It is the department's goal to conduct a minimum of 2 trainings per fiscal year to address our policies, procedures and any changes to the authorization process including the Service Utilization Guidelines.*

2021 Opportunities For Improvement

Despite the interventions that occurred during 2020, the provider experience with UM did not meet the 80% performance standard in 2020. This requires interventions during 2021, designed to address *each* of the ten areas of the survey. Interventions will include UM department staff, Residential Services, Access and Crisis Services, network practitioners and the Utilization Management Committee. Remeasurements will be tracked to monitor progress and achieve the targeted goal. The interventions are as follows:

- UM will participate in the interdepartmental effort to review survey findings, tool, methodology, and development of corrective action plans/performance improvement plan as needed.

Access Pillar– Affordability, Availability, Accessibility, Accommodation, and Acceptability.

Goal I - Advance the implementation of DWIHN's standardized UM Program Description to assure effective and efficient utilization of behavioral health services through ongoing development and oversight of the following:

- The Benefit Plans/UM Authorization Guidelines; and
- Setting standards and monitoring adherence to the delegated entities UM Plans

Goal Status: Partially Met

The Benefit Plans/UM Service Utilization Guidelines were finalized May 2020 and rolled out in the MHWIN system June 1, 2020. They are consistently reviewed and modified to meet consumer needs. Consumer's that fall within the set standard of care for their service utilization are automatically approved. Those that fall outside the standard level of care guidelines, are reviewed by the UM Department's clinical specialist team for service utilization and approval. The trainings held in FY 20 to address the SUGs are described above.
There are Service Utilization Guidelines for the following levels of care: Seriously Mentally Ill (SMI), Intellectually Developmentally Disabled (IDD), Autism Spectrum Disorders, Uninsured and Underinsured Adult and Child, Substance Use Disorder Service and MI Health Link.

DWIHN addresses the mechanisms to evaluate and address new developments in technology and new applications of existing technology for inclusions into its benefits plan to keep pace with changes and to ensure that members have equitable access to safe and effective care. The mechanisms are spelled out in detail in the DWIHN policy named "Proven Behavioral Health Technology Inclusion Application Guideline." Other than the use of Telehealth as a special request for assistive technology no other requests were reviewed and approved.

The Access Center and Crisis Service Vendor (COPE) were required to align their UM Program Plans and policies with those of DWIHN. Following a review, it was determined that the delegated entities UM Program Plans continued to align with DWIHN's UM Program Description. Children's Screening Entities were required to prepare and align their UM plans in 2020.
During this past fiscal year, the UM Department identified thresholds and mechanisms for monitoring Utilization Management functions, including those which are delegated to other entities. For example, turnaround times for authorization requests and determinations were reviewed by the UM Department to assure decisions are made according to contractual requirements and meet consumer accessibility guidelines. DWIHN, the Access Center, and Crisis Service Vendors utilized a standardized tool for reporting.

Results and Analysis

Children's Crisis Screener must align their UM Plan with DWIHN Utilization Management Program Description – *The Guidance Center, Children's Center and New Oakland all completed and submitted acceptable UM Program Descriptions.*

Planned Interventions for FY 2020

- UM Department will educate Children's Crisis Screeners on the purpose of the UM Plan and requirement of alignment with DWIHN Utilization Management Program Description - *Completed*
- UM Department will provide the tool to be used to document the Plan - *Completed*
- UM Department will provide Technical assistance as needed - *Completed*

Goal II - Promote participation and use of specialty behavioral health waiver programs:

1. Habilitation and Supports Waiver (HAB)
2. Autism Spectrum Disorder (ASD) Benefit,
3. Children's Waiver Program (CWP)
4. Serious Emotional Disturbances Waiver (SEDW).

Goal Status: Partially Met

Results and Analysis

The UM Department continues to perform utilization management functions for the Habilitation Supports Waiver and Autism Benefit Waiver programs. UM also works in collaboration with the Children's Waiver and Serious Emotional Disturbances Waiver programs. Representatives from the CWP and SEDW programs participate in the Utilization Management committee. As seen in the graph below, the Habilitation Supports Waiver maintained the use of assigned slots (1164) at 95% for 9 out of the 12 months in the FY. The State reduced the number of slots allocated to DWIHN to (1084) this past year. The Plan of correction for last year and status of the Habilitation Support Waiver is listed below.

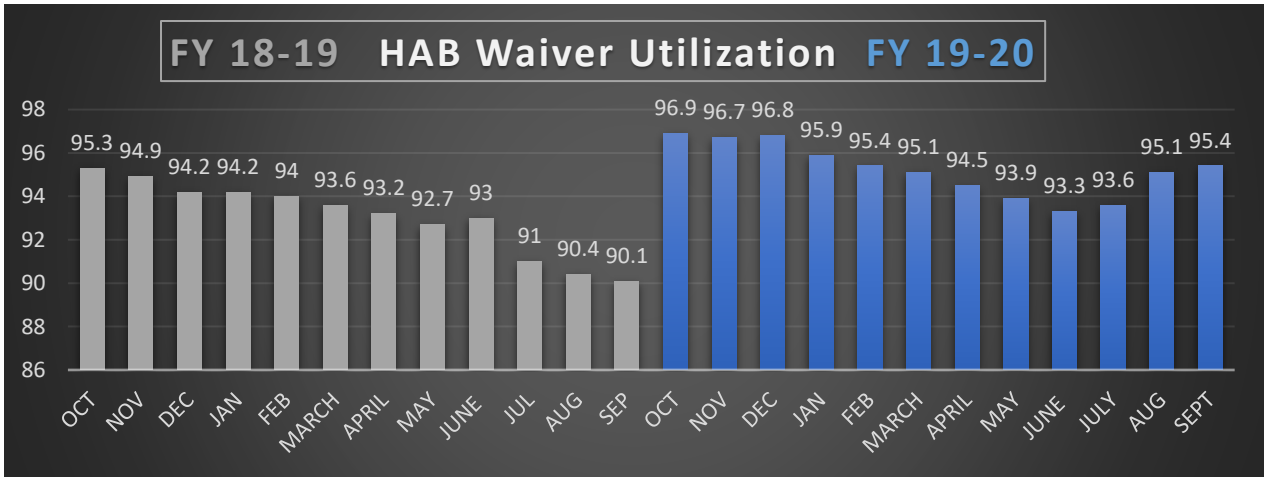
Habilitation/Supports Waiver (HSW)

Detroit Wayne Integrated Health Network (DWIHN) receives enhanced funding for participants enrolled in the 1915(b) Habilitation Supports Waiver (HSW) ranging from $3,500.00 to $5,500.00 per member/per month from the Michigan Department of Human Services (MDHHS). In order to be enrolled in the HSW program, applicants must meet the following requirements:

- Have an intellectual disability (no age restrictions),
- Reside in a community setting,
- Be Medicaid eligible and enrolled,
- Would otherwise need the level of services similar to an Intermediate Care Facilities/Individuals with Intellectual Disabilities, and
- Once enrolled, receive at least one HSW service per month

DWIHN took steps to modify our present HSW rate structure. In July an incentive program that provided a one-time payment of $1,000 per enrollee was made available to contracted supports coordinator agencies. As a result of the incentives, the percentage of filled slots is increasing as indicated: July – 93.6%, August – 95.1%, and September – 95.4%. DWIHN must fill at least 95% of the allocated 1084 slots throughout the year. FY 19 met the standard only 1 of 12 months versus 9 of 12 months FY 20.

Current HSW utilization is summarized below:



Source: DWIHN Reports (OCT 2020)

Planned Interventions for FY 2020

Habilitation Supports Waiver – Plan of Correction

- HSW team will provide more direct support to providers- *Completed*
- Continue to host quarterly provider meetings and discussion forums – *Occurs quarterly; ongoing*
- Host monthly meetings with individual providers to identify and review potential HSW participants, suggest approaches to enrollment, discuss and address barriers, and offer direct provider support- *Ongoing with two largest HSW providers: Wayne Center and CLS*
- Educate the providers on ways to properly complete a waiver application with minimal error and avoid disenrollment- *Provided trainings directly to Supports*

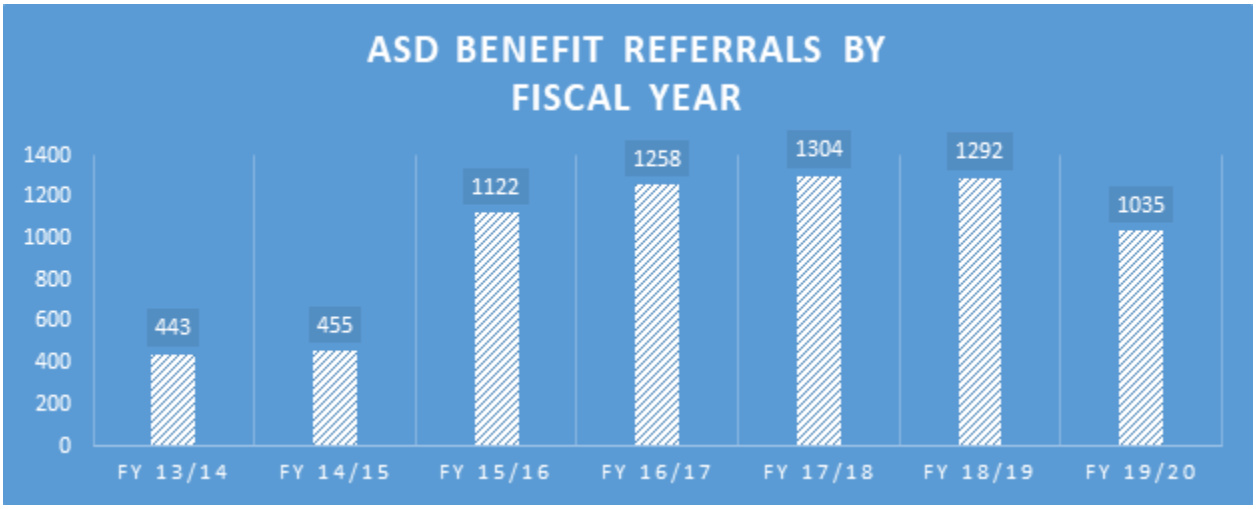
Coordinators; follow-ups and additional training provided upon request or apparent need.

- Ongoing review of statistical data used to identify individuals within the agency who could potentially benefit from the waiver program- Completed - *Deemed no longer necessary with implementation of incentive payment.*
- Review the Waiver expectation of 3-5 new participants from each provider- *Superseded by Incentive Payment*

Autism Spectrum Disorder (ASD) Benefit

The ASD benefit is a MDHHS carve out benefit that funds Applied Behavior Analysis (ABA), an evidenced based treatment for autism spectrum disorder. Medicaid consumers are eligible through age 21 years old. All referrals begin with Wellplace. Parents wanting their child screened for the benefit call Wellplace who completes a preliminary screening. The consumer is then scheduled for an in-depth evaluation with an Applied Behavior Analysis (ABA) provider. The ABA provider would complete a Diagnostic Evaluation to determine diagnosis, including autism and/or other differential diagnosis that may be present. The evaluation results are used to provide treatment recommendations to best fit medically necessary services to treat the child's symptomology and diagnosis. Throughout the year several barriers to the process were identified; an inherent conflict of interest with the assessor being the service provider, verification of written notices provided to families, and potential inconsistent benefit determinations with several providers doing their own evaluations. As DWIHN recognized these barriers, swift actions were taken to implement opportunities for improvement. Initiation of services was transitioned from Wellplace to an internal DWIHN department. In early 2020, DWIHN made the decision to put out a Request for Proposal for Autism Spectrum Disorder Diagnostic Testing Services. The goal of having an independent Testing Service is to provide flexibility for scheduling for consumer's initial assessment, timely written notifications of eligibility, and minimizing an inherent conflict of interest. By no longer delegating this function as of October 1, 2020, DWIHN will be closer to the care of consumers and complete all denials only after a full review and approval has been done by the appropriately credentialed professionals.

The graph below indicates the number of referrals that DWIHN has in its provider network. There are currently 1,710 cases open in the ASD benefit.



As indicated in the chart below, there are currently 1710 cases open in the benefit. During FY 19-20, 98.4% of authorization reviews were completed in 14 days or less exceeding the NCQA standard timeliness disposition of 90%.

ASD Cases Served 2013 – 9/30/2020

ASD Cases Served 2013-9/30/20				
Status	**Level of Care**		**Did Not Receive ABA Direct Services**	**Total**
	Focused Behavioral Intervention (*Lower Level of Care)*	**Comprehensive Behavioral Intervention** *(Higher Level of Care)*		
Closed	599	1065	3493	5157
Open	462	1083	165	1710
Total	1061	2148	3658	6867

Note that not all referrals to the ASD benefit result in a consumer receiving direct services. A service of the benefit is completing evaluations to determine if a consumer's diagnosis and symptomology meets criteria for the benefit. Consumers may be evaluated and found not to have a diagnosis or symptomology to qualify for the benefit or may meet criteria but decline services.

During the fiscal year DWIHN worked with PCE to develop a process to allow for some ASD Benefit authorization requests to be automatically approved upon submission to DWIHN.

Service requests for open consumers must fall within the current service utilization guidelines and between key dates determined by MDHHS. This system allows for providers to receive immediate notice of their authorization approval and for speedier signature of the IPOS without waiting for the manual review, reducing risk of potential gaps or delays in service provision.

As part of this system, electronic worksheets were developed to capture data from the evaluations and behavior assessments. Implementation of the electronic worksheets, has allowed DWIHN to resume responsibility in determining if a consumer meets medical necessity criteria for the ASD Benefit. Previously, DWIHN had delegated this responsibility to the service providers.

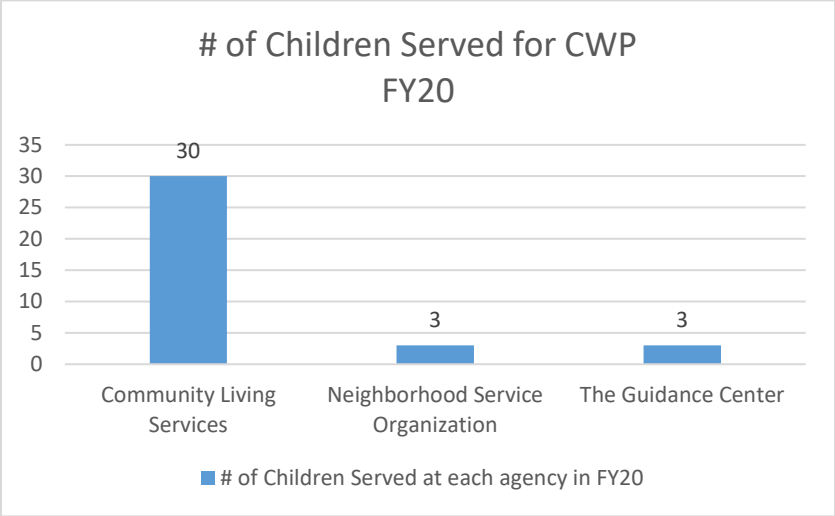
As is the case with many service areas, the ASD Benefit has been impacted by COVID-19. Historically, many of the service providers have only offered center-based treatment. At the onset of the pandemic in March 2020, many of the ASD Benefit services were initially not allowed to be provided via telehealth per MDHHS.

After the onset of the pandemic, MDHHS quickly made adjustments to allow nearly all ABA services to be administered via telehealth when clinically appropriate while also being more flexible on evaluation date requirements. While these changes were a tremendous help to the providers and consumers, some consumers opted to temporarily discontinue services until they felt they could safely receive services at the centers. Some consumers also chose to wait to pursue referrals into the ASD Benefit out of similar concerns. COVID-19 is likely a leading factor for the 19.89% decrease in referrals from last year to this year.

Children's Waiver Program

The Children's Waiver Program (CWP) makes it possible for Medicaid to fund home and community-based services for children with Intellectual and/or Developmental Disabilities who are under the age of 18 when they otherwise wouldn't qualify for Medicaid funded services. Three Provider Agencies deliver services to children and youth on this waiver: Community Living Services (CLS), Neighborhood Services Organization (NSO) Life Choices, and The Guidance Center (TGC).

During FY 20, DWIHN had 36 children, youth and their families served by the different agencies on this waiver. On October 1, 2020, the Michigan Department of Health and Human Services took steps to expand this waiver to an additional 50 children throughout the state increasing the available slots from 469 to 519, with an ultimate goal of 569 slots for the State of Michigan by the end of 2021.



Source: DWIHN Reports (OCT 2020)

Children's Serious Emotional Disturbance Waiver (SEDW)

Children's Serious Emotional Disturbance Waiver (SEDW) provides services that are enhancements or additions to Medicaid State Plan coverage for children and youth under the age of 21. MDHHS operates the SEDW through contracts with Community Mental Health Service Programs (CMHSPs) The SEDW enables Medicaid to fund necessary home and community-based services for children and youth who have a serious emotional disturbance and meet criteria for admission to the state inpatient psychiatric hospital (Hawthorn Center) and/or are at risk of hospitalization without waiver services.

DWIHN is currently responsible for the assessment of potential waiver candidates. Wayne County currently has 5 SEDW providers; Black Family Development Inc., Development Centers, Southwest Counseling Solutions, The Children's Center and The Guidance Center. During FY 19-20, 81 children and youth were served in the waiver.

Effective 10/01/19, the waiver moved from a fee-for-service program to managed care payment. Additionally, the SEDW will be offered state wide, allowing young people to receive waiver services regardless of proximity within the State of Michigan. Lastly, two new SEDW services will also be added to the array; Choice Voucher and Overnight Health and Safety Support.

Workforce Pillar – Competent and engaged employees and providers.

Goal I - Assure fair and consistent UM/review decisions based on MCG, Local Coverage

Determination (LCD), National Coverage Determination (NCD) and/or American Society of Addiction Medicine (ASAM) medical necessity criteria by monitoring the application of the applied criteria and service authorizations for behavioral health services (including substance use disorders) using a standard inter-rater reliability process system wide. (also addressed under the quality pillar)

Goal Status: Met

MCG-Indicia

DWIHN was the first Prepaid Inpatient Heath Plan (PIHP) to implement use of the MCG Behavioral Health Guidelines in 2017. When first purchased and rolled out, the interactive software, Indicia was a stand-alone product, with users having to log into multiple applications. DWIHN actively participates in a consortium of the Prepaid Inpatient Health Plans called the Michigan Consortium for Health Excellence (MCHE). Due to requirements from the Parity Act, CMS (the Centers for Medicare and Medicaid Services) mandated MDHHS to have standardized medical necessity criteria to assist in demonstrating parity of behavioral health services statewide. MCHE initiated a Request for Proposal process and after review purchased the use of MCG Behavioral Health Guidelines in 2019. The majority of the PIHPs began preparing to use the encyclopedic version of the guidelines or interactive software in 2020.

DWIHN IT and the UM department collaborated with PCE and MCG to integrate the interactive software into our MH-WIN system. DWIHN began using the integrated version in January, 2020. In preparation for the integration, training of COPE, Children's Center, Guidance Center and New Oakland screeners and the ACT teams occurred on Tuesday, November 5th. DWIHN UM staff were trained on Wednesday, November 6th 2019. Forty-eight (48) staff attended hands-on computer training for Indicia by an MCG instructor in one of the four sessions held. The training focused on the modified workflow as users had already been trained on the behavioral health guidelines.

The guidelines are currently used to screen consumers for inpatient and partial hospitalizations as well as crisis residential services. During FY 20, our adult and children's' screening entities and ACT programs screened consumers using the MCG product, Indicia. As of September 30, 2020, 9,315 cases have been entered into Indicia, which averages 36 cases per day since Go Live on January 13, 2020.

Each year, MCG updates the guidelines after an extensive review and analysis of research and literature. The updates are shared with various committees such as the Utilization Management Committee (8/18/2020 meeting), and are available for review in both the MCG Learning Management System and within the guidelines. Each year the Improving Practice Leadership Committee (IPLT) and the Medical Director approve use of the guidelines. DWIHN is currently using the 24th Edition of the MCG Behavioral Health guidelines which were presented and approved at the September 1, 2020 IPLT meeting.

DWIHN recognizes that demonstrating consistent guideline application and identifying staff improvement opportunities can help improve the consistency and delivery of services. As a result, DWIHN purchased the inter-rater reliability (IRR) module from MCG to be used with the screening entities, providers, and DWIHN UM staff. All staff who make UM decisions are tested with the IRR module to ensure consistent application of the guidelines and medical necessity criteria. A total of 171 staff received and passed cases studies achieving a score of 90% or above. If staff failed to complete the case studies on the first administration or scored less than 90% on each case study, a second administration occurred. Supervisors were encouraged to work with staff to assist in navigating guidelines, fielding questions, ensuring no technical difficulties. DWIHN expects that in the event that a staff person does not meet the testing thresholds with the second administration, a corrective action plan is implemented which may include such activities as face to face supervision, coaching, education, taking learning modules within the Learning Management System and/or retraining. There were 19 Corrective Action Plans submitted by supervisors. All staff completed the corrective action plans, and were successful in passing the case studies. DWIHN continues to work with the vendor to assist in developing metrics and functionality that are user friendly to both front end users and system administrators. MCG developed a video tour training to assist users but it has not yet been rolled out. Quarterly meetings are held with the vendor (MCG) to continually address any challenges with the system.

The table below reflects the staff groups and results of testing including the number requiring corrective action plans. All requiring corrective action plans have successfully completed the case studies

FY 19/20 Interrater Reliability Results Summary

Group	# of Staff Successful After 1st/2nd Administration	# of Staff Requiring Corrective Action Plans	# Successfully Passed(including CAPS)
ACT Staff- TGC, NEG, CCIH, LBS, AWBS, CCS, DCI, Team	54	7	61
COPE	43	7	50
New Oakland, Children's Center, Guidance Center	27	0	27
DWIHN Residential	10	2	12
DWIHN UM - including, Autism, SUD, MDs	18	3	21
Totals	152	19	171

Source: Learning Management System, 1/29/2021

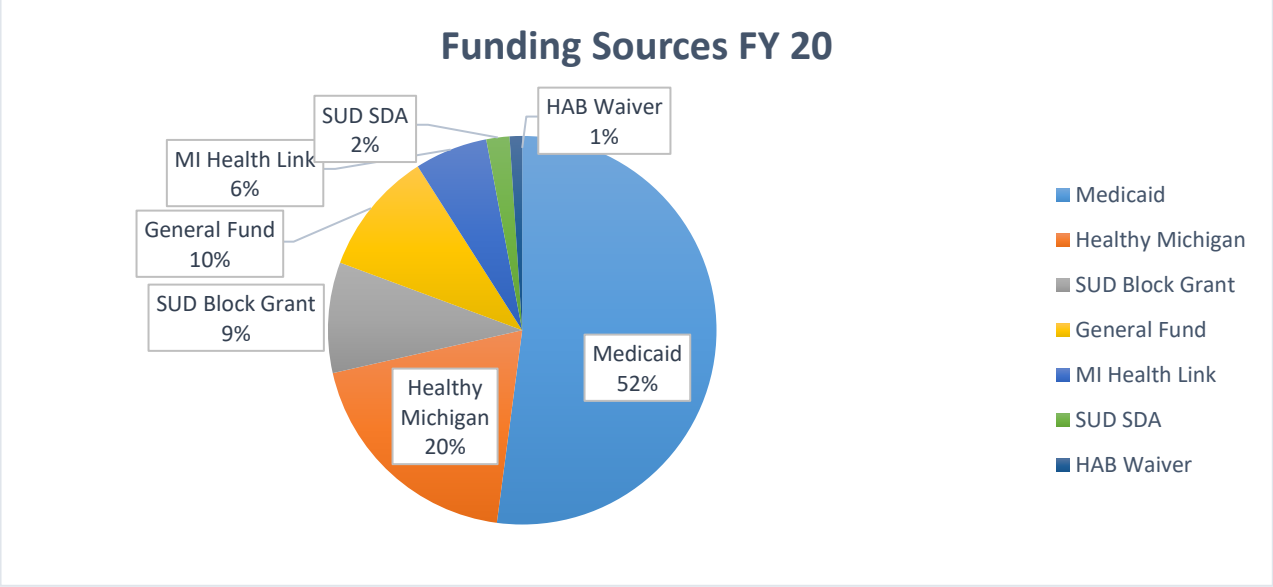
Finance Pillar– Commitment to financial stewardship and to the optimal prioritized allocation of scarce resources across a plethora of growing and competing needs to best fulfil its mission, vision and values.

Goal I - Promote collaboration and provide guidance to the system by identifying patterns of behavioral health service utilization by funding source and by monitoring over and underutilization of services using dashboards.

Goal Status: Partially Met

Results and Analysis

The chart below indicates funding sources utilized to pay for an individual's service in FY 20. It combines general Medicaid, Healthy Michigan, Habilitation Waiver and other waiver programs which are all Medicaid, accounting for 73% 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 11%; decreased from 18% last fiscal year. General Fund is reflected at 10% (changed from 9%) and MI Health Link is at 6% (a change from 5%). The funding source mix is very similar to last year. Further analysis is required to determine if funding source impacts overall utilization.



Source: DWIHN Agency Profile dashboard on 11/23/20. Funding Source is the funding source that paid for the service. This is a potentially duplicated count as an individual's services can be paid for by multiple Funding Sources throughout the year.

Over and Under Utilization

The UM Department now has several reports available that provide data to help monitor the over and underutilization of all behavioral health services. Using this data, it was noted that providers submit requests for significantly higher amounts of services than what is actually utilized. The UM Team analyzes the data and shares it with the DWIHN administrative team. Adjustments to the Service Utilization Guidelines are also made based on the analysis of the data. It is also the department's goal to share the over and under-utilization of codes and services within the next fiscal year.

General Fund Exceptions

During FY 19-20, the UM department approved 4,014 General Fund Exception authorization requests for a range of outpatient services for SMI, SED and IDD consumers. There was an additional unknown number of requests that were *not* approved because of eligibility or inadequate information or over usage issues. An additional unknown number of automated General Fund Exception approvals were generated through HIE at the time of the IPOS, beginning in August 2020.

The General Fund requests approved during FY 19-20 represents a 71% increase from the 2,346 approvals during FY 18-19. That number was a marked increase from FY 17-18, when 827 approvals were processed. Each of these increases are a result of the introduction of General Fund authorization requests that are submitted via MH-WIN, beginning October 2018.

Planned Interventions for FY 2020

- Development of a dashboard to help shape UM decision making and UM activity with providers through application of real time monitoring:
    - Patterns among providers requesting or not requesting General Fund Exception; - *Not Met*
    - Patterns among specific consumer populations experiencing lapses in Medicaid benefits - *Not Met*

The UM department did not implement the stated planned interventions during FY 20 and the status is unmet. Also, since the elimination of the MCPNs in 2018, DWIHN continues to need a pharmaceutical arrangement for dispersal of outpatient medication through General Fund Exception.

County of Financial Responsibility

County of Financial Responsibility ("COFR") provides a contractual basis with the Michigan Department of Health and Human Services ("MDHHS") for determining financial responsibility and a process for resolving disputes, regardless of funding source. The COFR Committee's main objective is to review and render a decision on the Out of County cases, as well as provide the mechanisms for contracting and payment for those members ongoing. The COFR Committee is composed of members from various departments - Finance, Legal, Managed Care, and Utilization Management. There are currently 129 open COFR Cases; a decrease of three (3) cases from January 2020. *Note: All referrals result in an open case. To address the backlog of open cases, the committee has increased its meeting frequency. The COFR Committee, which was meeting every two weeks for an hour in January 2020, currently meets two times weekly for a minimum of one hour. The full committee meets at the start of the week to render decisions on new and existing cases. A sub-committee meets at the end of the week to provide follow-up on work completed outside of the committee meeting.

Out of Network Requests/Service Authorizations

Out of network authorizations are reviewed and processed by both the Crisis Service Vendors and those that are received retrospectively by Utilization Management. DWIHN network was able to service all consumer requests and special needs in 2020. Any requests from a non-contracted inpatient facility that are urgent, the UM Team handles these when notified of the admission within 24 business hours. Post service request from a non-contracted provider are handled within 30 calendar days of the request.

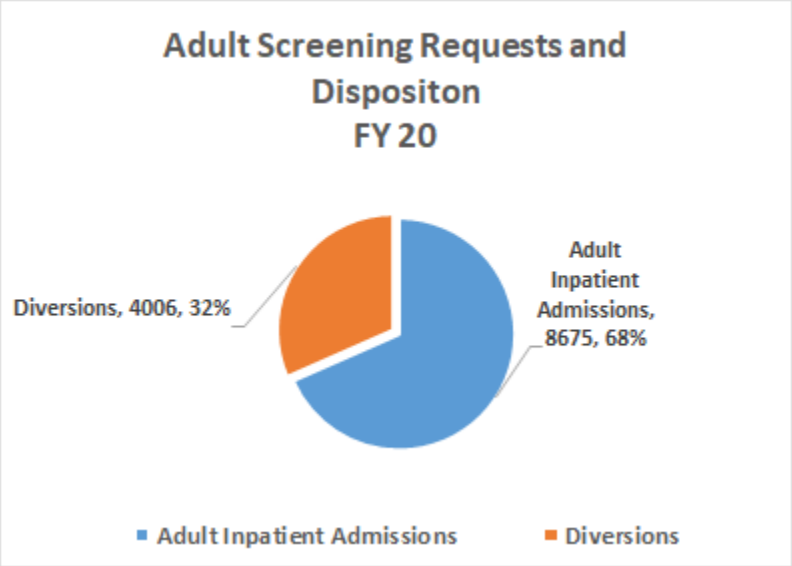
Evidenced Based Supportive Employment

Evidenced Based Supportive Employment (EBSE) are services that help support those with severe and persistent mental illness seek out, obtain, and maintain employment. Case managers assist consumers with job-readiness skills including writing resumes, development of interview skills, and managing mental illness while being employed. The UM Department approved 1,043 EBSE authorization requests this year. Over 99.9% of EBSE authorizations were completed in 14 days or less exceeding the NCQA standard timeliness disposition of 90%.

Requests for Service and Diversions from Hospitalization

The following pie charts indicate the volume of requests for service received by COPE and the Children's Screening Entities. The screeners for children and adolescents are The Children's Center, The Guidance Center, and New Oakland Family Services. A preadmission review is conducted to determine need for hospitalization. Hospitalization is the most restrictive and expensive level of care. Diversions are not only cost effective but provide a less restrictive environment for consumers. UM is actively involved with both Adult and Children's bi-weekly huddles to address hospital and diversion issues/request. This

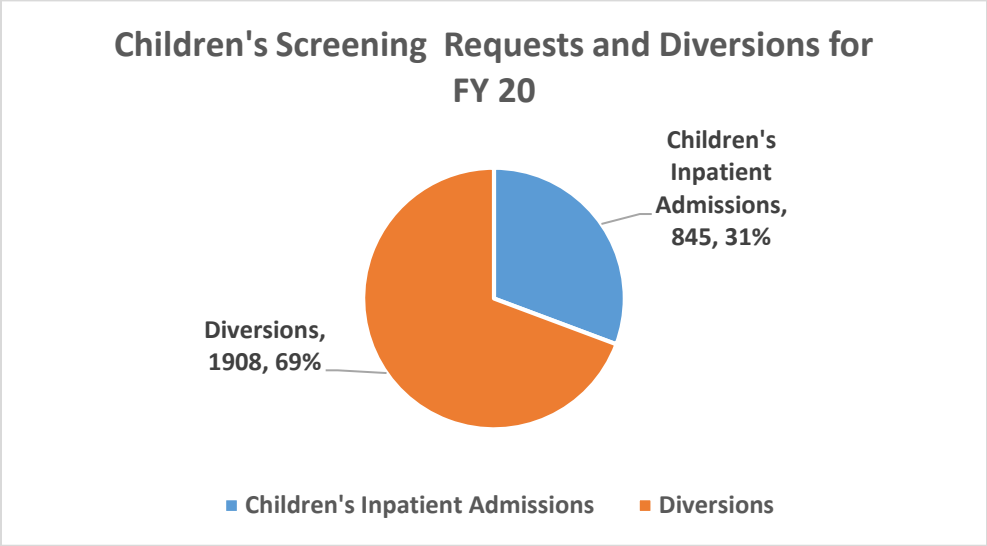
includes but is not limited to: COPE, hospital liaison and children's huddles. UM staff enter the discharge summaries in MH-WIN after hospitalization to assist in tracking after-care appointments and success of consumer engagement.



Source: MH-WIN reports, 11/4/2020

Results and Analysis

The above chart indicates that COPE screened 12,681 consumers. Sixty one percent (68%) were hospitalized and the other 32% diverted to the other levels of care which include outpatient, crisis residential, partial hospital, SUD residential, withdrawal management and other. The other referral categories may include home, health plan or other community resource. COPE also reported that 1277 (10% of consumers screened) had to wait more than 23 hours from time of request to time of placement. Additionally, 132 clients were admitted due lack of a crisis residential bed. This is reduced significantly from the previous year where 286 were admitted due to lack of a crisis residential bed in FY 19.

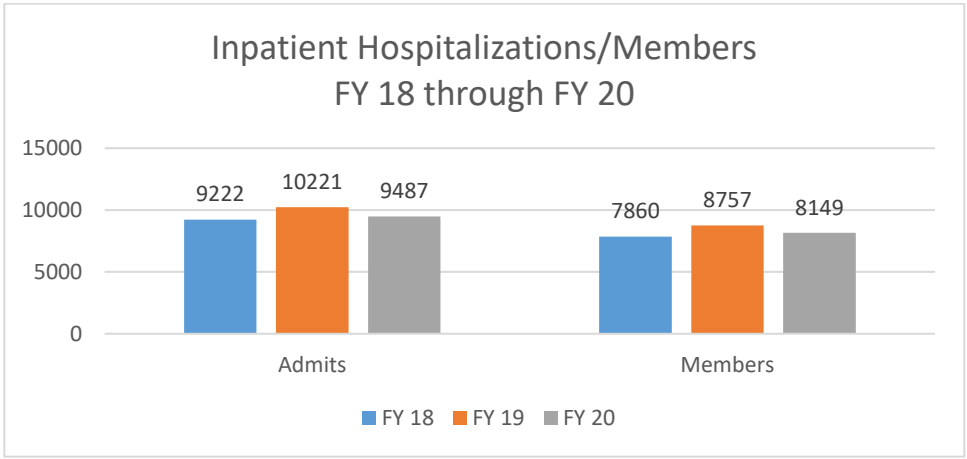


Source: MH-WIN Reports, 11/4/2020

The chart above indicates children's screeners received 2,753 requests for services, 69% (1098) were diverted to settings other than the hospital; mostly to home or outpatient services. The remaining 845, or 31% were hospitalized. Additionally, it was reported that 1015 consumers were seen for crisis stabilization services.

Inpatient Admissions and Other Metrics

The bar graph below depicts the trend of Inpatient Admissions as well as count of Unique Consumers admitted network wide for the past three fiscal years.



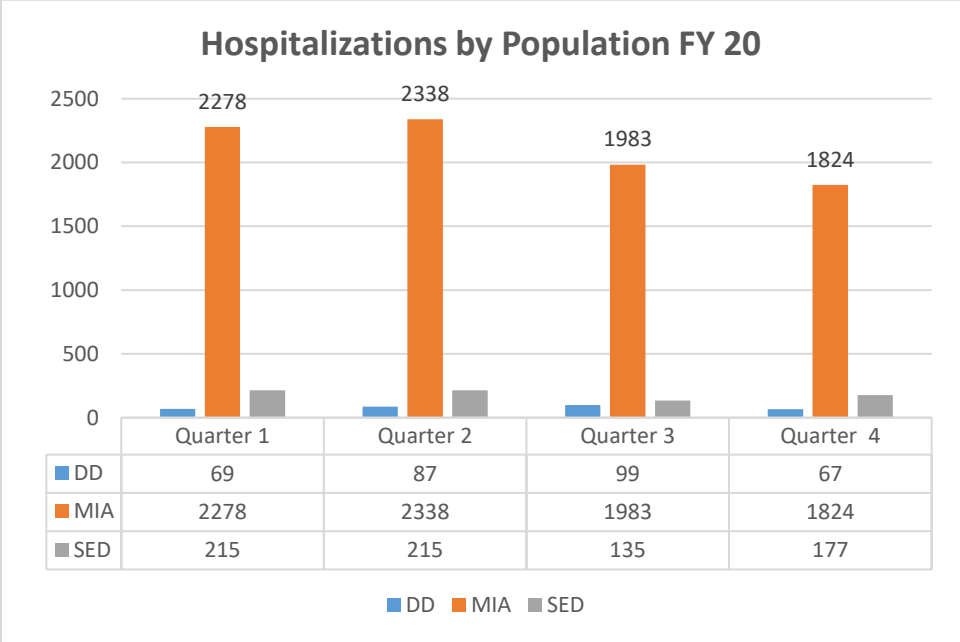
Note: The data was pulled from the hospitalization dashboards on 11/23/20. The data includes Dual Eligible. Figures from FY 2018 and 2019 are from last year's report.

Results and Analysis

The data for Inpatient Hospitalizations indicates a decrease in number of admissions and unique members hospitalized during FY 20 compared to FY 19. This is consistent with decrease in overall members served this FY.

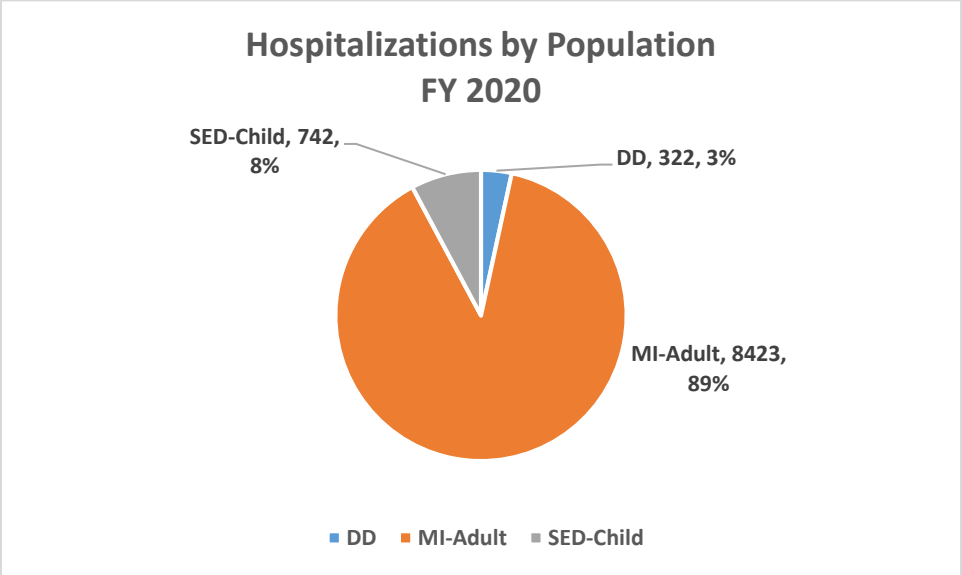
When reviewing the percentage of Admissions per the number of members served for the past 3 fiscal years, the following emerges:

- FY 18 we served 74,932 individuals and had 7860 consumers hospitalized for a percentage of 10%
- FY 19: we served 73,307 individuals and had 8757 consumers hospitalized for a percentage of 12%.
- FY 20: we served 69,333 individuals and had 8149 consumers hospitalized for a percentage of 8.5%.



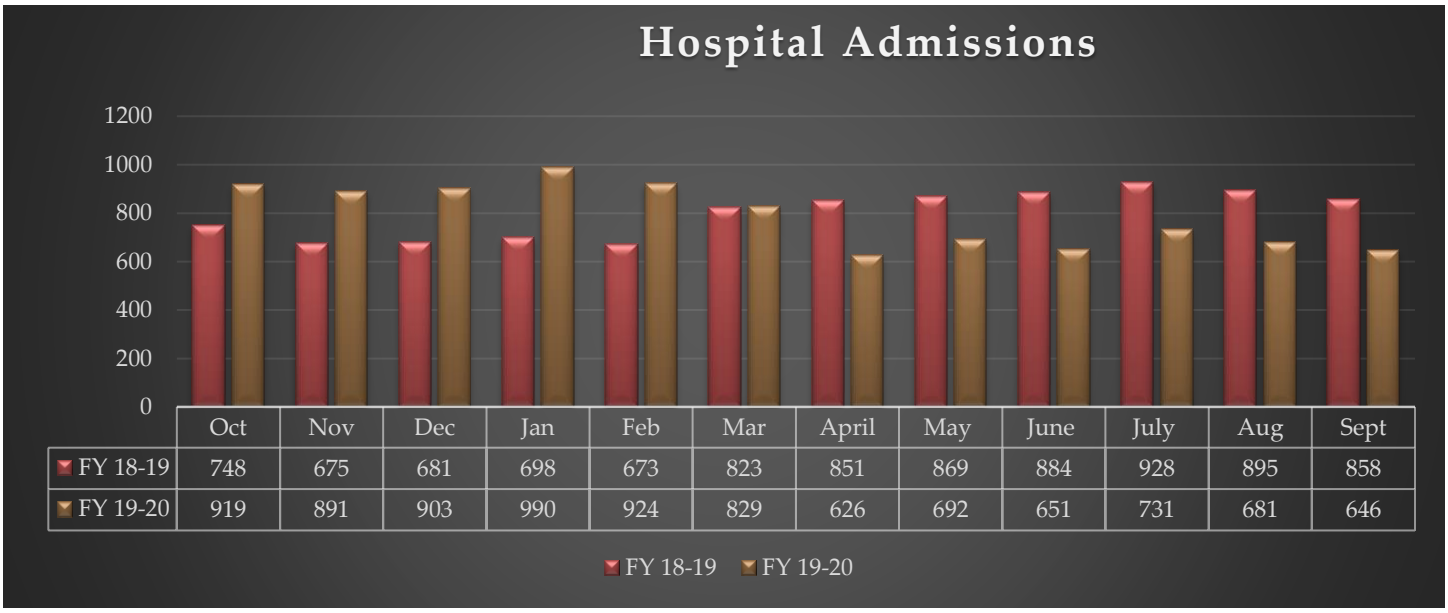
	Quarter 1	Quarter 2	Quarter 3	Quarter 4
DD	69	87	99	67
MIA	2278	2338	1983	1824
SED	215	215	135	177

Source: Dashboard 12/8/2020



As indicted above, adults with mental illness account for 89% of the 9487 hospital admissions; children with serious emotional disturbance account for 8% of the hospital admissions, and individuals with developmental disabilities account for 3% of the hospital admissions.

A more detailed analysis for number of admissions per month for the last two fiscal years is included in the chart below. The number of admissions may vary minimally as reported above as new report was built to capture monthly admissions in FY 20.



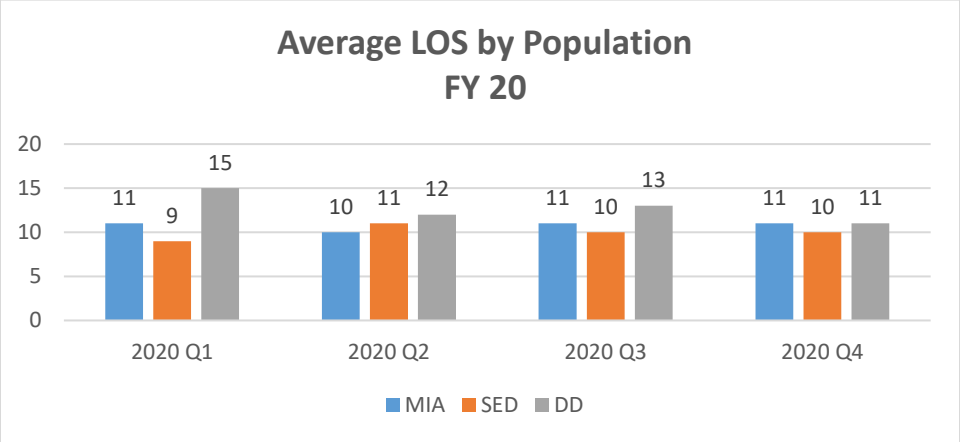
	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept
FY 18-19	748	675	681	698	673	823	851	869	884	928	895	858
FY 19-20	919	891	903	990	924	829	626	692	651	731	681	646

Source: MH-WIN reports

The charts below depict the average length of stay and median length of stay per population per quarter for FY 20.

The Utilization Management department in an effort to decrease length of stay and hospital admission has developed meetings with the physician consultant to review cases with length of stay greater than 14 days. Additionally, there is a Residential/UM work group that identifies cases with ability to transition from inpatient to Crisis Residential Unit or from a Crisis Residential Unit to an Adult Foster Care facility.

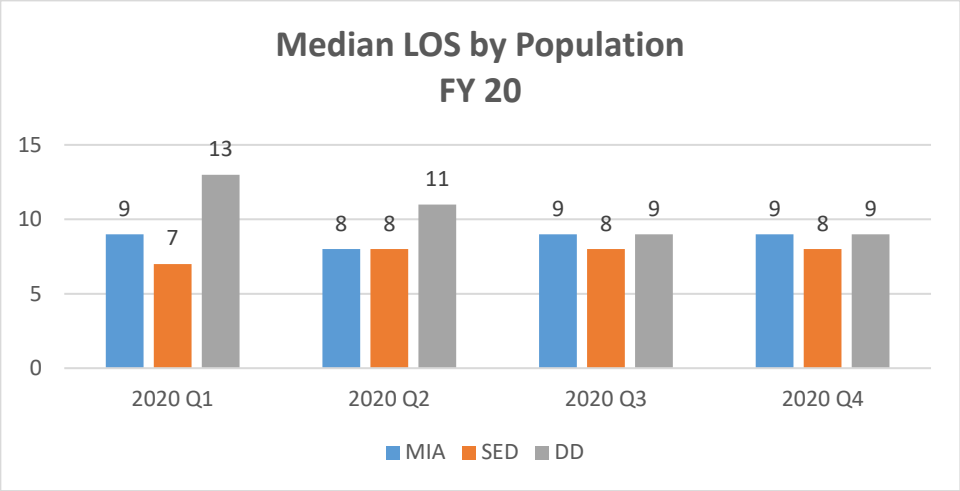
At the onset of COVID, hospitals decreased capacity to allow for single rooms and social distancing. Units were also created for individuals who tested positive or asymptomatic. Additionally, staff were tested to ensure the health and safety of the consumers. There was a decrease in hospitalizations but an increase in crisis services provided, including development of more crisis plans systemwide. The reduction in hospitalizations may in part be related to crisis stabilization services diverting consumers from inpatient services.



Source: Dashboard 12/8/2020

Results and Analysis

The chart above shows the average Length of Stay (LOS) for Adults with Severe Mental Illness was 11 days. It was 10 days in FY 2019. The average LOS for Children with SED was 10 days up from 9 days last year. The average length of stay for Individuals with IDD was the highest at 13 days, but decreased from 14 days last year. National hospital databases do not usually distinguish the IDD population for statistical purposes as clients are hospitalized under a psychiatric diagnosis.



Source: Dashboard 12/8/2020

Results and Analysis

The median length of stay is a better measure of midpoints, as it is not affected by outliers. The median length of stay chart shows the median Length of Stay for Adults with Severe Mental Illness ranged between 8 to 9 days for each quarter. The median LOS for Children with SED was between 7 to 8 days. The median length of stay for Individuals with IDD ranged from 9 to 13 days. Because hospitalizations are smaller in number for IDD, several long lengths of stays for a few members can alter the median LOS.

Benchmarking Length of Stay

It is important to compare DWIHN's performance to other entity's performance that are comparable and available in regards to hospital lengths of stay. Some data bases may not include the Medicaid or uninsured population or take into consideration other social determinants that may vary by state or geographic location and may impact length of stay.

The 2019 SAMHSA Uniform Reporting System reports on lengths of stay of psychiatric Inpatient hospitalizations, including Medicaid and Non-Medicaid, and is representative of the consumers we serve. The table below compares DWIHN to Michigan and other States (23-29 states) reported performance:

2019 SAMHSA Uniform Reporting System		
Population	**Average LOS**	**Median LOS**
State of MI Adults	8	Not reported
State of MI Children	9	Not Reported
US Adults	55	30

US Children	37	37

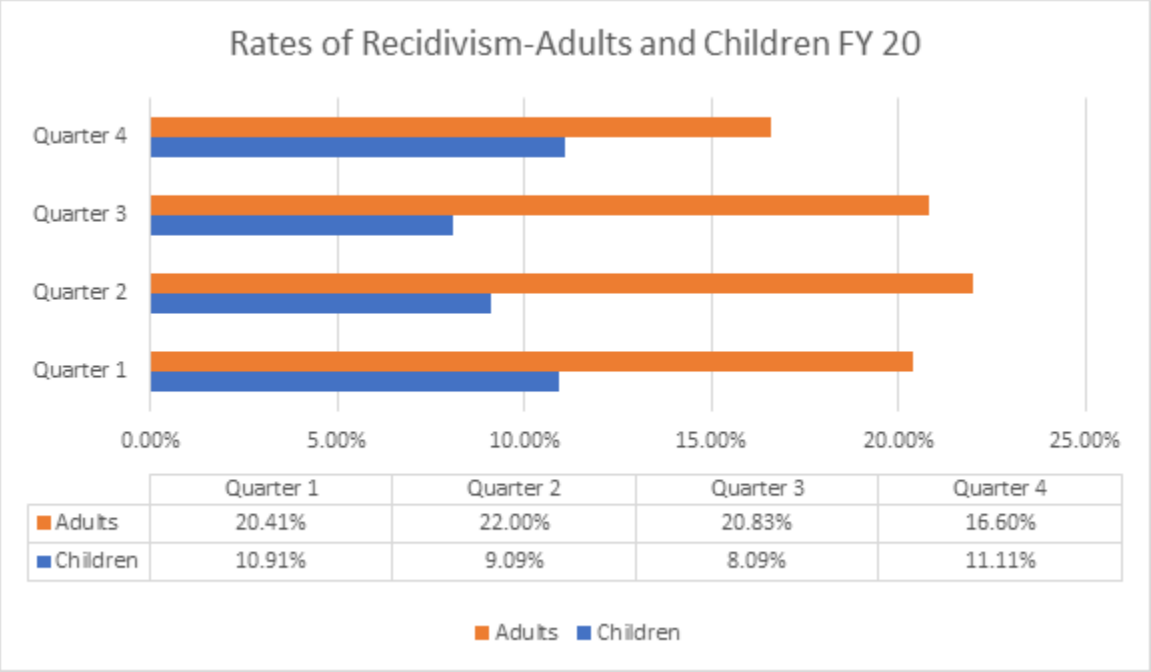
Source: 2019 SAMHSA Uniform Reporting System.

DWIHN FY 2020		
Population	**Average LOS**	**Median LOS**
DWIHN Adults	11	8-9
DWIHN Children	10	7-8

DWIHN's Median Length of Stay data is very close with the State average LOS and much lower than other states. Median LOS is more accurate than average LOS as it does not include outliers. The 24th Edition of the MCG Criteria, updated in 2019, lists the National Average Length of Stay for some of DWIHN's most frequently seen diagnoses including Bipolar Disorder, Schizophrenia, Attention Deficit Disorder, Post Traumatic Stress Disorder and Depression.

Although DWIHN current hospital metrics are not broken down by diagnosis, the national average length of stay of the above diagnoses range from 5 days to 14 days. Our average LOS for SMI adult and SED children falls within the range of 10-11 days.

Hospital Recidivism



Source: DWIHN Quality Assurance Department PIHP Report FY 19-20 (01/2021)

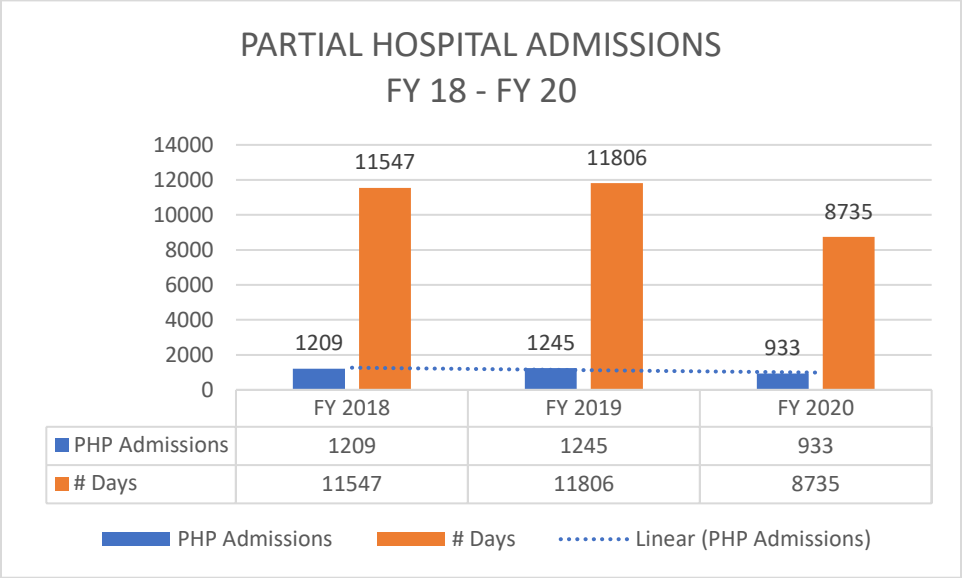
Results and Analysis

As part of the Michigan Mission Based Performance Indicator System, the Quality Department tracks hospital recidivism. Performance Indicator #10 tracks the percentage of consumers readmitted within 30 days of discharge from hospital and the data is compiled and analyzed by the Quality Department. The state benchmark of 15% or less was not met for adults during FY 20. Quarters 1, 2 and 3 for FY 20, resulted in rates of recidivism over 20%, while quarter 4 decreased to 16.6%, notably lower but still higher than the 15% state requirement for adults. The number of children admitted within 30 days of discharge, remained below the 15% threshold for the entire fiscal year. The first quarter of FY 19 resulted in 15.70% and 8.12% rates of recidivism for adults and children compared to 20.41% and 10.91% for the first quarter of FY 20. The rates for the fourth quarter of FY 19 were 19.27% and 16.33% and 16.60% and 11.11% for FY 20 for adults and children, respectively. *Recidivism data for FY 20 is inclusive of the MI Health Link population. *

DWIHN continues to provide mobile crisis stabilization services through Community Outreach for Psychiatric Emergency (COPE) with Hegira Programs, Northeast Guidance Center, Neighborhood Service Organization, The Children's Center, The Guidance Center and New Oakland Family Services for adults and children, respectively. DWIHN considers crisis care to be a foundation and core element of effective behavioral health care delivery and also recognizes the need to ensure consumers are actively engaged in treatment and services before they encounter a crisis.

Partial Hospitalization

Partial Hospitalization is a cost-effective diversion from inpatient hospitalization. New Oakland Child-Adolescent & Family Center served 933 consumers in FY 20. This was a 25% reduction from FY 19, with 1245 consumers served. This reduction in most probability is due to COVID-19. Average length of stay for Partial in FY 20 was 9.4 days.

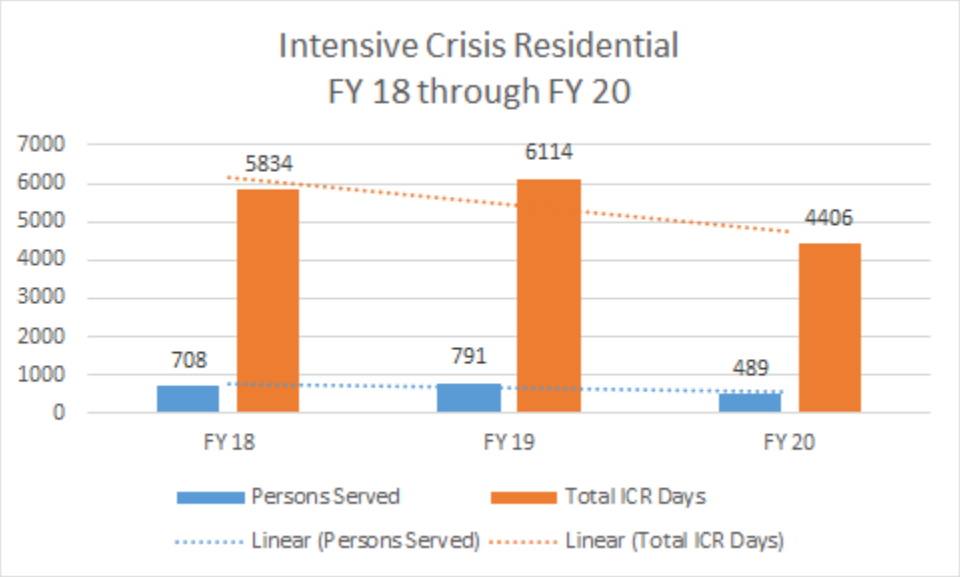


Source: DWIHN Claims database as of 11/2/2020

Results and Analysis

Partial Hospitalization is a cost-effective diversion from inpatient hospitalization. New Oakland Child-Adolescent & Family Center served 933 consumers in FY 20. This was a 25% reduction from FY 19, with 1245 consumers served. This reduction in most probability is due to COVID-19. Average length of stay for Partial in FY 20 was 9.4 days.

Intensive Crisis Residential



Source: DWIHN Claims database as of 11/2/2020

Results and Analysis

The number of consumers who received Intensive Crisis Residential Services decreased 38% from 791 consumers served in FY 19 to 489 served in FY 20. Likewise, the number of days utilized decreased 28% from 6614 in FY 19 to 4406 in FY 20. This decrease is directly related to the number of beds taken off-line during the COVID-19 pandemic. Providers decreased and continue to decrease capacity by 50% to adhere to social distancing. Hegira is the only adult provider with Oakdale House and Boulevard Crisis Residential. Inc. Safehaus is the only provider for children with serious emotional disturbance and served 85 children compared to 138 the previous year. Hegira served the remaining 404 adults with serious mental illness at Oakdale House and Boulevard Crisis Residential. The average LOS for Crisis Residential was 9 days up from 8 days last fiscal year.

Planned Interventions for FY 2020

The Quality Department leads DWIHN's interdepartmental efforts at reducing the number of consumers who are readmitted. Last fiscal year, the QAPIP report addressed the development of a recidivism work group. The workgroup began meeting in January 2020 and has taken the following steps to address the rates of recidivism:

- The need to engage and collaborate with consumers' outpatient (CRSP) providers to ensure continuity of care and when consumers present to the ER in crisis but may not require hospitalization.
- Chart alerts which notify the screening entities and CRSP of consumers who frequently present to the ER
- Properly navigating and diverting consumers to the appropriate type of service and level of care
- Referrals to Complex Case Management for consumers with high behavioral needs

DWIHN seeks to reduce acute inpatient admissions and provide safe, timely, appropriate and high-quality treatment alternatives while still ensuring consumers receive the appropriate care that their condition requires. DWIHN continues its efforts to expand the comprehensive continuum of crisis services, supports, and improve care delivery.

- Recidivism Task Force- to identify Familiar Faces and CRSP responsibility- create a plan to address the needs of persons served – Chart alerts developed in MH-WIN
- Coordinate and collaborate with crisis screeners on measures to decrease inpatient admissions
    - Identify individuals with increased hospitalization – *chart alerts developed in MH-WIN for providers and screening entities*

    - Engage CRSP and identify all diversions options – *work on crisis continuum continues; refer consumers to complex case management and divert when possible*
- Discuss with leadership incentive and incentive strategies to decrease hospitalizations – *Not addressed*

State Hospitalizations

DWIHN monitors the admissions and discharges of all Wayne County consumers in the state hospital system. The system consists of the Center for Forensic Psychiatry, Hawthorn Center for Children and three psychiatric hospitals for adults: Caro Center, Kalamazoo Psychiatric Hospital, and Walter Reuther Psychiatric Hospital. Walter Reuther is the assigned hospital for the Detroit-Wayne area, but consumers are placed according to their individual treatment needs. Specific to UM, the State Hospital Liaisons are embedded to facilitate coordination of activities between state hospital facilities and network providers such as placement and NGRI oversight. Liaisons also provide technical and subject matter expertise on DWIHN policies and procedures, and ensure the best utilization of resources by managing state hospital length of stays via admissions and discharges.

Throughout FY 19-20, state hospital bed availability has been limited resulting in extended wait times for admission. At the beginning of the fiscal year, wait times in excess of nine months were documented across all hospitals. Priority for forensic admissions, an increase in community hospital referrals, and limited community placement options remained challenges to the state hospital admission process. Additionally, the COVID-19 pandemic exacerbated these challenges as state hospitals were forced to place admissions on hold intermittently to treat and prevent COVID cases among patients and staff. Currently, all hospitals have established quarantine units and have restricted outside visitors/providers to prevent COVID transmission. To date, 38% of DWIHN state hospital inpatient cases have contracted COVID-19.

To address these challenges, DWIHN consulted with MDHHS to address the shortage of state beds and expanded efforts among the Wayne County Jail, Center for Forensic Psychiatry, COPE, and crisis providers to explore placement alternatives. Specifically, efforts from diversion programs such as the DCPP (Direct-to-Community-Placement Program) facilitated by MDHHS and coordinated by liaison staff have expedited the release of consumers found Not Guilty by Reason of Insanity (NGRI) and Incompetent to Stand Trial (IST). Additionally, liaison staff have continued to coordinate discharges remotely and via Telehealth to limit member exposure to COVID-19 and secure available community beds.

State hospital census counts remained relatively unchanged throughout the fiscal year as discharges were also limited. Individual placement barriers; legal status, minimal family

support, substance use history, criminal history, and co-morbid health conditions, have been longstanding challenges to discharge and were intensified by COVID-19. Wait times for discharge increased to 8 months as discharges were delayed by COVID positive cases, community bed shortages, and quarantine restrictions. Additionally, limited secured placement sites for the most severe I/DD and SMI members also continued to prolong discharge planning and increase hospital length of stays.

State Facility FY 19-20	Total Admissions	Total Discharges	Average Monthly Census	Average Length of Stay (Days)	Total ALS/NGRI Consumers	Total ALS/NGRI Completion
Caro	1	0	1	120	0	0
Kalamazoo	4	4	14	445	1	0
Walter Reuther	43	50	109	748	77	21

Results and Analysis

During FY 19-20, state hospital statistics remained consistent with figures reported in FY 18-19. Walter Reuther averaged a longer length of stay than the other listed hospitals reflecting increased forensic admissions, which require longer length of stays due to the legal process. Caro Center and Kalamazoo Psychiatric length of stays also reflected an increase as forensic admissions were prioritized and accounted for more than half of DWIHN inpatient cases.

The length of stay across all state hospitals for members referred from community inpatient settings averaged 438 days, a significant decrease from 816 days in FY 18-19. This is more reflective of the rates in previous years and is attributed to the decrease in community referrals for state hospital level of care in lieu of forensic admissions. At the end of FY 19-20, seventy-seven (77) Not Guilty by Reason of Insanity (NGRI) members (compared to 82 during FY 18-19) were in the community on a 5-year Authorized Leave Status (ALS) contract undergoing intensive treatment services. Twenty-one (21) of these members successfully completed the contract, in comparison to 8 who completed the contract during FY 18-19. FY 19-20 accounted for the largest cohort group to complete the ALS contract.

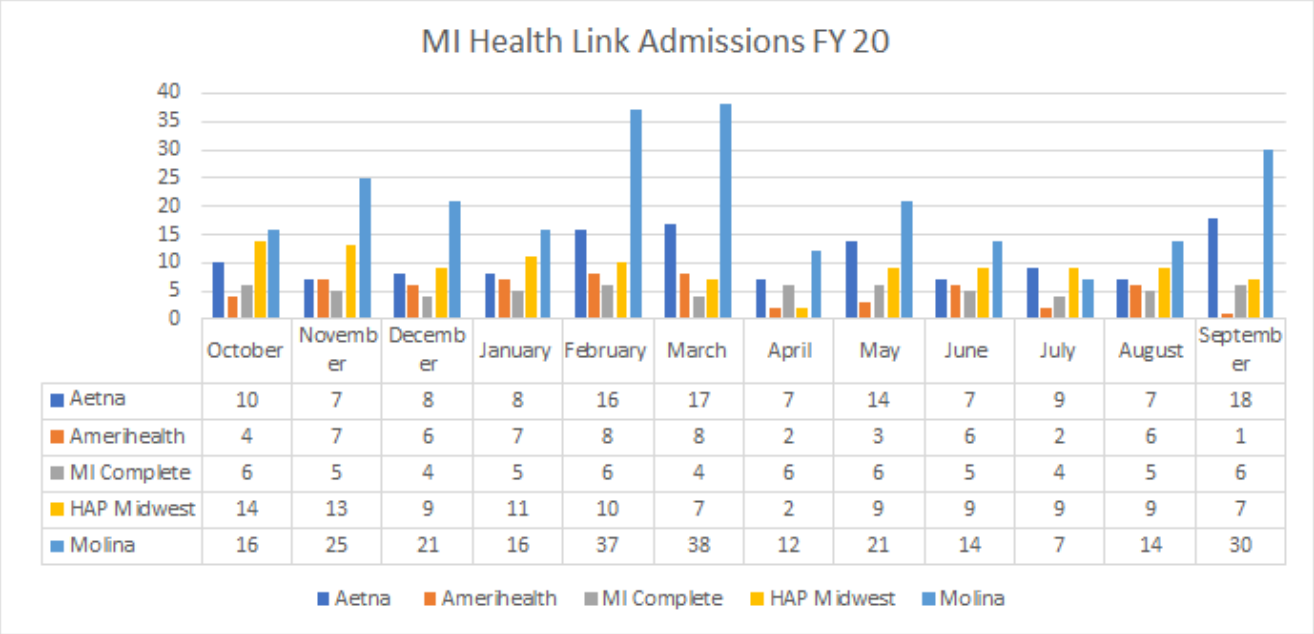
MI-Health Link (Dual Eligible) Program

MI Health Link is a health care option for Michigan adults, ages 21 or over, who are enrolled in both Medicare and Medicaid. MI Health Link offers a broad range of medical and behavioral health services, pharmacy, home and community-based services and nursing

home care, all in a single program designed to meet individual needs. Also, there are no co-pays for in-network services and medications.

For MI Health Link enrollees, all behavioral health services covered by Medicare and Medicaid are managed by Michigan Pre-paid Inpatient Health Plans (PIHPs). Behavioral health services are delivered through the local Community Mental Health Services Provider (CMHSP). Below is a breakdown of acute inpatient hospitalizations and ALOS by ICO for FY 19-20.

Source: DWIHN REPORTS (OCT 2020)



	October	November	December	January	February	March	April	May	June	July	August	September
Aetna	10	7	8	8	16	17	7	14	7	9	7	18
Amerihealth	4	7	6	7	8	8	2	3	6	2	6	1
MI Complete	6	5	4	5	6	4	6	6	5	4	5	6
HAP Midwest	14	13	9	11	10	7	2	9	9	9	9	7
Molina	16	25	21	16	37	38	12	21	14	7	14	30

Results and Analysis

DWIHN worked with the following health plans in FY 20: AmeriHealth, Aetna, Michigan Complete, Molina and HAP Midwest. The Agency Profile within I-Dashboards indicates 5,271 MI Health Link consumers were enrolled with DWIHN in FY 20, compared to the 5,010 members reported as enrolled last fiscal year. MI Health Link enrollees are a significantly small subset of DWIHN members. (6%). There were 616 MI Health Link (MHL) members hospitalized during FY 20. During FY 19, DWIHN managed 560 community hospital admissions of MI-Health Link members.

According to iDashboard, 92 MHL members were readmitted in FY 19 and in FY 20, there were 58 members who were readmitted within 30 days of discharge. The number of readmissions decreased by 45% in FY 20. Molina saw the highest number of admissions during FY 20 at 251, 40% of the DWIHN MHL admissions for FY 20. AmeriHealth had the lowest number with 60 members admitted, followed by MI Complete, with 62 admissions.

The UM department recognizes the need for one report that provides data specific to the MI Health Link population which includes the following: the number of admissions for inpatient treatment, crisis residential and partial hospitalization, recidivism, average length of stay and inpatient and discharge days. The current data regarding MI Heath Link admissions is taken from the MHWIN consumers in the hospital report and manually calculated for monthly reporting. There are plans to collaborate with IT to develop a report during FY 21.

Substance Use Disorder Services(SUD)

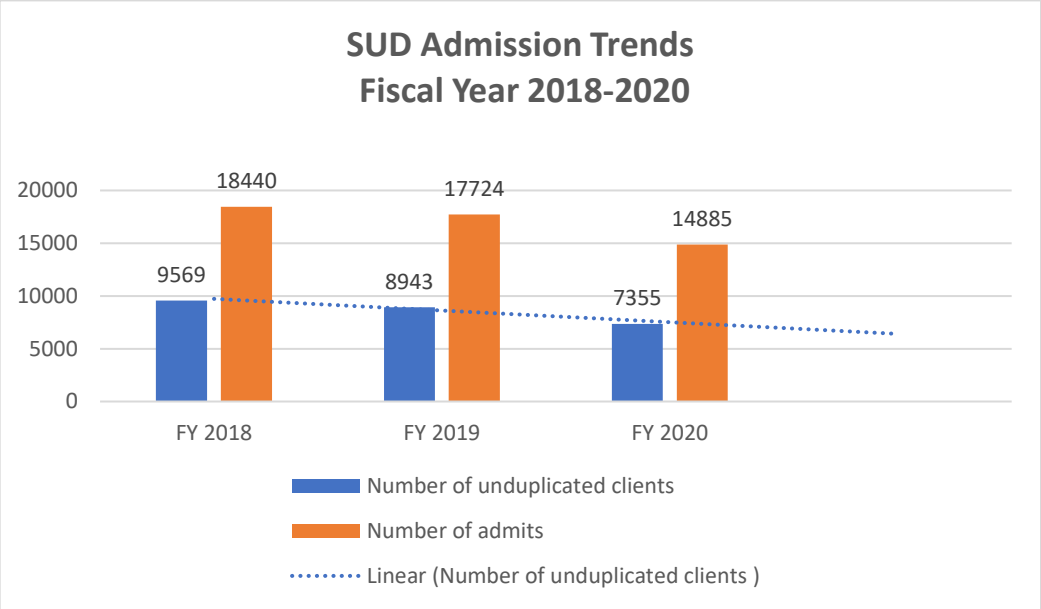
Substance Use Disorder Services

Wellplace, DWIHN'S access center conducts initial screening and referral for SUD services based on the American Society of Addiction Medicine (ASAM) level of care and medical necessity criteria. The UM Department's SUD Review Specialists provide medical necessity reauthorization determinations of SUD services for all levels of care including withdrawal management, residential services, medication assisted treatment (MAT), intensive outpatient, outpatient, and recovery services. UM SUD staff completed 24,413 authorizations in FY 20.

There were 7,355 unique individuals that received SUD services for FY 20. This is a 18% decrease from FY 19 with 8,943 unique individuals served. Consistent with the decrease in individuals served, there were 14,885 admissions, a decrease of 19% from FY 18 with 17,724 admissions. This decrease can be attributed to COVID-19 which greatly reduced the capacity of many providers to serve consumers in both residential and outpatient settings.

Results and Analysis

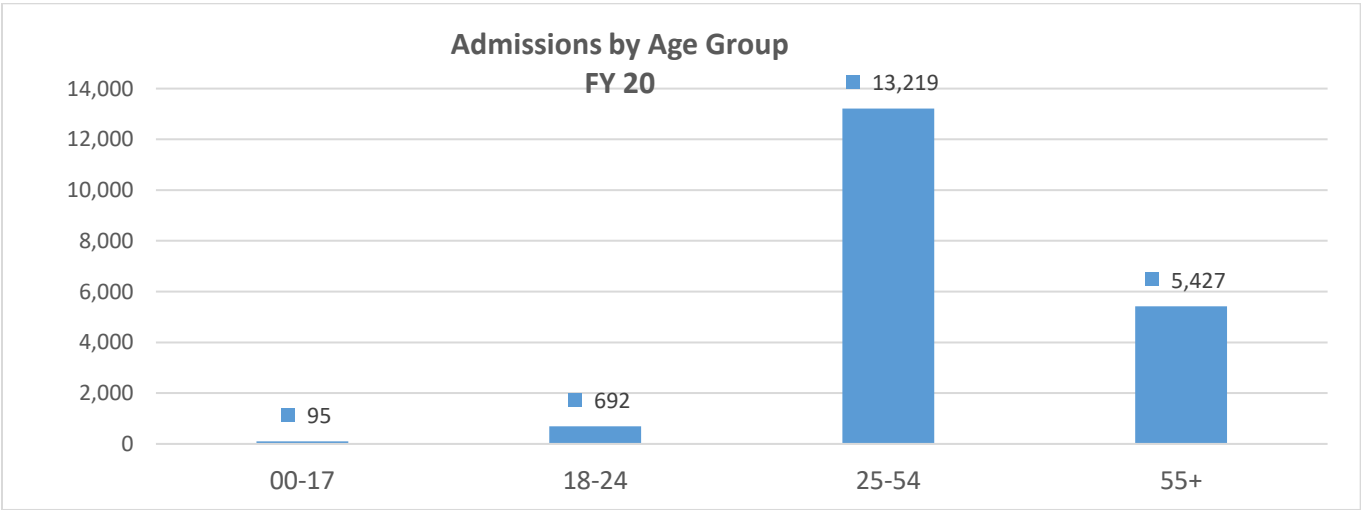
The bar graph below shows the trend of admissions and the number of unique individuals served for the past 3 fiscal years. From FY 18 to FY 20, there has been a decrease in the number of individuals served. A large portion of the reduction in FY 20 can be attributed to COVID. Each change in level of care is considered an admission. Some individuals receive more than one level of care, such as withdrawal management, followed by residential services and outpatient and/or recovery services.



Source: SUD Admissions and Discharges within MH-WIN 10/23/2020

Results and Analysis

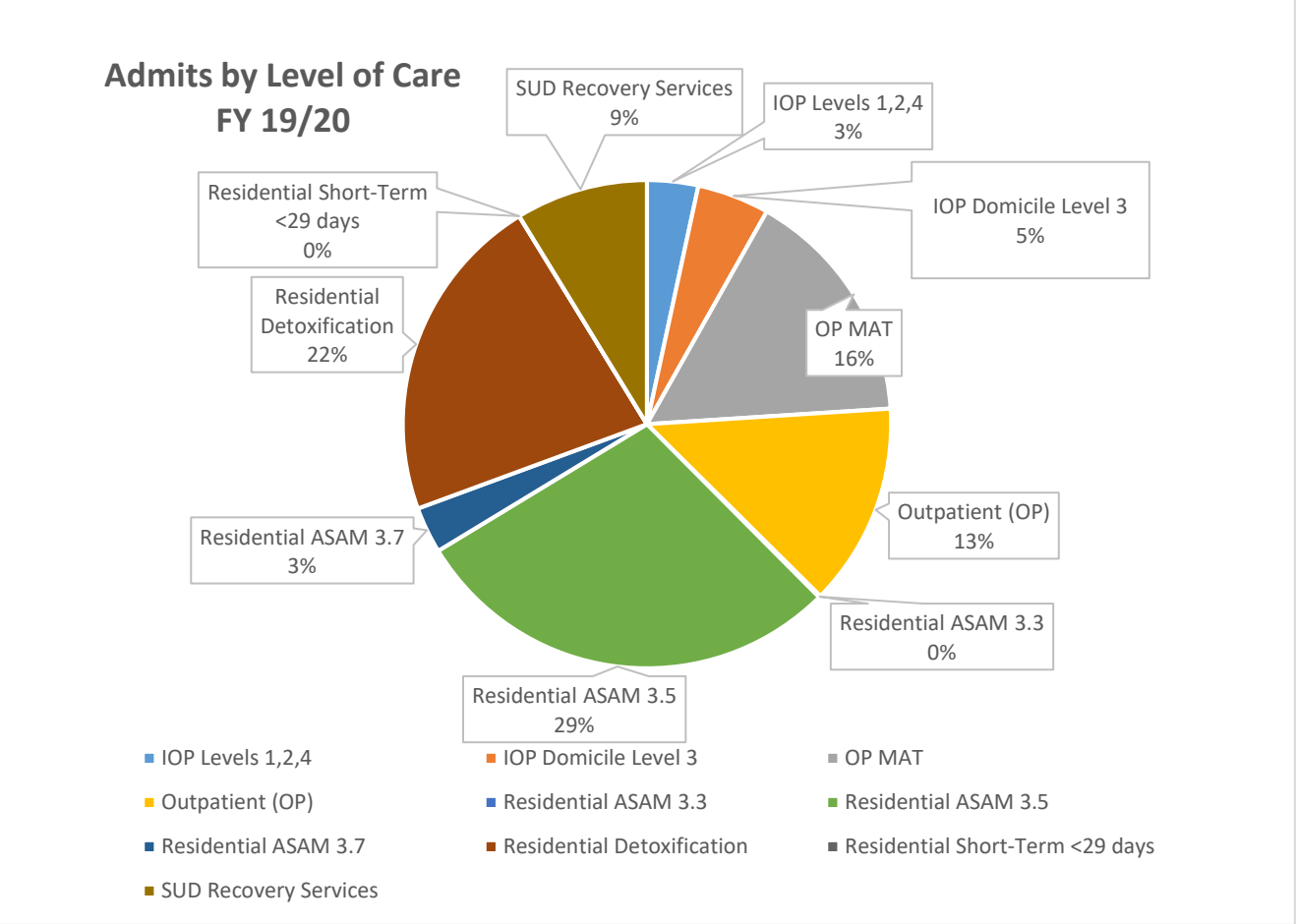
The age distribution metric has remained relatively constant over the last several years. During FY 20, 68% percent of individuals admitted were between 25-54 years of age. Twenty-eight (28%) of individuals admitted were for 55+ years of age. Four (4%) were for individuals age 18-24, and less than 1% were admissions individuals between 0-17.



Source: MH-WIN Admission and Discharge Records 10/23/20

Admission level of care is determined at time of access to services according to ASAM criteria. Any change in level of care after the admission requires review and approval of presented clinical justification by the provider to the Access Center. Later in treatment,

changes in level of care must be approved by UM staff. The chart below shows the SUD admissions by level of care for FY 20. The admissions are inclusive of new admits that occurred in the current fiscal year. It should be noted that, MDHHS discontinued use of the labels “short-term” and “long term residential” and began using the ASAM levels of care of 3.3, 3.5 and 3.7. Short-term residential is included in the pie chart below as COPE used this label for several cases.



Source: MHWIN Admissions and discharge Records 10/23/20

Results and Analysis

Withdrawal management services (WMS) previously detoxification, accounts for 22% of admissions. If all levels of residential services are combined, it accounts for 32% of admissions. Outpatient admits account for 13% of admissions. Intensive Outpatient, IOP Level 1 through Level 4 account for 8 % of admissions. Admissions for Medication Assisted Treatment including methadone account for 16% of admissions, followed by Recovery Services at 9%. (Note: some categories that are less than 1% of whole, reflect 0% even though there are admissions reflected in those categories). The percentage served in each category remains relatively consistent, and is correlated with the available capacity of the provider network. Even though number of consumers admitted was reduced overall, the level of care service mix remains consistent.

UM SUD staff completed 24,413 authorizations in FY 20. Timeliness of authorizations which measures how long it takes UM staff to render a disposition is addressed later in the report. UM SUD staff completed 24,413 authorizations in FY 20. Timeliness improved after a vacancy was filled.

This year UM worked with finance, IT, Managed Care, SUD Administrators, to implement detailed and significant changes as to how Medication Assisted Treatment is billed for MI-Health Link providers. New procedure codes were rolled out that bundled services and resulted in modified fee schedules. All these changes are reflected in the applicable rate sheets and service utilization guidelines. The Procedure Code Workgroup also produced a bulletin to address this change. Additionally, the SUD treatment and provider network was required to submit Request for Proposals in FY 2020 and their intent to continue contracting with DWIHN. Several UM staff participated in this rigorous review process, which resulted in a reduced number of SUD treatment providers.

Quality Pillar – Safe, Patient Centered, Efficient, Equitable, Timely, and Effective.

Goal I - Engage community stakeholders in the development and implementation of processes that promote clinical review procedures, practices and corrective actions to ensure system wide compliance with DWIHN, State, Federal regulations.

Goal Status: Met

Consumer Involvement

DWIHN's Customer Service Department instituted a Rapid Response process for inquires coming from consumers and other stakeholders via the DWIHN website. Questions are forwarded by IT to Customer Service staff and then directed to the appropriate department for a rapid response. The goal is to provide a prompt, positive, productive experience for anyone regarding Authority processes, clinical programs or procedures, or other practices impacting the community.

The Consumer Voice (Persons Points of View) is a quarterly newsletter, edited and written by consumers, that is distributed throughout the provider network. Each of the FY 20 editions contained language regarding the "Affirmative Statement" to advise consumers that UM decision making is based only on appropriateness of care and no rewards or financial incentives influence those decisions.

Provider Network Involvement

With system transformation, dissolution of the MCPNs, increased activity with the Integrated Care Organizations, and changes in many of the authorizations processes, UM continues to

modify processes impacting authorization and subsequently continue to train providers on documentation required to support authorizations. UM staff collaborate on a daily basis with providers, including hospital staff to ensure medical necessity is met and consumers receive the appropriate amount, scope and duration of services. UM responds to inquiries in timely fashion and will meet with providers as necessary to improve UM processes.

UM staff routinely participate in regularly held meetings with hospital providers and both the adult and children's screening entities. Additionally, specialty program areas such as Autism and Habilitation waiver continue to improve and require modification based on MDHHS audit or review findings. In the area of Habilitation Supports, DWIHN meets quarterly with representatives of agencies providing Habilitation Supports Waiver services. Utilization rates, updates or changes to policy and procedures, including program incentives, potential barriers to participation of qualified individuals and similar topics are discussed at every meeting. Other topics, such as goal writing, accurate form completion, common reasons as to why applications or authorizations are returned and other similar topics discussed throughout the year as needed.

On a bimonthly basis, substance use disorder providers meet with SUD leadership and key staff from Access, Finance, IT, UM, Quality, and Managed Care Operations to discuss clinical and administrative operations. Focus is placed on activities to improve efficiency, effectiveness, and overall quality of care of consumers receiving substance use disorder services.

Goal II - Provide oversight of delegated UM functions through use of policies that reflect current practices, standardized/inter-rater reliability procedures and tools, pre-service, concurrent and post-service (retrospective) reviews, data reporting (i.e. timeliness of UM decisions and notifications), outcome measurements and remedial activities

Goal Status: Met

Delegated Entities UM Program Evaluations

The Crisis Vendors submitted FY 20 annual evaluation reports in accordance with the required template provided by the UM department. Each spoke to the elements of the template and some of their findings are included in this report. Wellplace has encountered technical difficulties and to-date has not submitted their annual evaluation. COPE reported an issue of placing consumers in Transitional Housing as the number of homes willing to provide placement was reduced due to COVID-19. Per COPE this was brought to DWIHN's attention and addressed. Many homes continue to require a negative COVID test prior to accepting individuals.

Compliance with UM Decision-making Timeframes and UM Notification

The UM Program Description articulates the need to ensure fair and timely utilization decisions.

Below is a breakdown of the timeliness of decision making for FY 20 by delegated entity and DWIHN line**s** of business.

Timeliness of electronic or written notification of the UM decision is also required in accordance with the turnaround time frame given for the type of request. The Timeliness of UM Decisions Making and UM Notification is reported on a quarterly basis during the Utilization Management Committee meeting

Timeliness of UM Decision Making by Delegated Entities

Results and Analysis

All of the delegated entities met the 90% threshold for timeliness of urgent preservice UM decision making during FY 20.

Timeliness of UM Decision Making-COPE

	Urgent Concurrent	Urgent Preservice	Non-Urgent Preservice	Post-Service
Numerator*	N/A	9015	N/A	N/A
Denominator#	N/A	9400	N/A	N/A
Rate	N/A	96%	N/A	N/A

Source: COPE 12/16/2020

Timeliness of UM Decision Making Children's Center

	Urgent Concurrent	Urgent Preservice	Non-Urgent Preservice	Post Service
Numerator *	N/A	381	N/A	N/A
Denominator #	N/A	381	N/A	N/A
Rate	N/A	100%	N/A	N/A

Source: Children's Center 12/16/20

Timeliness of UM Decision Making-The Guidance Center

	Urgent Concurrent	Urgent Preservice	Non-Urgent Preservice	Post Service
Numerator *	N/A	1257	N/A	N/A
Denominator #	N/A	1268	N/A	N/A
Rate	N/A	98%	N/A	N/A

Source: The Guidance Center 12/16/2020

Timeliness of UM Decision Making-New Oakland Family and Child Center

	Urgent Concurrent	Urgent Preservice	Non-Urgent Preservice	Post Service
Numerator *	N/A	558	N/A	N/A
Denominator #	N/A	559	N/A	N/A
Rate	N/A	99%	N/A	N/A

Source: New-Oakland 12/16/2020

Timeliness of UM Decision Making-DWIHN MI Health Link Program

	Urgent Concurrent	Urgent Preservice	Non-Urgent Preservice	Post-Service
Numerator *	99	50	272	39
Denominator#	100	50	291	39
Rate	99%	100%	93%	100%

Source: DWIHN Dashboard 12/16/2020

Timeliness of UM Decision Making-Substance Use Disorder

Results and Analysis

The urgent concurrent category improved from 85% in FY 19 to 91.1% in FY 20. This improvement has led to SUD meeting the 90% threshold for the urgent concurrent category. In the prior fiscal year, the threshold was not met due to staff vacancy and authorizations received over the weekend were currently not approved until Monday. Since FY 19, new staff has been hired and a process has been put in place for staff to work on the weekends to ensure that requests for services are authorized.

The non-urgent category for SUD increased from 76% in FY 19 to 88% in FY 20. Although SUD has made great strides in this category, there was a staff vacancy in the first quarter, making it difficult to meet the 90% threshold. Subsequent quarters were over the 90%

Timeliness of UM Decision Making-Substance Use Disorder

	Urgent Concurrent	Urgent Preservice	Non-Urgent Preservice	Post-Service
Numerator*	6037	N/A	11976	N/A
Denominator#	6625	N/A	13630	N/A
Rate	91.1%	N/A	88%	N/A

Source: DWIHN Dashboard 12/16/2020

Planned Interventions FY 2020

- New staff hired December, 2019 - *Completed*
- Substance Use Disorder UM Authorization Queue will be monitored for adherence to timelines – *Completed and Timeliness Improved since new hire in December, 2019*
- Capacity Assessment will be completed – *Completed Review of Provider Network and staff assignments*

Timeliness of UM Decision Non-Urgent Preservice Decision Making – Autism

Timeliness for UM Decision Making for Autism has met the

	Urgent Concurrent	Urgent Preservice	Non-Urgent Preservice	Post-Service
Numerator*	N/A	N/A	5922	N/A
Denominator#	N/A	N/A	6020	N/A
Rate	N/A	N/A	98%	N/A

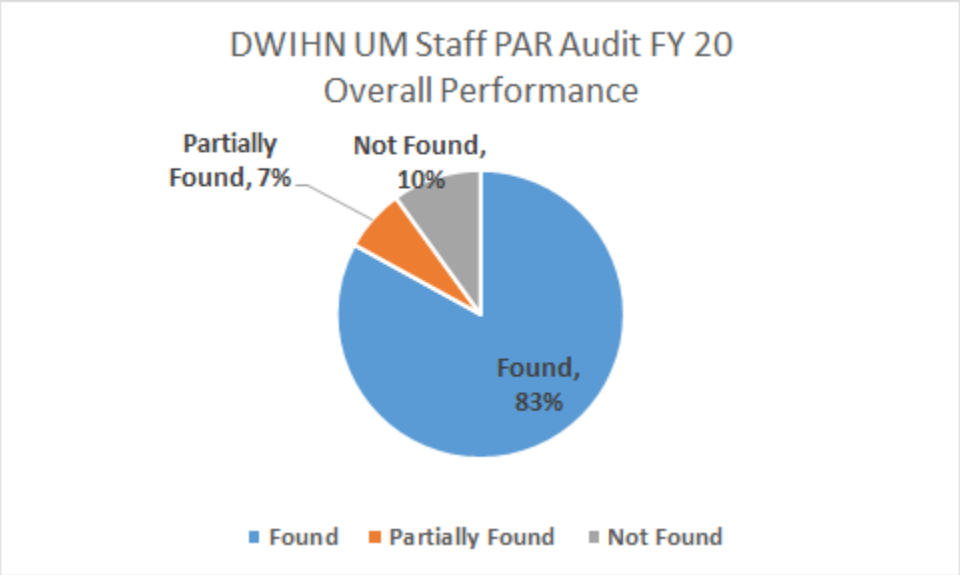
Source: DWIHN Dashboard 12/16/2020

Chart Reviews of Prior Authorized Reviews (PARs)

Chart reviews of PARS were conducted quarterly by the Crisis Service Vendors & the Access Center and DWIHN. DWIHN also reviewed the submitted report. A total of 365 Approval and Denial cases were reviewed**.** Documentation and content are the measures included in the tool. The findings include missing last names (clinicians), credentials, lab results, medications dosages, incomplete vital signs or discharge plans.

Supervisory staff share findings with individual staff and systemic issues are shared with the group. Some entities scored at 100% and others will require a plan of correction with outcomes reported to the DWIHN UM department/UM Committee during FY 21.

Quarterly chart audits were also conducted for the internal continued stay reviews. A detailed report was completed outlining the results of the audit and included recommendations for updating the PAR audit tool used to complete the review. The overall fiscal year compliance score was 83%, which is 2% below the standard. The chart below outlines the UM Staff overall performance.



The recommendations made in the summary of the review will be implemented in the second quarter of FY 21 included:

- Ensuring consistent documentation of discharge planning
- Accuracy in reporting length of stay
- Individualized, robust goal statements
- Documentation of evidence of crisis or behavioral treatment plans
- Updating of MHWIN to reflect Clinical Specialists and provider credentials and contact information
- The internal PAR audit process

Denial and Appeal Category Analysis

During FY 20, a review of all denials and appeals indicated each of the following were handled according to established procedures.

Appeal Disposition	Denials			
	Medical Necessity Denial	Administrative Denials	Medical Necessity Appeal	Administrative Appeal
	73	412	20	8
Upheld			17	2
Overturned			3	6
Partially Denied				

*Administrative denials issued due to provider not adhering to timeliness guidelines for submission of authorizations.

Also, during FY 20, the Michigan Peer Review Organization MPRO) served as the independent review organization. The Medical Officer served as the last level of appeal.

Standardized Individual Plan of Service (IPOS) / Authorizations/Service Utilization Guidelines

Having a standardized Individual Plan of Service (IPOS) provides a method for the network to consistently document the Person-Centered Planning process. Throughout this year, Clinically Responsible Service Providers (CRSP) were at various stages of having their electronic health record transfer the essential elements of the standardized Individual Plan of Service (IPOS) to DWIHN or they had the option to enter the IPOS directly into MHWIN. Clinically Responsible Service Providers' electronic health records were fully transitioned by Quarter 4. To prepare the network workforce, system training on the standardized Individual Plan of Service (IPOS) was held in Quarter 1; two trainings were in-person and two trainings were on a virtual platform.

Throughout the year, UM continued efforts to build the skillset of the network in the area of Person-Centered Planning. Person Centered Planning and IPOS Development training sessions were held in Quarter 3; two specific trainings for adults and two specific trainings for children/family. Over 600 individuals participated in the trainings. In addition, two sessions in Quarter 3 were held where the subject matter was the implementation of the Service Utilization Guidelines (SUG). Services that do not fall within the guidelines, will require authorization from the UM Department. During the SUG training sessions, there was additional instruction on the Golden Thread which details the process of weaving relevant clinical information throughout the assessment, IPOS, and Progress Notes.

Self-Determination/Self Directing

The UM Department further demonstrated its commitment to supporting our members' ability to exercise autonomy over their life by developing the infrastructure so that all populations could Self-Direct their services if they choose to do so. MDHHS put forth concerted efforts this year to distinguish the difference between Self-Determination and Self-Directing services. Self-determination (SD) is the right of all people to have the power to make decisions for themselves; to have free will. The goals of SD, on an individual basis, are to promote full inclusion in community life, to have self-worth and increase belonging while reducing the isolation and segregation of people who receive services. Self-determination builds upon choice, autonomy, competence and relatedness which are building blocks of psychological wellbeing. Self-direction (Self-Directing services) is a method for moving away from professionally managed models of supports and services. It is the act of selecting, directing, and managing ones services and supports. People who self-direct their services are able to decide how to spend their CMH services budget with support, as desired. Various

Clinically Responsible Service Providers (CRSP) were trained on Self-Determination and Self-Directing services throughout the year. As of Quarter 4, DWIHN has transitioned 150 individuals who are supported by various CRSPs to Self-Directed Arrangements.

III. Status of Utilization Management Department Technology Recommendations

Advocacy Pillar

Goal Status: Met

Goal I - Provide collaboration in shaping state and regional policies, procedures and practices relative to utilization management development and implementation of processes that promote clinical review procedure, practices.

MCG Integration

DWIHN is an active member of the Michigan Consortium for Healthcare Excellence (MCHE), MCG was awarded the contract for use of its behavioral health guidelines statewide. This workgroup has focused on procurement of the MCG Behavioral Health guidelines to assist in demonstrating parity. As noted earlier, the majority of the PIHPs began preparing to use the guidelines or interactive software in FY 20. The Parity workgroup believes the MCG criteria is one tool that assists in determining medical necessity, but must also be used in conjunction with standardized assessment tools while preserving person-centered planning values.

RESULTS AND ANALYSIS

- The Parity workgroup continues to work with MDHHS to ensure movement toward parity throughout Michigan. DWIHN IT department has worked with PCE and MCG to integrate/embed the tool into our MH-WIN system and began using the integrated software in January, 2020 The Parity workgroup has drafted a Principles of Parity document that includes the history of the federal mandate including the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The document describes current assessment tools (Level of Care Utilization System (LOCUS); CAFAS (Child and Adolescent Functional Assessment Scale); SIS (Supports Intensity Scale) and ASAM-PPC (American Society for Addition Medicine-Patient Placement Criteria used in Michigan that assist in application of medical necessity and benefits. Also described is the need for exception processes to medical necessity guidelines which must include documentation to support exceptions and how they are applied to service planning discussions with individuals served.

Dashboard/Report Development/Technology

The UM Department continues to collaborate with IT on the development of the following dashboards/reports:

- Inpatient Recidivism – *Report is complete and available*
- Enhancements to the hospitalization dashboard – *Report development not dashboard*
- improved metrics for readmissions - *Report is complete and available*
- hospital utilization will be expanded to include standardized measures that consider the population, for hospitalization, recidivism, length of stay, level of care and procedure code utilization for all programs and populations including Substance Use Disorders. – *Report is complete and available*
- Development of Electronic Reviews – The electronic review process is slated to roll-out in the second quarter of FY 21. It will start with a piloting of the process with 2 of DWIHN's Inpatient Hospital providers and eventually include all in-network Inpatient, Crisis Residential and Partial Hospitalization providers. It is expected to streamline the process for reviewing urgent concurrent requests for continued authorization.
- General Fund Utilization Monitoring -*Report is complete and available, needs further updating to gather meaningful data.*

  In FY 20, UM Department had several pivot tables trainings from I.T Additional reports were completed that provide data for the analysis of over and underutilization of behavioral health services.

  In review of FY 20, it is evident that many lines of business experienced a reduction in consumers served. Due to the pandemic and governor's order, effective 3/16/2020, screening entities, providers and residential facilities made changes in their face-to-face services, and in a short period of time, adapted to delivering telephonic services when possible. Residential facilities and transitional housing facilities reduced capacity to ensure social distancing and safety of consumers. DWIHN contracted with SUD residential providers to designate two (2) facilities to serve COVID positive patients. Initiatives to ensure availability of personal protective equipment (PPE) and provider network knowledge of COVID-19 testing were rolled out and continue. As we progress through FY 21, DWIHN UM will continue to monitor impact of COVID-19 on overall utilization and the need to adapt workflows to ensure consumers continue to receive medically necessary services.

Opportunities for Improvement for FY 2021

Utilization Management Opportunities for Improvement
FY 2021

Strategic Pillar	Goal and Timeline for Completion	Brief Description	Responsible Leader/UMC
Customer	UM will participate in interdepartmental efforts to improve FY 20 survey findings of both Member and Provider Surveys by 7/2021	Member and Provider satisfaction;	UM Director and designated staff
Access	UM will monitor timely written notification of ABA eligibility and data reported in the Risk Matrix (provider evaluation) FY 21	Delegated functions	UM Director and designated staff
Quality	Continue efforts to reduce consumer recidivism and improve the Michigan based state performance indicator	Recidivism	UM Department and Recidivism Task Force, COPE huddle, Children's Screeners Huddle, Hospital Liaison Meetings
Finance	Over and Under Utilization Reports; Establish schedule and reporting of selected and prioritized data for review FY 21	Potentially select high volume, high cost, high risk service codes	UMC
Quality	Ensure 2 provider trainings per year regarding Service Utilization Guidelines; by end of FY 21	Ongoing collaboration and improvement of service utilization guidelines	UM Administrator
Finance	Ensure application of level of care guidelines, use of assessment tools and	Minimum annual review of Service Utilization Guidelines, Level of	UM Department, UM Clinical Specialists, UMC and other committees and

	application of medical necessity criteria across all service arrays	Care Assessment tools, and medical necessity criteria	stakeholders as defined in UM program evaluation
Advocacy	Continue bi-monthly meetings and contribution to Michigan Consortium for Healthcare excellence in ensuring access, parity, and uniform application of benefits for Michigan consumers	MCG Behavioral Health Guidelines, Interrater Reliability	Parity Workgroup, UM Administrator; UM Clinical Specialist

Attachment A

FY 2016- 2017, 2018-2019, 2019-2020
DWIHN Report on Practitioner Network Satisfaction Survey
UTILIZATION MANAGEMENT

During FY 2016-2017, FY 2018-2019 and FY 2019-2020, DWIHN collected survey data to determine network experiences with DWIHN. This report analyzes practitioner satisfaction with Utilization Management during the three fiscal years. This report addresses **NCQA UM standard 1A: Utilization Management Structure, Factor 2, "**The organization considers member and practitioner experience data when evaluating its UM program, and updates the UM program based on its evaluation."

I. OVERVIEW

The methodology for this survey is under the auspices of DWIHN's Customer Services division. There were 33 practitioner respondents for the FY 2016-2017 survey, 146 practitioner respondents for the FY 2018-2019 survey and 180 practitioner respondents for the FY 2019 -2020 survey. It should be noted, there was a FY 2017-2018 DWIHN Provider Satisfaction Survey that utilized a different survey tool that cannot be integrated into this report. The respondents identified as working with all consumer populations served by DWIHN.

II. QUANTITATIVE FINDINGS

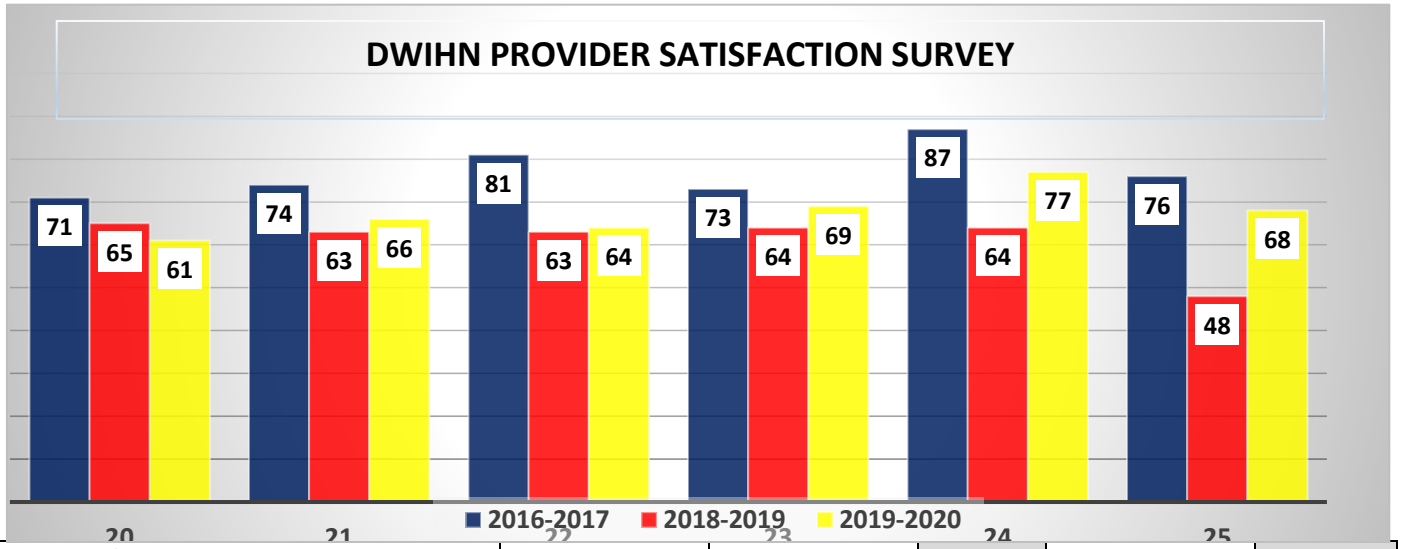
PART A: Participants were anonymous and were given the following options for scoring **Questions 20-25**: Completely Satisfied, Somewhat Satisfied, Neither Dissatisfied or Satisfied, Somewhat Dissatisfied, Completely Dissatisfied, Not Applicable. For the purposes of this report, the level of satisfaction was calculated for *each* question as follows:

Number of "Completely Satisfied/Somewhat Satisfied/Neither Satisfied or Dissatisfied

Total Number of Respondents Minus the Number of N/A's

COPE is a delegated UM entity that reports to the DWIHN Access and Crisis Services division

QUESTION	2016-2017 %Satisfaction	2018-2019 %Satisfaction	Rate of Change	2019-2020 %Satisfaction	Rate of Change
20. How satisfied are you with the ease of obtaining DWIHN's initial authorizations through COPE*, SUD, Autism Spectrum Disorder, and/or MI Health Link?	71%	65%	-6%	61%	-4%
21. How satisfied are you with the ease of obtaining DWIHN's continued stay authorizations through COPE*, SUD, Autism Spectrum Disorder, and/or MI Health Link?	74%	63%	-11%	66%	-3%
22. How satisfied are you with the consistency of application of Medical Necessity Criteria for determination of appropriate level of care?	81%	63%	-18%	64%	+1%
23. How satisfied are you with the ease of placement in the suitable setting necessary for reduction or stabilization of symptoms/disabilities and	73%	64%	-9%	69%	+5%



improvement/stabilization of level of functioning?					
24. How satisfied are you with the Provider Appeal process for denials?	87%	64%	-23%	77%	+13%
25. How satisfied are you with the MH-WIN authorization functions?	76%	48%	-28%	68%	+20%

Findings:

1. The targeted 80% satisfaction rating was met/exceeded in the FY 2016-2017 survey by two **measures; #22**, "How satisfied are you with the consistency of application of Medical Necessity Criteria for determination of appropriate level of care?" and **#24**, "How satisfied are you with the Provider Appeal process for denials? However, both measures, then *fell below* the 80% satisfaction standard in FY 2018-2019 and again in FY 19-20.
2. None of the factors achieved the 80% satisfaction standard during FY 2018-2019 or FY 2019 – 2020.

There were plan of actions to improve these ratings. Overall, the 80% satisfaction standard has not been consistently met. **PART B:** Participants were given the following options for scoring **Questions 26-29**: Well Above Average, Somewhat Above Average, Average, Somewhat Below Average, Below Average, Not Applicable

The level of satisfaction was calculated for *each* question as follows:

Number of "Well Above Average", "Somewhat Above Average", "Average" Responses
Total Number of Respondents Minus the Number of N/A's

QUESTION	2016-2017 %Satisfaction	2018-2019 %Satisfaction	Rate of Change	2019-2020 %Satisfaction	Rate of Change
26. Access to knowledgeable DWIHN Utilization Management staff.	78%	81%	+3%	62%	-19%
27. Procedures for obtaining pre-certification/referral/authorization information.	76%	80%	+4%	68%	-12%

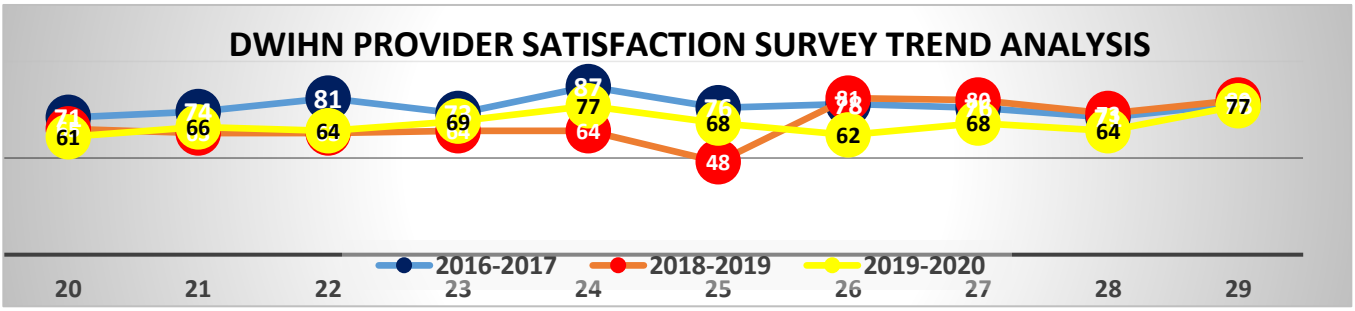
28. Timeless of obtaining pre-certification/referral/authorization information.	71%	73%	+2%	64%	-9%
29. Facilitation/support of appropriate clinical care for patients	78%	80%	+2%	77%	-3%

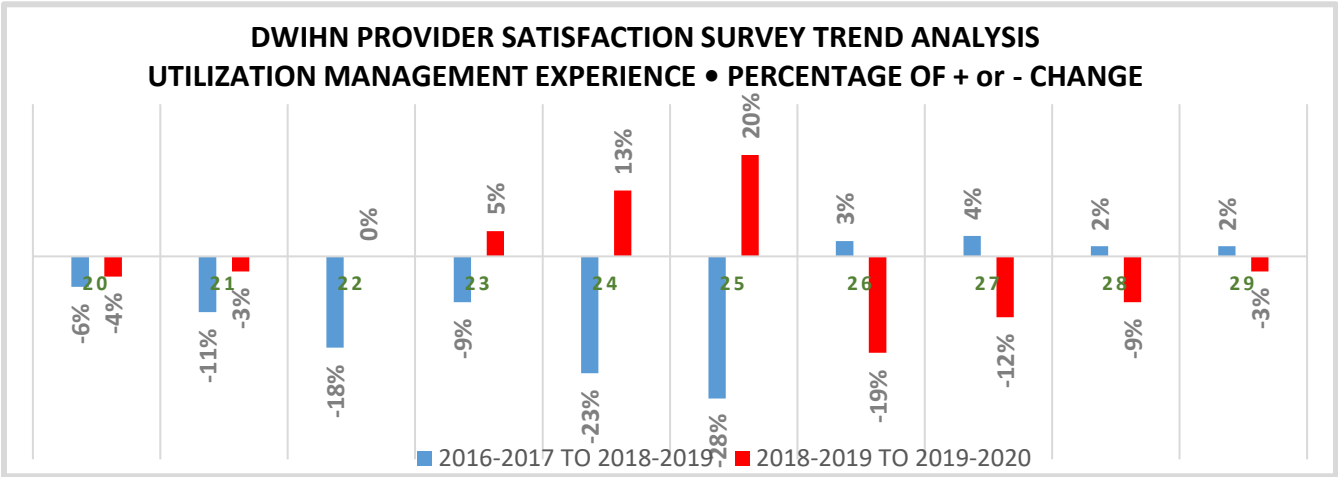
Findings:

The 80% target was *not* met for measures **#26, #27 and #29** in the FY 2016-2017 survey. The 80% satisfaction target was then met/exceeded in the FY 2018-2019 survey . In FY 2019-2020, each measure then fell *below* the FY 2016-2017 ratings. Two of these measures had a 2016-2017 plan of action. The outcome was a *2% increase* in the satisfaction rating for FY 2018-2019 from 78% to 80%. The increase met the 80% standard. The measure fell to 77% satisfaction in the 2019-2020 survey.

Measure #28, "Timeliness of obtaining pre- certification/referral/authorization information." had a 2016-2017 action plan. The outcome was a *2% increase* in the satisfaction rating for FY 2018-2019 from 71% to 73%, but *decreased* to 68% in FY 2019-2020. The measure does not yet meet the 80% standard.

PART C: DATA TREND ANALYSIS





1. Overall, scores were higher in the FY 2016-2017 survey than in the FY 2018-2019 and FY 2019-2020. The average score in the FY 2018-2019 was 8.4% lower than average score in the FY 2016-2017 survey. The median score in the FY 2018-2019 was 7.4% lower the median in the FY 2016-2017 survey. The average score in the FY 2019-2020 survey was 1% lower than the average score in the

FY 2018-2019 survey. The median score in the FY 2019-2020 was 3.5% lower the median in the FY 2018-2019 survey.

2. Over the course of three measurement periods, there were 30 opportunities to meet or exceed the 80% target score. This occurred five times; twice in FY 2016-2017 and three times in FY 201802019. This is a 17% level of compliance with the target 80% score.
3. The *lowest* scores did not occur in the same measures during the three survey periods.
4. The *highest scores* did not occur in the same measures during the three survey periods.

II. QUALITATIVE FINDINGS

Survey participants responded to the survey question, "What can DWIHN do to improve its services to your organization?" Unedited practitioner comments can be found in the DWIHN Network Satisfaction Survey for FY 2016 – 2017, FY 2018 - 2019 and FY 2019 – 2020. Some of the comments are directly related to the DWIHN UM department (especially the bolded comments) and some are more related to UM processes through Wellplace, COPE, the children's crisis service vendors and DWIHN's Residential Services department. And others are inclusive of *any* DWIHN division for consideration for improvement of the provider experience, including the UM division. Many of the sentiments expressed during the three-year study period regarding UM functions resonate with each survey period**.**

III. Recommendation

The surveys have identified several opportunities for improvement. It is recommended the UM Program Evaluation FY 2019 – 2020 Plan of Correction include the provider experience survey goal of achieving the 80% standard on *each* of the ten measures of the FY 2020-2021 practitioner experience survey. Specific interventions for each of these opportunities for improvement should be developed, implemented and tracked through a collaborative effort, inclusive of UM department staff, Residential Services, Access and Crisis Services, network practitioners and the Utilization Management Committee. Remeasurements should be tracked in Cascade to monitor progress and achieve the targeted goal