Detroit Wayne
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PROGRAM COMPLIANCE COMMITTEE MEETING
Virtual Meeting
Thursday, January 13, 2021
1:00 p.m. – 3:00 p.m.

REVISED AGENDA

I. Call to Order

II. Moment of Silence

III. Roll Call

IV. Approval of the Agenda

V. Follow-Up Items from Previous Meeting
A. **Year-End Reports**
1. **Customer Service** – Provide a summary of the provider satisfaction surveys administered to the providers and practitioners
2. **Integrated Health Care** – Provide a breakdown of referrals by ICOs

VI. Approval of the Minutes – November 12, 2020

VII. Report(s)
A. Corporate Compliance Report
B. Children's Redesign Update
C. Utilization Management's Quarterly Report

VIII. Utilization Management Review(s)
A. Annual Utilization Management Program Evaluation FY 2020
B. Utilization Management Program Description FY 2019-2021

IX. Strategic Plan – Access Pillar

X. Quality Review(s)
A. QAPIP Description Plan (October 2020-September 2022)

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

XII. Chief Clinical Officer's Report

XIII. Unfinished Business

A. **BA #21-23 (Revised)** – Provider Network System
B. **BA #21-40 (Revised)** – School Success Initiatives

XIV. New Business
(Staff Recommendations):

A. **BA #21-53** – HUD Permanent Supportive Housing – Coalition on Temporary Shelter (COTS) and Central City Integrated Health (CCIH)

XV. Good and Welfare/Public Comment

Members of the public are welcome to address the Board during this time up to two (2) minutes ***(The Board Liaison will notify the Chair when the time limit has been met)***. Individuals are encouraged to identify themselves and fill out a comment card to leave with the Board Liaison; however, those individuals that do not want to identify themselves may still address the Board. Issues raised during Good and Welfare/Public Comment that are of concern to the 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).

XVI. Adjournment

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Date: January 9, 2021

To: Dr. Iris Taylor, Chair Program Compliance Committee
From: Darlene D. Owens, Director of Substance Use Disorder Initiatives
RE: COVID Update FY 20 & FY 21

COVID Update
3rd & 4th Quarter FY 20 COVID Sentinel Events

Number Tx Staff tested Positive	Number of Client tested Positive	Number of Staff Death	Number of COVID Client Deaths
48	123	12	35
Number Prevention Staff tested Positive	**Number of Client tested Positive**	**Number of Staff Death**	**Number of COVID Client Deaths**
14	41	0	8

COVID Update
1st Quarter FY 21 COVID Sentinel Events

Number Tx Staff tested Positive	Number of Client tested Positive	Number of Staff Death	Number of COVID Client Deaths
60	86	0	13
Number Prevention Staff tested Positive	**Number of Client tested Positive**	**Number of Staff Death**	**Number of COVID Client Deaths**
8	5	0	0

January 7, 2021

Fiscal Year 20 Provider/Practitioner Survey Summary

Overview:

Detroit Wayne Integrated Health Network's (DWIHN) Customer Services Department administers the DWIHN Annual Provider/Practitioner Survey for FY 20 during the month of September 2020.

The survey is designed to measure DWIHN's contracted provider organizations and practitioner's assessment of its performances. The survey covered 5 components:

1. DWIHN's effectiveness in meeting our contractual obligations
2. DWIHN's support of providers in meeting the needs of DWIHN's members
3. DWIHNs responsiveness to providers.
4. Uncover gaps and/or deficiencies in DWIHN's operation.
5. Identify opportunities for improvement and /or for corrective actions where needed.

The survey was distributed to approximately 450 provider organizations and approximately 2,000 individual practioners. The survey was comprised of 76 questions and covered all areas of DWIHN's operation inclusive of the following departments: Utilization Management, Claims, Residential, Managed Care Operations, Quality Management and Credentialing.

Response Rate FY 2020:

DWIHN experienced a significant increase in the survey response rate from FY 19. 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%. *"Note DWIHN's targeted response rate is 50-60% response rate".*

Barriers:

A. The survey results revealed the following opportunities for improvement:

1. Even-though the response rate increased by 25% we are still below the targeted rate of 50% -75% participation
2. Length of survey (76 questions) may dissuade provider organizations and practitioners to complete survey. *"As it was reported to have taken 30 minutes to complete"*

3. Based upon number of surveys that bounced back there is further need to clean up our email database to void invalid email addresses
4. Data base on practitioner contact not updated by providers, still contains inactive practitioners
5. Some rating system categories require more interpretation (e.g. somewhat average, neither satisfied or dissatisfied).

B. Provider organizations and individual practitioners' request for the following:

1. Improvement in clear, consistent, transparent communication,
2. More resources/funding to improve practitioner/client service time
3. Improved timeliness in approval of authorizations,
4. Increased CRSPs involvement in decisions on authorizations
5. Improvement in response to emails
6. More training when changes occur
7. A reduction/elimination in duplication of information for same information from multiple departments.
8. Request to shorten the survey
9. Increased awareness of the "My Strength Program"

Planned Next Steps, Corrective Action & Follow-up:

An ad-hoc group will be formed in early 2021 to review the FY 2019 and FY 2020 survey results, survey tool as well as the specific requests for improvement submitted by providers/practitioners as noted in the comment section. 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.

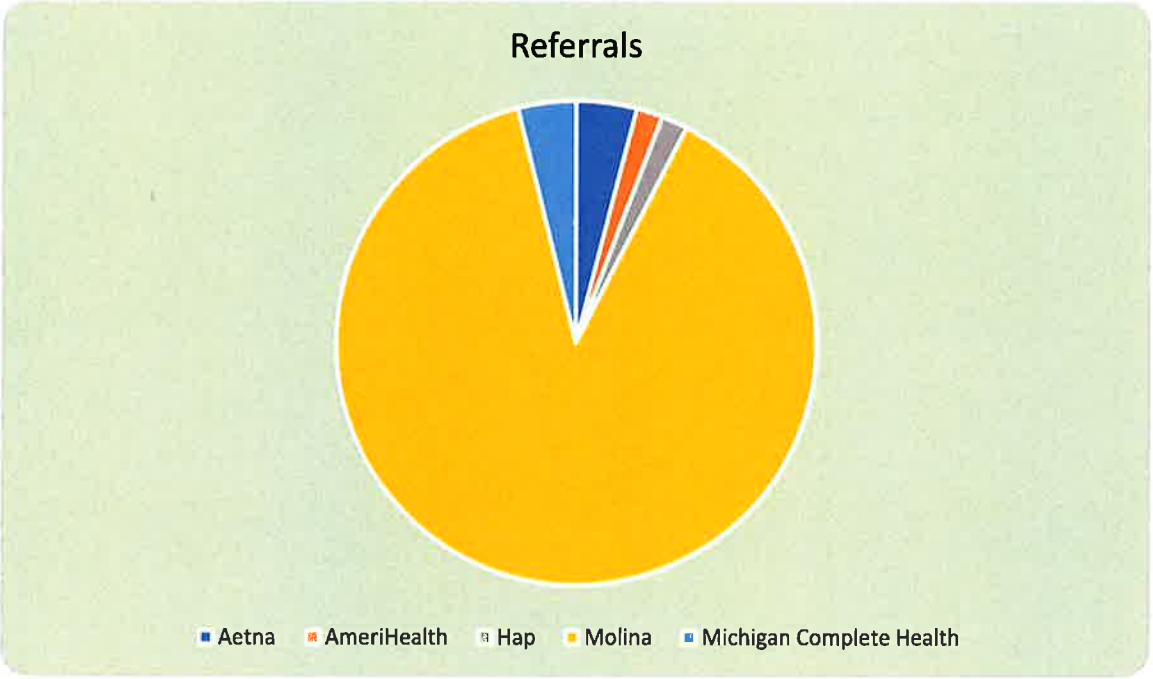
Conclusion

A Comparison of FY 2019 and FY 2020 surveys, surveys indicate that provider participation increased overall by 25%; 50% for provider organizations and 21% for individual practitioners. In addition, MCO will continue to put initiatives in place aimed at reaching the DWIHN's targeted response rate of 50%-60%. Secondly, the Provider Survey Ad-Hoc Task Force will utilize the findings from the FY 2019 and FY 2020 surveys, note and confirm the opportunities for improvement and develop Corrective Action Plan for implementation.

Summary of MI Health Link Referrals

FY 2020

The Detroit Wayne Integrated Health Network (DWIHN) received 5,137 MI Health Link referrals from the five Integrated Care Organizations (ICO) during FY20. 210 (4%) of the referrals were received from ICO Aetna, 91 (2%) were received from ICO AmeriHealth, 91 (2%) were received from ICO Hap, 204 (4%) were from Michigan Complete Health, and 4560 (88%) were from ICO Molina.



Each of the ICO's, other than Michigan Complete Health, submit Mi Health Link referrals to DWIHN electronically. Michigan Complete Health restructured internally and submitted referrals via secure fax during FY20. Out of the 4,933 referrals received electronically, 780 individuals were enrolled with DWIHN at the time that the referral was received. 4,153 individuals referred to DWIHN were not enrolled with DWIHN at the time of the referral. 247 of the referred members had a disability designation of Intellectual/Developmental Disability (I/DD), 173 had a disability designation of Mild to Moderate Mental Illness, 10 had a disability designation of Substance Use Disorder, 1800 had a disability designation of Serious Mental Illness, and 2703 individuals did not have a disability designation. Individuals would not have a disability designation assigned if they were unable to be reached or if they refused to participate in the screening.

1,164 of the referrals had a level of care assessment completed and submitted to the ICO. The LOCUS is the level of care assessment for persons with mental illness, the SIS is the level of care assessment for persons with I/DD and the ASAM is the level of care assessment for persons with SUD disability designations. Of the LOCUS assessments that were completed, 97 were completed by IHC staff. The remaining LOCUS assessments were completed by either WellPlace staff or network provider staff.

3,769 of the referrals were voided due to the member declining to receive behavioral health services or inability to reach the member after five attempts.

PROGRAM COMPLIANCE COMMITTEE

MINUTES **NOVEMBER 12, 2020** **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:** Chief William Riley, III; Kenya Ruth; Dr. Cynthia Taueg and Dr. Iris Taylor **Committee Member(s) Excused:** Dr. Lynne Carter **Board Member(s) Present:** Dorothy Burrell **Staff:** Brooke Blackwell; Willie Brooks; Jacquelyn Davis; Eric Doeh; Kimberly Flowers; Tina Forman; Shirley Hirsch; Bernard Hooper; Melissa Moody; Darlene Owens; Crystal Palmer; Ebony Reynolds; April Siebert; Michele Vasconcellos; and June White

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. Staff requested that the agenda be amended to add BA #20-54 (Revised) - NCQA Professional Consultant Services – Joseph J. Barr to the agenda for review and approval for the purpose of NCQA compliance. The Chair called for approval of the agenda as amended. **Motion:** It

	was moved by Chief Riley and supported by Mrs. Ruth to approve the agenda as amended. **Motion carried.**

V. Follow-Up Items from Previous Meetings

DISCUSSION/ CONCLUSIONS	A. **BA #21-13** – Wayne county CFS; Jails and Third Circuit Court – Provide information on the Clinic for Child Study Program and why it is important – ***Request from Full Board Meeting on October 12, 2020*** – Crystal Palmer, Director of Children's Initiatives submitted and gave a report on the history of the Clinic for Child Study program and why it is important. The committee requested that the board liaison send a copy of this report to the Finance Chair, Commissioner Killeen. **(Action)**

VI. Approval of Meeting Minutes

DISCUSSION/ CONCLUSIONS	The Chair called for approval of the October 14, 2020 meeting minutes. **Motion:** It was moved by Mrs. Ruth and supported by Dr. Taueg to approve the October 14, 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.**

VII. Reports

DISCUSSION/ CONCLUSIONS	A. **Corporate Compliance Report** - Bernard Hooper, Director of Corporate Compliance submitted and gave an update on the Corporate Compliance report: 1. **Health Services Advisory Group/Performance Measure Validation (HSAG PMV)** – The PMV review was conducted on July 9, 2020 and a draft report was received on August 25, 2020 with feedback based on the findings from the review due to HSAG by September 1, 2020. DWIHN met all required reportable areas with the exception of BH-TEDS Data Elements. PCE Vendor corrected the software issue including correction to historical data. HSAG submitted DWIHN's final report on September 25, 2020 with no plan of correction required. 2. **Performance Improvement Project (PIP) – Improving Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are using an Antipsychotic Medication** – The report was submitted to HSAG on June 30, 2020 and HSAG submitted to DWIHN a draft Preliminary Report on July 20, 2020 with the opportunity to address any Partially Met and/or Not Met due to HSAG by Friday, August 14, 2020. DWIHN's final report was submitted from HSAG on October 27, 2020. No Plan of Correction required. 3. **Compliance Review** – DWIHN received the final Compliance Report from HSAG on March 10, 2020 which required a Plan of Correction (POC). All required documentation has been submitted to HSAG as required with progress for the identified areas. DWIHN is currently waiting on feedback and acceptance of the implementation of the POC. B. **Children's Redesign Update** – Eric Doeh, Deputy CEO and COO submitted and gave an update on the Children's Redesign. Mr. Doeh reported that staff continues to partner with the Children's Community Mental Health agencies within Wayne County to complete Phase 1 (Increasing Accessibility-Prevention Services). Staff and the CMH's clinical team are developing and finalizing the

	four mental health prevention training modules to address the four identifiable risks: suicide; anxiety/depression; dating violence; and bullying. DWIHN would like to purchase the curriculum for the 11 CMH agencies to ensure the Michigan Model is reflective in the curriculum created. This model targets Pre-K through 12th grade students utilizing a skills-based approach. It may be necessary to have three versions of the identifiable risks to accommodate the developmental needs of the elementary, middle school and high school populations. There has been communication between Children's Initiatives and the Mayor's Office regarding collaboration to create access to services. Staff have also begun to focus on Phase II (Identifying Deliverables and Measurables). They are collecting data regarding CMH agency involvement in Wayne County schools in order to create the best plan to implement the rollout of the curriculum and how this data will be captured. This phase will also include collaboration between DWIHN and hospitals/clinics. Staff will a have a tentative design to present to the committee in January 2021. (Action) Discussion ensued. Dr. Taylor opened the floor for further discussion. There was no further discussion. The Chair bundled the Compliance Report and Children's Redesign Update. **Motion:** It was moved by Dr. Taueg and supported by Mrs. Ruth to accept the Corporate Compliance report and Children's Redesign update. **Motion carried.**

VIII. Year-End Reports

DISCUSSION/ CONCLUSIONS	A. **Children's Initiatives** – Crystal Palmer, Director of Children's Initiatives submitted and gave a year-end update. Discussion ensued. B. **Access and Crisis Services** – Jacquelyn Davis, Director of Access and Crisis Services submitted and gave a year-end update. Discussion ensued. C. **Clinical Practice Improvement** – Ebony Reynolds, Clinical Officer of Clinical Practice Improvement submitted and gave a year-end update. Discussion ensued. D. **Customer Services** – Michele Vasconcellos, Director of Customer Service submitted and gave a year-end update. The committee requested a summary of the surveys administered to the providers and practitioners. **(Action)** E. **Integrated Health Care** – Tina Forman, Director of Integrated Health Care submitted and gave a year-end update. The committee requested a breakdown of the MI Health Link referrals for services by ICOs. **(Action)** F. **Managed Care Operations** – June White, Director of Managed Care Operations submitted and gave a year-end update. No discussion ensued. G. **Residential Services** – Shirley Hirsch, Director of Residential Services submitted and gave a year-end update. Discussion ensued. H. **Substance Use Disorder** - Darlene Owens, Director of Substance Use Disorder Initiatives submitted and gave a year-end update. Discussion ensued. The committee requested that Ms. Owens' full report and the specifics of the 12-provider staff that passed away from COVID-19 be sent to the committee. **(Action)** The Chair bundled all year-end reports and called for a motion to accept the Children's Initiatives, Access and Crisis Services, Clinical Practice Improvement, Customer Service, Integrated Health Care, Managed Care Operations, Residential Services, and Substance Use Disorder Initiatives' year-end reports. **Motion:** It was moved by Dr. Taueg and supported by Mrs. Ruth to accept the Children's Initiatives, Access and Crisis Services, Clinical Practice Improvement, Customer Service, Integrated Health Care, Managed Care Operations, Residential Services, and Substance Use Disorder Initiatives' year-end reports. **Motion carried.**

IX. Strategic Plan – Access Pillar

DISCUSSION/ CONCLUSIONS	Jacquelyn Davis, Director of Access and Crisis Services submitted and gave her report on the Strategic Plan – Access Pillar. Ms. Davis reported that there are four (4) high-level goals under the Access Pillar and they range from 31%-82% completion: 1. Create infrastructure to support a holistic care delivery system (full array) by December 31, 2021 – 31% Completion; 2. Create Integrated Continuum of Care for Youth by September 30, 2020 – 82% Completion; 3. Establish an effective crisis response system by December 21, 2021 – 65% Completion; and 4. Implement Justice Involved Continuum of Care by September 30, 2020 – 67% Completion. The overall completion of this pillar is 61%. Dr. Taylor opened the floor for discussion. There was no discussion. The Chair called for a motion to accept the Strategic Plan – Access Pillar report. **Motion:** It was moved by Dr. Taueg and supported by Mrs. Ruth to accept the Strategic Plan – Access Pillar report. There was no discussion. **Motion carried.**

X. Quality Review(s)

DISCUSSION/ CONCLUSIONS	**A. QAPIP Work Plan** – April Siebert, Director of Quality Improvement submitted and gave highlights on the QAPIP Work Plan Report. Ms. Siebert reported that her report summarizes DWIHN's results from the third quarter of FY 2020 as well as comparison data of Q1, Q2, Q3 and Q4 (preliminary) and noted improvements with Indicator 10 (Recidivism). 1. **Michigan Mission Based Performance Indicators (MMBPI)** – The 3rd Quarter Performance Indicator data reporting (July 1-September 30, 2019) has been submitted to the MDHHS on September 30, 2020. Quarter 4 data is due to MDHHS on December 30, 2020. 2. **Results and Analysis** – Indicators 1, 4 and 4b continue to meet and exceed the 95% standard. The reporting criteria data for Indicator 2a, 2b and 3 has been updated/revised effective April 16, 2020 for Quarter 3. 3. **Q4 Indicator 10 (Recidivism) Noted Improvements** – Preliminary data has demonstrated an overall decrease in adult readmissions (16.50%) which is an average of 4.6% less than the prior three quarters. This decrease is noted to ongoing efforts which include review of members that recidivist. The Vice-Chair called for a motion to accept the QAPIP Work Plan report. **Motion:** It was moved by Chief Riley and supported by Mrs. Ruth to accept the QAPIP Work Plan report. Dr. Taueg opened the floor for discussion. There was no discussion. **Motion carried.**

XI. 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: 4. **COVID-19 and Inpatient Psychiatric Hospitalization** – Hospitalization data shows a slight decrease in admissions for the month of October by approximately 2%. There were three (3) reported cases of COVID-19 inpatient – 635 served for the month of October. 5. **COVID-19 Intensive Crisis Stabilization Services** – COPE had a 2.5% decrease for the month of October – 210 served; and Team Wellness had a 42% increase for the month of October – 60 served. 6. **COVID-19 Pre-Placement Housing** – There were no admissions for Forever Care Home and Detroit Family Homes for the month of October. 7. **Residential Department Report of COVID-19 Impact** – From 3/30/20 to 10/31/20, 169 positive cases were reported and 34 reported deaths. There were no new cases or deaths associated with COVID-19 reported in Residential Placement since the last report. 8. **COVID-19 Recovery Housing/Recovery Support Services** – There were seven (7) clients served for Quality Behavioral Health and two (2) served for the Detroit Rescue Mission Ministries (DRMM) for the month of October. 9. **COVID-19 Urgent Behavioral Health Urgent Care Sites** – There were seven (7) adults served for Community Care Services; 18 adults served for Northeast Integrated Health; and 15 youths served for The Children's Center for the month of October. 10. **COVID-19 Testing, Tracing and Reporting** – MDHHS sent out a notification stating that all licensed AFC and Home for the Aged facilities that have more than 13 beds within the facility need to follow a new COVID-19 testing and reporting guidelines starting October 28, 2020. DWIHN has provided this information to both our Clinically Responsible Service Providers and Residential Providers. Total number of confirmed COVID-19 cases in Michigan is 192,096 with 7,419 deaths. Wayne County is reported to have 24,157 confirmed cases and 1,347 deaths and Detroit is listed with 15,956 confirmed cases with 1,552 deaths reported. **(Source:www.michigan.gov/Coronavirus)** Discussion ensued. The Vice-Chair called for a motion to accept the Chief Clinical Officer's report. **Motion:** It was moved by Chief Riley and supported by Mrs. Ruth to accept the Chief Clinical Officer's Report. Dr. Taueg opened the floor for further discussion. Discussion ensued. **Motion carried.**

XII. Unfinished Business

DISCUSSION/ CONCLUSIONS	A. **BA# 18-34 (Revised)** – Medversant Contract Extension – ***Deferred to Executive Committee for Exigent Approval*** B. **BA #20-54 (Revised)** – NCQA Professional Consultant Services – Joseph J. Barr – The Chair called for a motion on BA #20-54 (Revised). **Motion:** It was moved by Chief Riley and supported by Mrs. Ruth to move BA #20-54 (Revised) to Full Board for approval. Staff requesting a one-year extension of contractual services for the period of 1/1/21 – 6/6/21 at the amount of $41,470.00 for the purpose of NCQA compliance. Dr. Taylor opened the floor for discussion. There was no discussion. **Motion carried.**

	C. **BA# 21-32 (Revised)** – Addendum to include PA2 Recovery Support Services missed on SUD Treatment allocation grant FY '21 – DWIHN Provider Network List included with board action – The Chair called for a motion on BA #21-32 (Revised). **Motion:** Chief Riley abstained from voting on Growth Work and Hegira Programs. It was moved by Mrs. Ruth and supported by Chief Riley to move BA #21-32 (Revised) to Full Board for approval. This revised board action is a request to increase the amount by $295,000.00 from the initial amount of $4,148,575.00 to $4.443.575.00. Dr. Taylor opened the floor for discussion. There was no discussion. **Motion carried.** D. **BA #21-33 (Revised)** – Allocation of PA2 dollars for Substance Use Disorder (SUD) Contractor for additional services in Southwest Detroit – DWIHN Provider Network List included with board action – The Chair called for a motion on BA #21-33 (Revised). **Motion:** Chief Riley abstained from voting on National Council for Alcohol and Drug Dependence (NCADD). It was moved by Mrs. Ruth and supported by Chief Riley to move BA #21-33 (Revised) to Full Board for approval. Staff requesting board approval to amend the FY '21 SUD Prevention Services program. The revised amount of the FY '21 SUD Prevention Services program is $4,925,054.00 and was increased by $133,000.00 from the initial amount of $4,792.054.00. **Motion carried.** Dr. Taylor, Chair excused herself from the meeting at 3:04 p.m. and Dr. Taueg, Vice Chair of the Program Compliance Committee assumed the role of Chair for the remainder of the meeting. E. **BA #21-38 (Revised)** – Self-Determination Services – Community Living Services – The Chair called for a motion on BA #20-38 (Revised). **Motion:** It was moved by Chief Riley and supported by Mrs. Ruth to move BA #20-38 (Revised) to Full Board for approval. Staff recommends this board action be revised to increase the annual funding by $8.1 million dollars. The service provider has increased the number of consumers who are receiving Habilitation Support Waiver (HSW) Services under this contract. Dr. Taueg opened the floor for discussion. There was no discussion. **Motion carried.**

XIII. New Business: Staff Recommendation(s) -

DISCUSSION/ CONCLUSIONS	A. **BA# 21-44** – MI-Health Link Demonstration Project – All Well-Being Services – The Chair called for a motion on BA #21-44. **Motion:** Chief Riley abstained from voting on Hegira Programs. It was moved by Mrs. Ruth and supported by Chief Riley to move BA #21-44 to Full Board for approval. Staff requesting board approval for a one-year continuation contract with the five (5) Integrated Care Organizations (ICO) to receive and disburse Medicare dollars to reimburse the Affiliated Providers for FY 2021. Dr. Taueg opened the floor for discussion. There was no discussion. **Motion carried.** B. **BA# 21-45** – Michigan Child Collaborative Care Program (MC3) – Starfish Family Services - The Chair called for a motion on BA #21-45. **Motion:** It was moved by Chief Riley and supported by Mrs. Ruth to move BA #21-45 to Full

	Board for approval. The MC3 Program and Behavioral Health Consultant Project provides behavioral health consultation for local primary care providers with MC3 child, adolescent and prenatal psychiatrists. Dr. Taueg opened the floor for discussion. There was no discussion. **Motion carried.** C. **BA# 21-48** – Community Foundation for Southeast Michigan's Philanthropic Grant for Opioid Use Disorders in Wayne County Jails – DWIHN Providers' Network List included in board action - The Chair called for a motion on BA #21-48. **Motion:** It was moved by Chief Riley and supported by Mrs. Ruth to move BA #21-48 to Full Board for approval. Staff requesting board approval for a one-year contract for an amount not to exceed $151,984.00 with Wayne State University ($28,000.00); Quality Behavioral Health ($43,000.00); Wayne County Health Communities ($30,000.00); and Abundant Recovery Services ($43,000.00). Dr. Taueg opened the floor for discussion. There was no discussion. **Motion carried.**

XIV. Good and Welfare/Public Comment

DISCUSSION/ CONCLUSIONS	The Chair asked if there were any Good and Welfare/Public Comment. a. Ms. C. White - (0806) addressed the committee regarding concerns with a family member receiving SUD services.

ACTION ITEMS	Responsible Person	Due Date
1. Send a copy of the Clinic for Child Study report to the Finance Committee Chair, Commissioner Killeen	Lillian Blackshire	**COMPLETED**
2. Year-End Report: **A. Customer Service** – Provide a summary of the surveys that were administered to the providers and practitioners	Michele Vasconcellos	**January 13, 2021**
B. Integrated Health Care – Provide a breakdown of the MI Health Link referrals for services by ICOs	Tina Forman	
C. Substance Use Disorder – Provide SUD full report and the specifics of the 12-provider staff that passed away from COVID-19 to the committee.	Darlene Owens	**COMPLETED**

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

ADJOURNED: 3:20 p.m.
NEXT MEETING: Wednesday, January 13, 2021 at 1:00 p.m. ***(Virtual Meeting)***

CORPORATE COMPLIANCE MEMORANDUM

TO: Dr. Iris Taylor, Chairperson
Program Compliance Committee

FROM: Bernard K. Hooper
Corporate Compliance Officer

DATE: January 13, 2021

RE: **REPORT TO PROGRAM COMPLIANCE COMMITTEE**

1. HAP ICO Plan of Correction – Compliance and Quality Improvement are providing final documents to HAP involving the POC associated with the 2020 Annual Compliance Review. These documents include that Compliance Audit Plan for FY 20-21. The Compliance Audit Plan will be completed on or before January 15, 2021.

2. DWIHN Compliance Committee – On December 21, 2020, the Corporate Compliance Officer convened a meeting of the Compliance Committee. The Corporate Compliance Officer presented the FY20-21 Annual Risk Assessment. The Annual Risk Assessment comprises primarily risks identified as a result of the HSAG and ICO audits as well as in preparation for the pending NCQA review. Prioritization of these matters was strongly influenced by the occurrence of repeat citations from previous audit periods and 'must-pass' NCQA standards. The Annual Risk Assessment is the basis for the development of the Compliance Audit Plan.

3. Attorney General Consultation regarding DWIHN's investigations of Harbor Oaks Hospital – On December 22, 2020, the Corporate Compliance Officer consulted with Agent Jason Evans of the State of Michigan's Attorney General's Office regarding the several audits and monitoring actions conducted by DWIHN regarding the operations of Harbor Oaks Hospital. The discussion derived from a larger matter involving facilities owned and operated in other states by the parent entity of Harbor Oaks. The discussion covered events and complaints arising in recent fiscal years although the scope of the action involving the parent entity includes several previous fiscal years. The initial conversation between Agent Evans and the Corporate Compliance Officer was comprehensive and Agent Evans has indicated that no further action is required by DWIHN regarding this matter.

DWIHN UTILIZATION MANAGEMENT QUARTER 1 REPORT

I. Executive Summary

- **Habilitation Supports Waiver:** There are 1,084 slots assigned to the DWMHA. As of the end December, 1058 slots (97.6%) are filled.

- **Autism:** There were 1422 authorization requests approved during the 1st Quarter. There are 1768 cases currently open in the benefit.

- **Evidence Based Supported Employment:** Quarterly Authorization Approvals; Q1 = 226 for Supportive Employment.

- **General Fund:** There were 1071 for Q1 (NOTE: Q4 =1152) General Fund Authorizations.

- **Provider Network Hospital admissions**: The UM Team managed the following Inpatient Admissions for Q1 = 2035. (NOTE: Q4 = 2113, Q3 = 2129 and Q2 = 2743 admissions,). That is an 4.79% decrease from Q4. Please note DEC-20 are preliminary.

- **MI Health Link**: For Quarter 1 of the new FY, there were a total of 190 admissions across all ICOs. There was a 33% decrease in admission since the beginning of the fiscal year. From November to December 2020, admissions decreased by 15.8% across all ICOs. Aetna's average length of stay decreased by 39%. MI-Complete had the highest average length of stay for the quarter in November at 22.6 days.

- **State Facilities:** Q1 = 10 admissions and 8 discharges. Q4 = 6 admissions and 15 discharges. 69 NGRI consumers are currently managed in the community.

- **SUD:** For the first quarter of FY 21, there were 3728 authorizations approved by UM reviewers. Of these, 3628 or 97% were approved in a timely fashion. One thousand eighty-seven (1087) were urgent and 1045 or 96% were approved in a timely fashion. Those considered nonurgent were 3728, where 3628 or 97% were authorized within 14-day period. The 90% benchmark was reached in all categories. There was an overall 3% increase from total authorizations from 3621 in 4th quarter FY 20, to 3728 this quarter.

- **MCG:** The Milliman Care Guidelines (MCG) are evidence-based care guidelines that were integrated within our MH-WIN system effective January 13, 2020. The majority of the PIHPs have adopted use of the MCG Behavioral Health guidelines to ensure parity across the state. DWIHN and other PIHPs are currently using the MCG BH Guidelines to screen for inpatient hospitalization, crisis residential and partial hospitalization. COPE, the Children's screening entities, and ACT teams during the 1st quarter of FY 21, screened a total of 3,118 cases. DWIHN UM staff continue reviewing patient's stay utilizing the guidelines for continued stay.

- New hire Interrater Reliability (IRR) continues to occur. For our Annual Interrater Reliability for FY 20, 152 users successfully completed the assigned IRR case studies. MCG updates their guidelines annually and a new release is expected the end of February, or March to the 25th edition of the Guidelines.

- **Timeliness:** Timeliness: The timeliness report calculates rates of adherence to time frames for each category of request (urgent concurrent, urgent preservice, nonurgent preservice and post-service) for each factor. The numerator represents the number of cases meeting the decision time frame. The denominator represents the total number of requests.

- **Denials and Appeals:** There were a total (22) medical necessity Denials and (8) Appeals for the 1st Quarter. All denials did not meet MCG medical necessity criteria for continued inpatient hospitalization and ABA services.

Utilization Management FY20-21 Quarter 1 Report

Utilization Management Report By Area

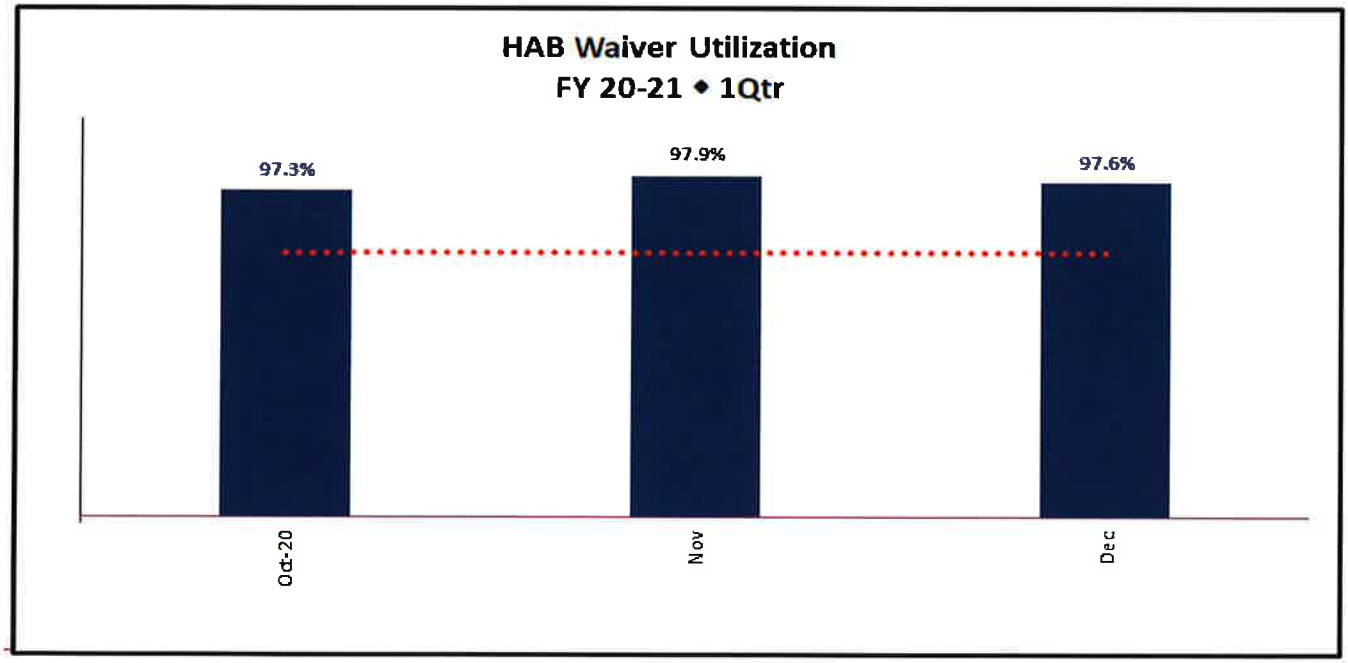
Habilitation/Supports Waiver (HSW):

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

Habilitation/Supports Waiver (HSW):

Current HSW utilization is summarized below:



	Oct	Nov	Dec
Allocated	1,084	1084	1084
Used	1,055	1,061	1,058
Available	29	23	26
% Used	97.3%	97.9%	97.6%
Required Minimum	95%	95%	95%

As of July 1, 2020, DWIHN instituted a onetime payment of $1,000.00 to provider agencies for each new HSW certification. The number of onetime incentive payments made to CRSPs thus far is summarized below:

Month	#
July	15
August	26
September	24
October	19
November	8
December*	6
*TENTATIVE	

Outcome Measurement	Oct	Nov	Dec
# of applications received	16	2	7
# of applications reviewed	16	2	7
# of app. Pended PIHP level for more information	9	1	0
#of pended app. resubmitted	9	1	0
# of app. withdrawn	0	0	0
Total of application sent to MDHHS.	16	2	7
Technical Assistants contacts	5	8	5
# of deaths/disenrollments (recertification forms reviewed & signed)	1 death	4 all deaths	4 deaths 1 moved out of state
# of recertification forms reviewed and signed	91	77	121
# of recertification forms pended	16	16	23
# of dis-enrollments (not meeting HSW criteria)	0	0	0

As indicated, DWIHN's HSW utilization leveled somewhat following rapid growth during the preceding quarter. Submissions of new certifications continue, although at a slower pace, to be received and are under review. Outreach and the provision of technical assistance to our provider network continues.

Serious Emotional Disturbance Waiver (SEDW)

MONTH	JULY	AUGUST	SEPTEMBER
# of youth expected to serve in the SEDW for FY 20	65	65	65

# of active youth served in the SEDW, thus far for FY 19-20	77	81	81
# of youth currently active in the SEDW for the month of September	52	53	47
# of referrals received in September	12	7	8
# of youth approved/renewed for the SEDW in September	3	4	3
# of referrals currently awaiting approval at MDHHS	1	0	2
# of referrals currently at SEDW Contract Provider	10	10	11
# of youth terminated from SEDW in September	2	3	1
# of youth transferred to another County, pursuing the SEDW	3	1	3
# of youth coming from another county, receiving the SEDW	1	0	1
# of youth moving from one SEDW provider in Wayne County to another SEDW provider in Wayne County	0	0	0

Autism Spectrum Disorder (ASD) Benefit: Quarter 1

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 wishing to have their child screened for the benefit call Wellplace who completes a preliminary screening and then schedules the consumer for an in-depth evaluation with an Applied Behavior Analysis (ABA) provider who determines if the consumer is eligible for the benefit.

The auto approval system, which began rollout in June 2020, continues to be successful. The system is designed for authorization requests to be processed through the service utilization guidelines and a number of key dates identified by MDHHS. If the request falls within the perimeters set, then the request is automatically approved the moment it is submitted. DWIHN UM staff then receives a daily report listing the approved authorizations so that they can be checked for accuracy and then entered in to MDHH'S Waiver Supports Application. Many requests have still been referred for manual review, as the auto approval system was developed pre COVID-19 and some perimeters from MDHHS have since changed since the system was developed. DWIHN has not updated the perimeters in the system at this time, as it is

expected that MDHHS will revert back to the original conditions as the pandemic is resolved. DWIHN UM Department will continue to evaluate the need to make changes to the auto approval system.

Previously, the ASD providers were notifying consumers when they did not meet criteria for medical necessity for the ASD Benefit. In Quarter 1, DWIHN resumed responsibility for medical necessity denials. This was able in part due to the auto approval system, which includes electronic reporting of eligibility evaluations and recommendations provided by the ASD providers.

ASD Referrals by Month 1st Quarter	Number
October	107
November	60
December	Pending Data update in the WSA

	Number of Authorizations Approved Per Month (Manual + auto approved = total) *	Number of Open Cases Per Month
October	473+135=608	1718
November	269+157=426	1747
December	235+153=388	1753

Evidence Based Supportive Employment (EBSE) Benefit: FY 2020-2021

Evidenced Based Supportive Employment offers support for consumers with a severe and persistent mental illness who need employment assistance. Case managers assist consumers in developing job skills such as resume writing, interview preparation, job seeking, and ongoing support in managing mental illness while working.

During this quarter, DWIHN approved 236 authorizations for Evidenced Based Supportive Employment.

Month	Number
October	82
November	71
December	73
Total Quarter 1	**236**

Note: The UM Department continues to partner with the Clinical Practice Improvement Team who provides oversight for EBSE Providers.

County of Financial Responsibility (COFR)

The COFR Committee meets weekly for one (1) hour to determine DWIHN's responsibility for behavioral health services. During the 1st Quarter, the COFR committee had 4 Adult COFR requests, zero children's cases and 11 cases resolved. There are currently 125 pending cases.

	Adult COFR Case Reviews Requests	Children COFR Case Reviews Requests	Resolved	Pending*
October	0	0	2	131
November	1	0	6	129
December	3	0	3	125

*This is a running total.

*Note: Not all new cases referred are reviewed within the month they are received. All new cases are added to COFR Master List with date referral is received. Cases are reviewed by priority of the committee.

General Fund Exceptions

UM continues to receive General Fund Exceptions requests for individuals currently living in the community and receiving multiple services. UM continues to address needs for Supports Coordination or Targeted Case Management staff to verify insurance/waiver coverage and on-going eligibility. The below reflects the number of General Fund Approvals for each quarter.

Number of General Fund Approvals FY 2020-2021 1st QTR	
October 20	425
November 20	252
December 20	394
Total Quarter 1	**1071**

Number of General Fund Approvals FY 2019 – 2020 4TH QTR	
JULY - 20	435
AUG - 20	394
SEPT – 20	431
Total Quarter 4	**1260**

A historical perspective

Number of General Fund Approvals FY 2019 – 2020 2nd 3rd QTR's	
Jan - 20	330
Feb - 20	292
Mar - 20	394
Total Quarter 2	**1016**
Apr - 20	457
May - 20	318
Jun - 20	286
Total Quarter 3	**1061**

General Fund Authorization Requests as a result of the impact of MDHHS COVID - 19 related limited services to the public, including the processing of Medicaid new and renewal applications.

Provider Network Hospital admissions: The UM Team managed the following Inpatient Admissions for Q1 = 2035. (NOTE: Q4 = 2113, Q3 = 2129 and Q2 = 2743 admissions,). That is an 4.79% decrease from Q4. Please note DEC-20 are preliminary.

Provider Network - Hospital Utilization Reports

Inpatient	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	July-20	Aug-20	Sept-20	Oct-20	Nov-20	Dec-20
Admissions/month	991	926	834	642	816	671	731	681	701	712	710	613*
Bed Days/month	9716	9360	9055	7529	8744	5005	8344	8291	8517	8489	8486	6019*
ALOS	11	10	11	11	12	12	10	10	11	12	11	13*

*NOTE: DEC-20 are preliminary

Month	JULY-20	AUG-20	SEP-20	OCT-20	NOV-20	DEC-20
Partial Hosp Admission/month	89	81	109	150	96	80
Crisis Residential Admission/month	42	42	62	48	44	35

In an effort to decrease length of stay and hospital admission, the Utilization Management department continues to have Bi-weekly meetings with the physician consultant to review cases with length of stay greater than 14 days. Additionally, there is a Residential/UM work group to identify cases with ability to transition from inpatient to CRU or from CRU to AFC.

Please note that the COVID concerns continue with hospital admissions and at times decreases their capacity to allow for single rooms and social distancing. Units are available for individuals who tested positive or asymptomatic. Additionally, staff were tested to ensure the health and safety of the consumers. The Crisis Residential Unit remains at 50% due to COVID restrictions.

- Safehaus – Please note at the end of the 1st Quarter (i.e., December, 2020), there were 10 consumers (i.e., 1 male and 9 females). Additionally, all of these consumers were at Warren location. Grand Rapids and Rose City location have been permanently closed.
- At the end of the 1st Quarter (December) the following positive COVID-19 cases were identified:
  PHP = 2 cases
  Stonecrest = 4 cases

Prior positive cases:

NOV-20

PHP = 2

Stonecrest = 1

Samaritan = 5

OCT-20

St. Mary's = 1

Pontiac Gen = 1

Havenwyck = 1

Kingswood = 1

MI Health Link

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.

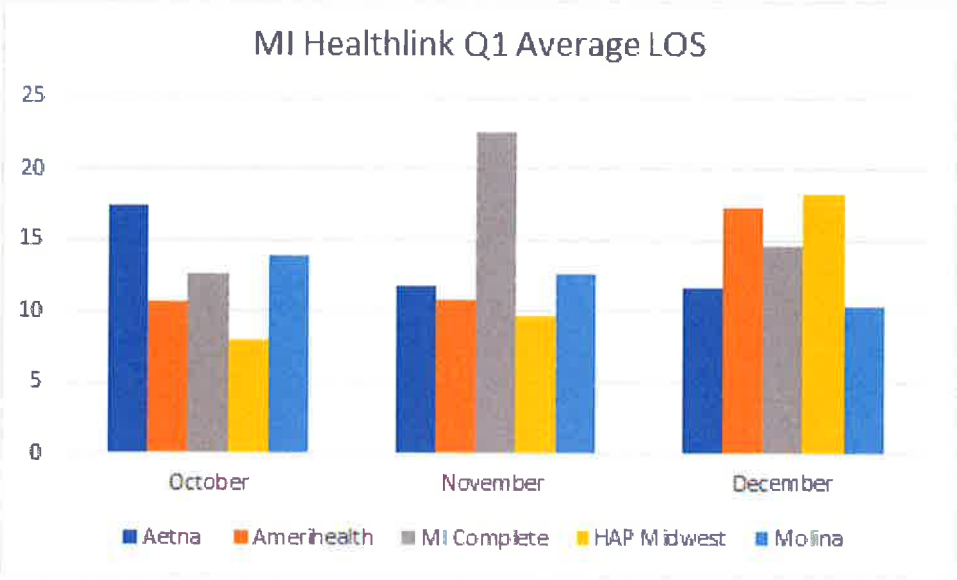
For MI Health Link enrollees, all behavioral health services covered by Medicare and Medicaid will be managed by Michigan Pre-paid Inpatient Health Plans (PIHPs), organizations that the Department of Community Health contracts with to administer the Medicaid covered community mental health benefit. Behavioral health services are delivered through the local Community Mental Health Services Provider (CMHSP). Below is a breakdown of acute inpatient hospitalizations by ICO for Q1 of FY 21.

For Quarter 1 of the new FY, there were a total of 190 admissions across all ICOs. There was a 33% decrease in admission since the beginning of the fiscal year. From November to December 2020, admissions decreased by 15.8% across all ICOs. Aetna's average length of stay decreased by 39%. MI-Complete had the highest average length of stay for the quarter in November at 22.6 days.

Oct-20	Admissions	Discharges	Discharge days	Average Length of Stay	# Recidivistic Consumers
Aetna	13	11	192	17.4	1
AmeriHealth	4	3	40	10.6	0
Fidelis	14	11	139	12.6	2
HAP Midwest	7	2	24	8	0
Molina	36	23	320	13.9	4

Nov-20	Admissions	Discharges	Discharge days	Average Length of Stay	# Recidivistic Consumers
Aetna	9	9	107	11.8	3
AmeriHealth	5	4	54	10.8	0
Fidelis	5	5	113	22.6	1
HAP Midwest	10	7	97	9.7	4
Molina	34	26	330	12.7	3

Dec-20	Admissions	Discharges	Discharge days	Average Length of Stay	# Recidivistic Consumers
Aetna	10	10	117	11.7	1
AmeriHealth	3	5	52	17.3	1
Fidelis	8	8	117	14.6	0
HAP Midwest	8	9	147	18.3	1
Molina	24	21	250	10.4	4



State Hospital Report

Admissions remained limited as hospitals continued to shift patients to accommodate COVID-19 protocols. Currently, all hospitals have established quarantine units and restricted outside visitors/providers to prevent COVID transmission. Additionally, liaison staff have continued to coordinate discharges remotely and via Telehealth to limit member exposure to COVID-19 and secure available community beds.

- Forensic admissions remain a priority and account for half of all current Wayne County inpatient state hospital admissions.
- Hospitals are maintaining strict guidelines to limit increasing COVID cases. Restriction of visitors, quarantined units, and daily COVID testing are all in place to prevent further transmission among patients and staff.
- MDHHS initiated a new pilot program to expedite discharges from the state hospital. Selected providers are contracted with MDHHS to provide placement for 90 days with transfer to the CMHSP. Two members have been transferred through this program.
- Liaison staff continue to manage cases referred through the Direct-to-Community Placement Program, DCPP, facilitated by MDHHS. There are currently 16 NGRI consumers in the community that have been released through this program.

The census at the end of the 1st quarter of FY 2020 – 2021 is as follows:

Hospital	Caro Center (MI)	Kalamazoo (DD)	Walter Reuther (MI)
Census	1	14	115
Wait List	0	0	15
Admissions	0	1	9
Discharges	0	3	5
ALS Status	0	1	68

Previous Quarter:

The census at the end of the 4th quarter of FY 2019 – 2020 is as follows

Hospital	Caro Center (MI	Kalamazoo (DD)	Walter Reuther (MI)
Census	1	16	109
Wait List	0	0	1
Admissions	0	1	3
Discharges	0	0	5
ALS Status	0	1	77

Milliman Care Guidelines (MCG)

The Milliman Care Guidelines (MCG) are evidence-based care guidelines that were integrated within our MH-WIN system effective January 13, 2020. The majority of the PIHPs have adopted use of the MCG Behavioral Health guidelines to ensure parity across the state. DWIHN and other PIHPs are currently using the MCG BH Guidelines to screen for inpatient hospitalization, crisis residential and partial hospitalization. COPE, the Children's screening entities, and ACT teams during the 1st quarter of FY 21, screened a total of 3,118 cases. DWIHN UM staff continue reviewing patient's stay utilizing the guidelines for continued stay.

New hire Interrater Reliability (IRR) continues to occur. For our Annual Interrater Reliability For FY 20, 152 users successfully completed the assigned IRR case studies. MCG updates their guidelines annually and a new release is expected the end of February to the 25th edition of the Guidelines.

Substance Use Disorders

For the first quarter of FY 21, there were 3728 authorizations approved by SUD UM reviewers. Of These, 3628 or 97% were approved in a timely fashion. One thousand eighty-seven (1087) were urgent and 1045 or 96% were approved in a timely fashion. Those considered nonurgent were 3728, where 3628 or 97% were authorized within 14-day period. The 90% benchmark was reached in all categories. There was an overall 3% increase from total authorizations from 3621 in 4th quarter FY 20, to 3728 this quarter.

authorization Requests 1st Quarter FY 21	#Authorizations	#Reviewed Timely	Percentage of Compliance (Benchmark 90%)
Urgent	1087	1045	96%
Non-Urgent	2641	2633	97%
Totals	3728	3628	97%

Bi-Monthly SUD Provider Meeting

At the end of FY 21, Q1 the SUD Provider meeting was held December 2nd. There are several subcontracted providers still having access issues with MH-WIN and difficulty entering authorizations. These are addressed by IT and the help desk as they occur.

Denials and Appeals

For the 1st Quarter there are 22 denials that did not meet MCG medical necessity criteria for continued inpatient hospitalization and ABA services. There are 8 appeals.

Timeframe	Denials	Appeals
Q1	22	8

DWIHN is required to monitor the turnaround time for all decisions (denials and approvals) including the decisions themselves and the notifications of the decisions. This is for initial determinations and does not include appeals. It is for both benefit and medical necessity determinations.

Below you will find the timeliness report. The timeliness report calculates rates of adherence to time frames for each category of request (urgent concurrent, urgent preservice, nonurgent preservice and post-service) for each factor. The numerator represents the number of cases meeting the decision time frame. The denominator represents the total number of requests.

All Crisis Centers are compliant with the timeliness (decision and notification) threshold of 90%. Internally, the UM Department, Autism and MI Health Link timeliness response met or exceeded the 90% threshold. Substance Use Disorder response times were out of compliance for the 2nd quarter. Corrective measures were implemented, weekend coverage, review of timeliness requirements and monitoring.

Timeliness of UM Decision Making

Note: COPE and The Guidance Center measures are not available at the time of the report.

Quarter 1 (Oct. – Dec., 2020)

Threshold is 90%

Timeliness of UM Decision Making-DWIHN-Autism Program

	Urgent Concurrent	Urgent Preservice	Non-Urgent Preservice	Post-Service
Numerator *	N/A	N/A	768	N/A
Denominator#	N/A	N/A	772	N/A
Rate	N/A	N/A	99.5%	N/A

Timeliness of UM Decision Making-DWIHN-MI Health Link Program

	Urgent Concurrent	Urgent Preservice	Non-Urgent Preservice	Post-Service
Numerator *	6	0	n/a*	0
Denominator#	6	0	n/a*	0
Rate	100%	n/a	n/a*	n/a

Please note: * these numbers appear inaccurate and we are working with IT to correct

Timeliness of UM Decision Making-DWIHN- Substance Use Disorders

	Urgent Concurrent	Urgent Preservice	Non-Urgent Preservice	Post-Service
Numerator *	1045	N/A	2633	N/A
Denominator#	1087	N/A	2641	N/A
Rate	96%	N/A	97%	N/A

Timeliness of UM Decision Making- Children's Center

	Urgent Concurrent	Urgent Preservice	Non-Urgent Preservice	Post-Service
Numerator *	N/A	33	N/A	N/A
Denominator#	N/A	33	N/A	N/A
Rate	N/A	100%	N/A	N/A

Timeliness of UM Notification- COPE (NOTE: data not available at time of report)

	Urgent Concurrent	Urgent Preservice	Non-Urgent Preservice	Post-Service
Numerator *	N/A		N/A	N/A
Denominator#	N/A		N/A	N/A
Rate	N/A	%	N/A	N/A

Timeliness of UM Decision Making- Guidance Center (NOTE: data not available at time of report)

	Urgent Concurrent	Urgent Preservice	Non-Urgent Preservice	Post Service
Numerator *	N/A		N/A	N/A
Denominator #	N/A		N/A	N/A
Rate	N/A	%	N/A	N/A

Timeliness of UM Decision Making- New Oakland

	Urgent Concurrent	Urgent Preservice	Non-Urgent Preservice	Post-Service
Numerator	N/A	137	N/A	N/A
Denominator	N/A	138	N/A	N/A
Rate	N/A	99.28%	N/A	N/A

NCQA

The UM Team continues work diligently to finalize the UM Standards. The file upload to NCQA has begun and weekly meetings to finalize the process continue. The final submission date is 2/16/2021 and the is review is scheduled 4/5/2021 - 4/6/2021.

DETROIT WAYNE INTEGRATED HEALTH NETWORK

Annual Utilization Management Program Evaluation Fiscal Year 2020

UM Department

- UM authorizes services in the following areas and Levels of Care that require prior authorization:

- Inpatient
- Partial Hospital
- Substance Use Disorder Services
- Outpatient
- Crisis Residential
- Autism Services

Current Staffing: 33 FTEs , in FY 20 new UM Director and UM Administrator hired

Utilization Management (UM) Program Evaluation FY 20

Elements:

- Evaluation of UM Program Description & Goals by Strategic Plan Pillars
- UM Department Technology Recommendations

Utilization Management (UM) Program Evaluation

- UM Program Goals were aligned with and evaluated using the Strategic Plan Pillars of Access, Finance, Quality, Customer, Workforce Development and Advocacy

- There were 8 UM Program Goals in FY 20

- The next slides highlight accomplishments, key metrics and identify opportunities for improvement, (Not all goals will be addressed)

Access Pillar -Promote participation and use of Specialty Waiver Programs

- 1,710 cases opened in the Autism Spectrum Disorder Benefit; Last year's report indicated 1,659 cases.(51 more consumers served than FY 19); Referrals reduced by 20% from last year, probably due to COVID-19. Timeliness of authorizations 98% in FY 20.

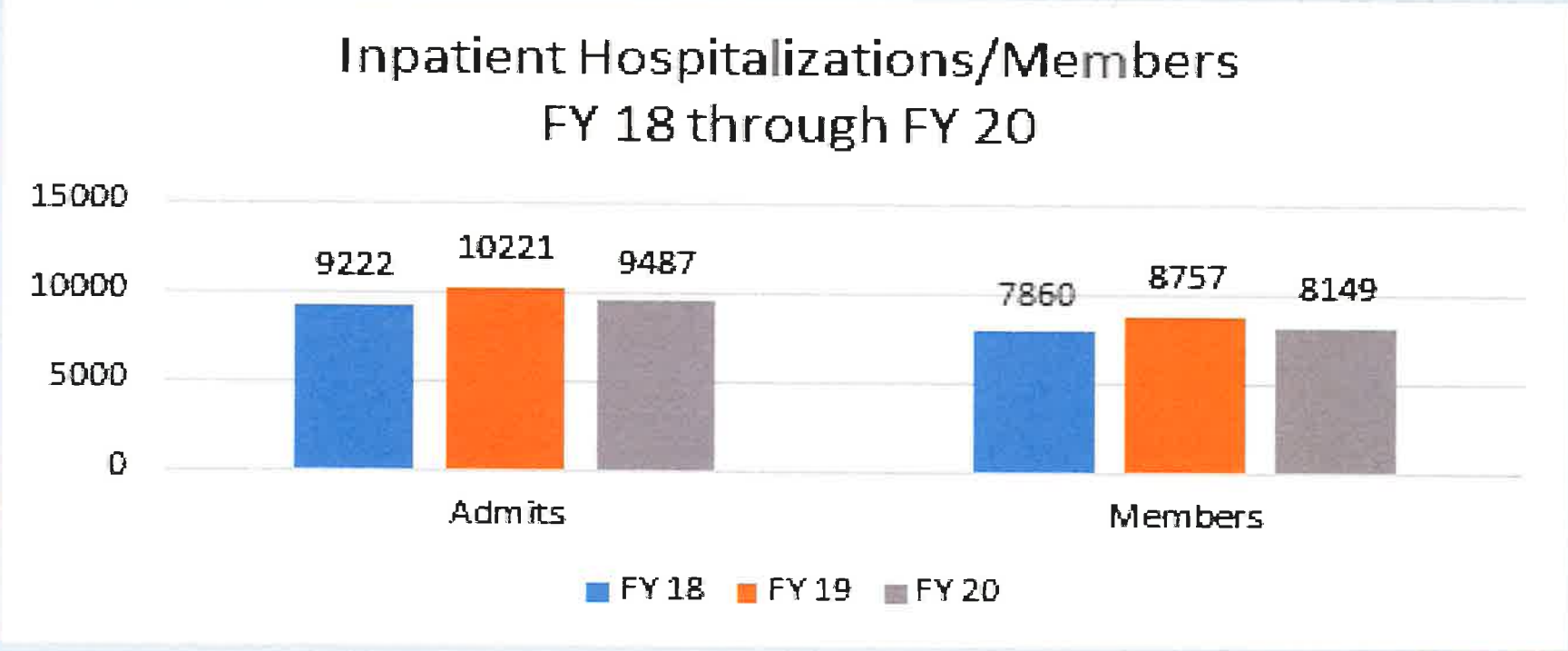
- 36 Children are enrolled in the Children's Waiver Program. MDHHS plans to expand slots statewide for 50 additional children.

- DWIHN served 81 children and youth in the Children's SED Waiver in FY 20. Last year's report indicated 84 served in FY 19.

Access Pillar- Promote participation and use of Specialty Waiver Programs

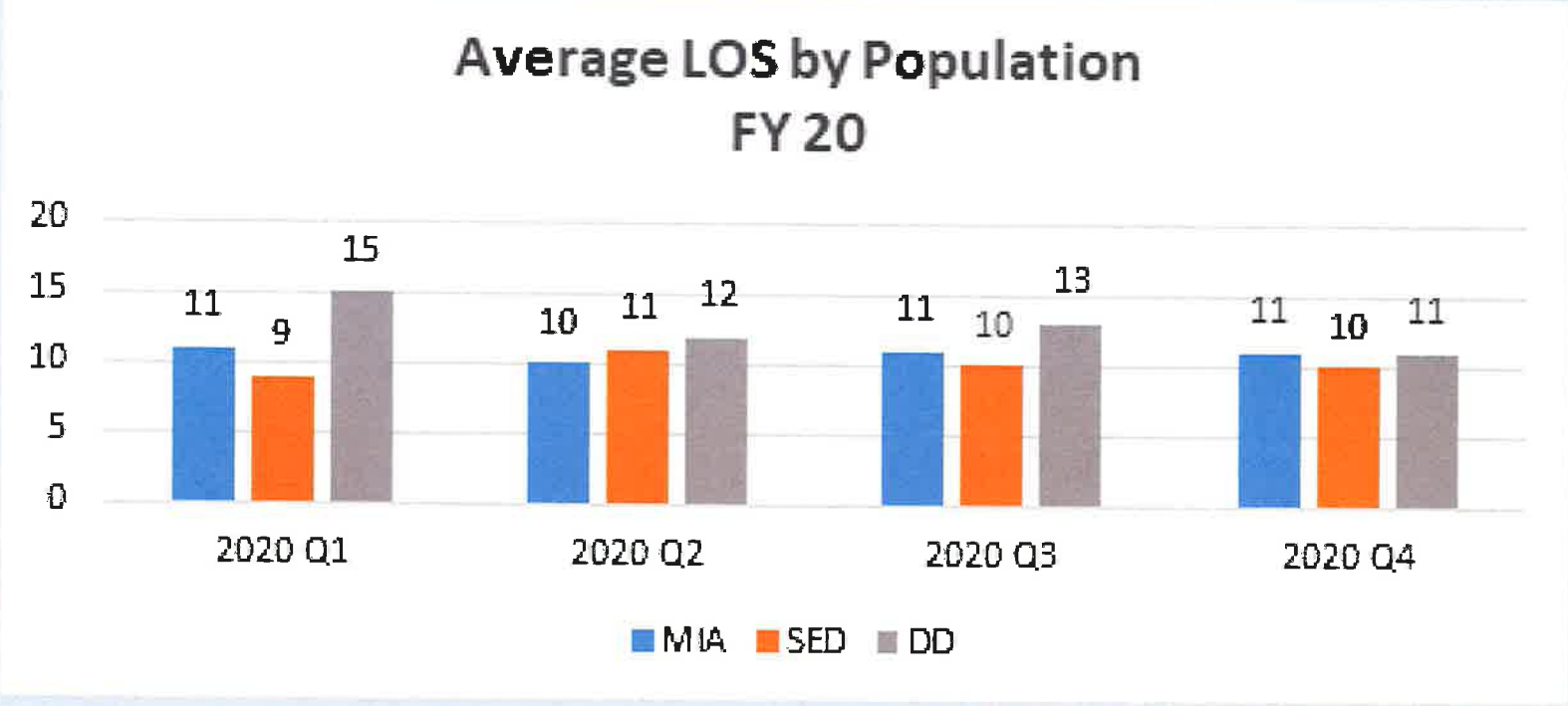
- Per MDDHS, Habilitation Supports Waiver, 1084 slots are to be filled at 95%. Last year DWIHN met this 1/12 months.
- In July 2020, incentive program of one time payment of $1000 per enrollee was made available.
- In FY 20, we improved and met this requirement 8/12 months.
- Monthly and Quarterly provider meetings to address barriers continue.
- UM provided targeted trainings to minimize returned applications from MDHHS

Finance Pillar - Identify patterns of behavioral health service utilization including over and under-utilization



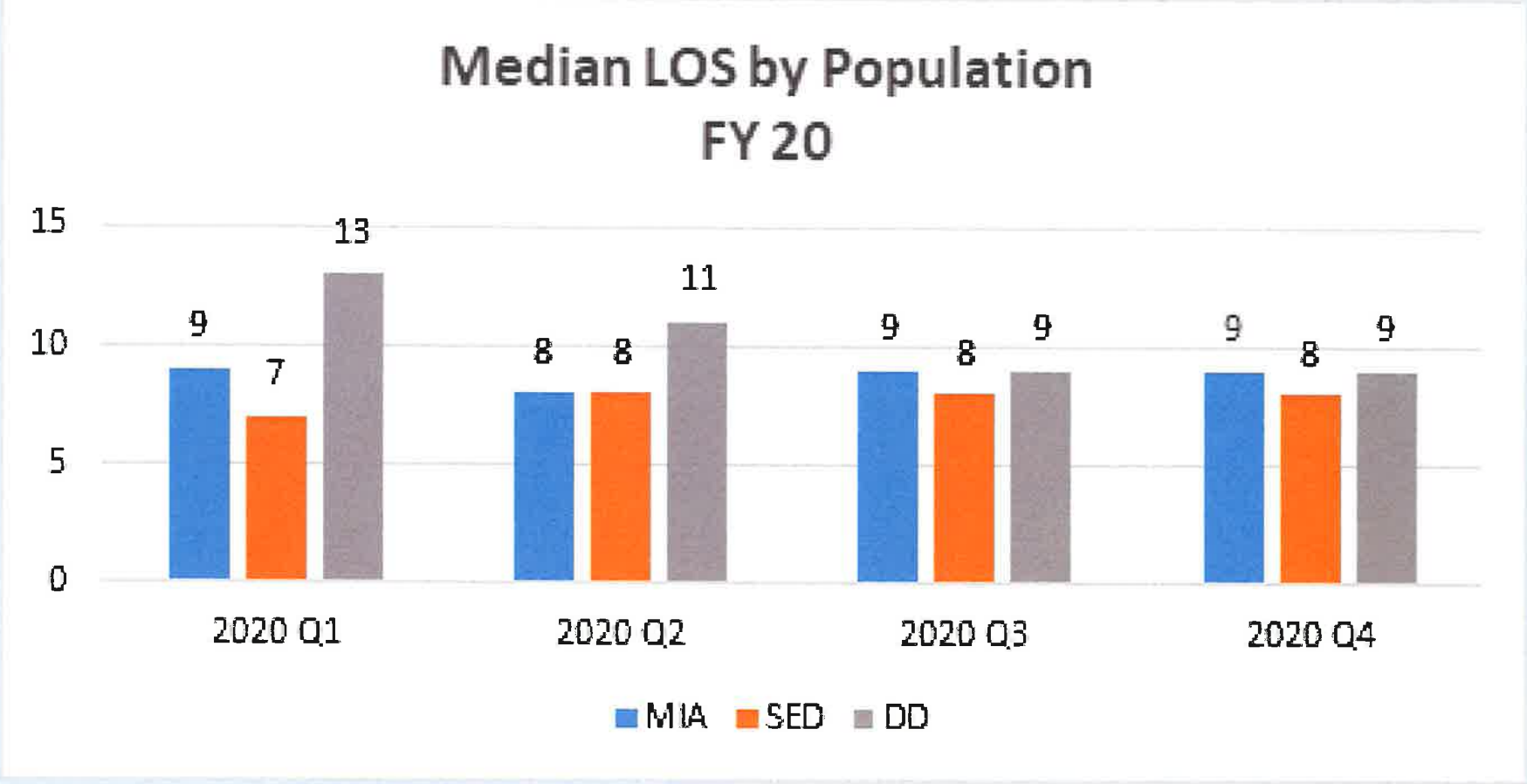
Note: The data was pulled from the hospitalization dashboards on 11/23/20. The data includes Dual Eligibles. Figures from FY 2018 and 2019 are from last year's report. There is a decrease number of admissions and members hospitalized from FY 19 to FY 20. This is consistent with a decrease in overall members served.

Finance Pillar - Key Utilization Metric , Average Length of Stay



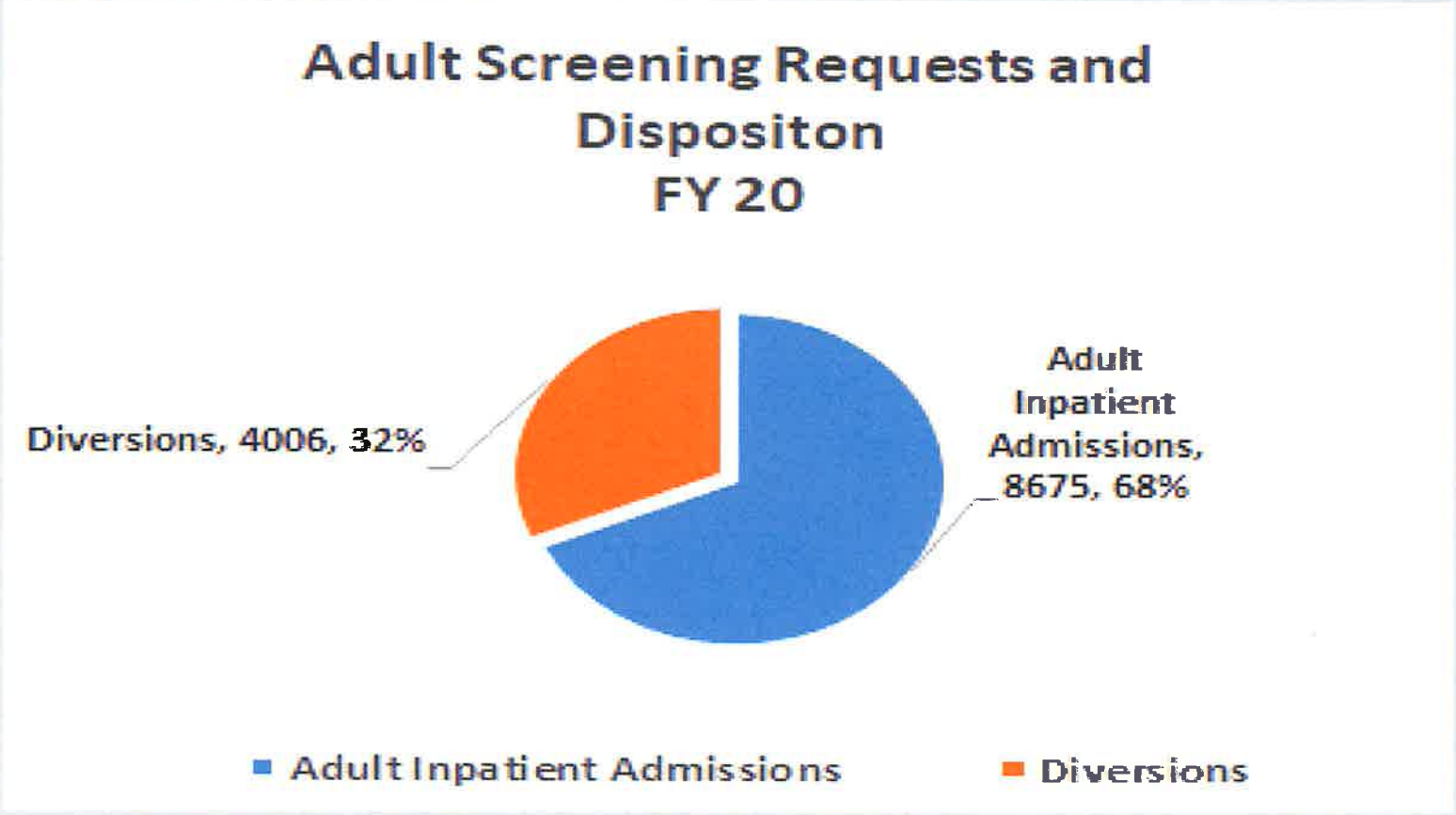
Average LOS for Adults with SMI was 11 days ; 10 days for Children with SED, and IDD LOS was 13 days. SMI and SED categories are up one day from last year's average LOS. IDD average LOS was 13 days, reduced from 14 days last year.

Finance Pillar - Key Utilization Metric , Median Length of Stay



Median LOS for Adults with SMI was 9 days each quarter , 8 days for Children with SED, and IDD LOS was 11 days. Median LOS is more accurate as it does not include outliers.

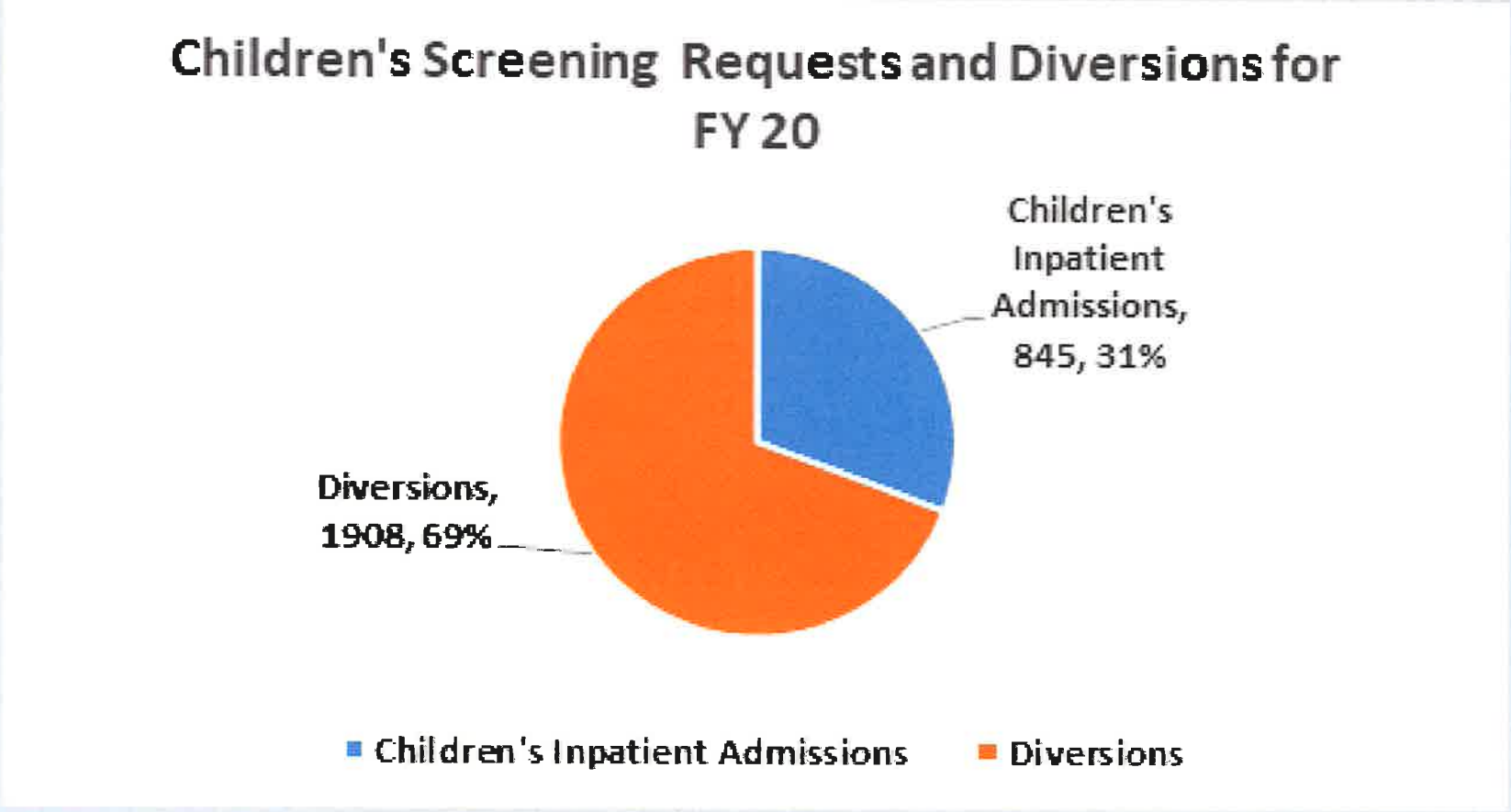
Cope Requests for Service and Diversions



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

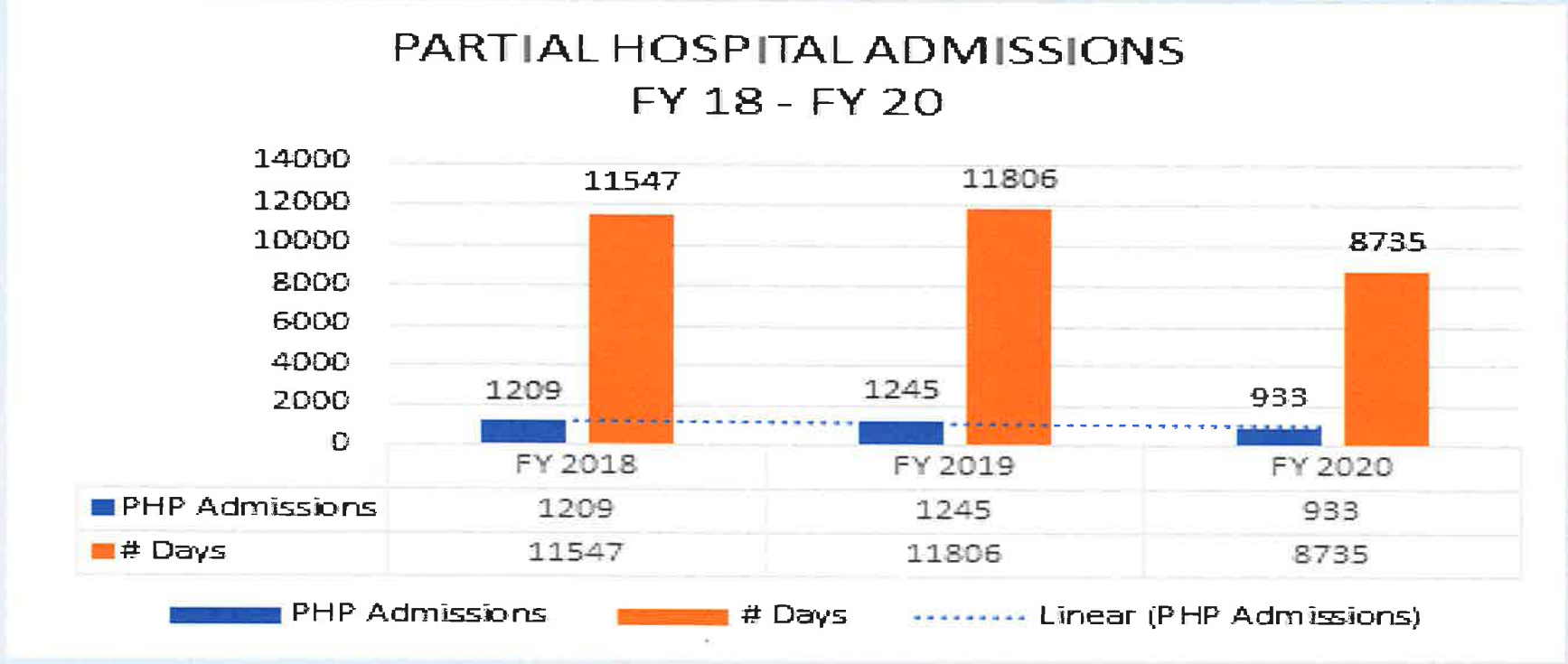
COPE screened 12,681 consumers. Sixty one percent (68%) were hospitalized and the other 32% diverted to the other levels of care. This is very similar to FY 19.

Children's Crisis Request for Service and Diversions



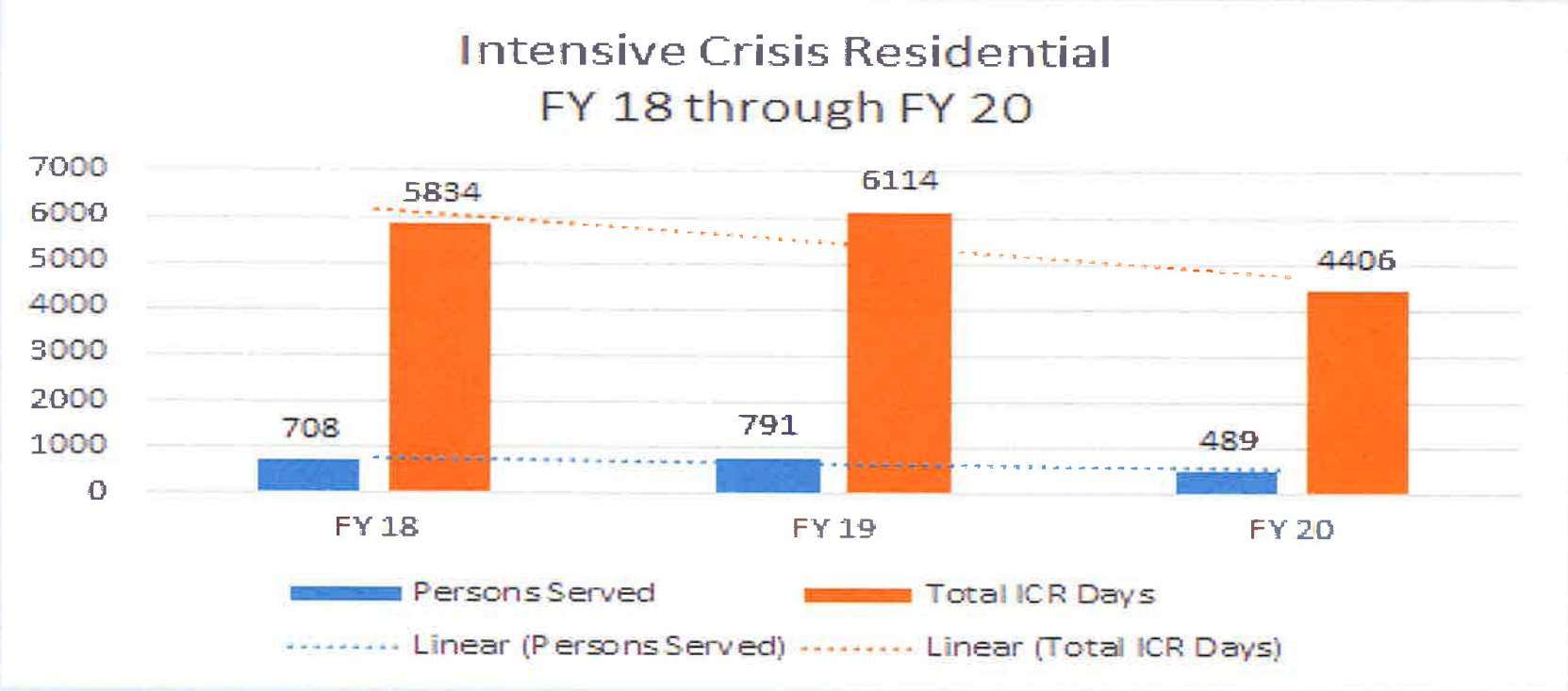
Source: MHWIN report 11/4/2020. The chart above indicates children's screeners received 2,753 requests for services; 69% (1098) were diverted to settings other than the hospital; mostly to home or outpatient services. The remaining 845, or 31% were hospitalized. This is very similar to last FY.

Finance Pillar - Key Utilization Metric, Partial Hospitalizations



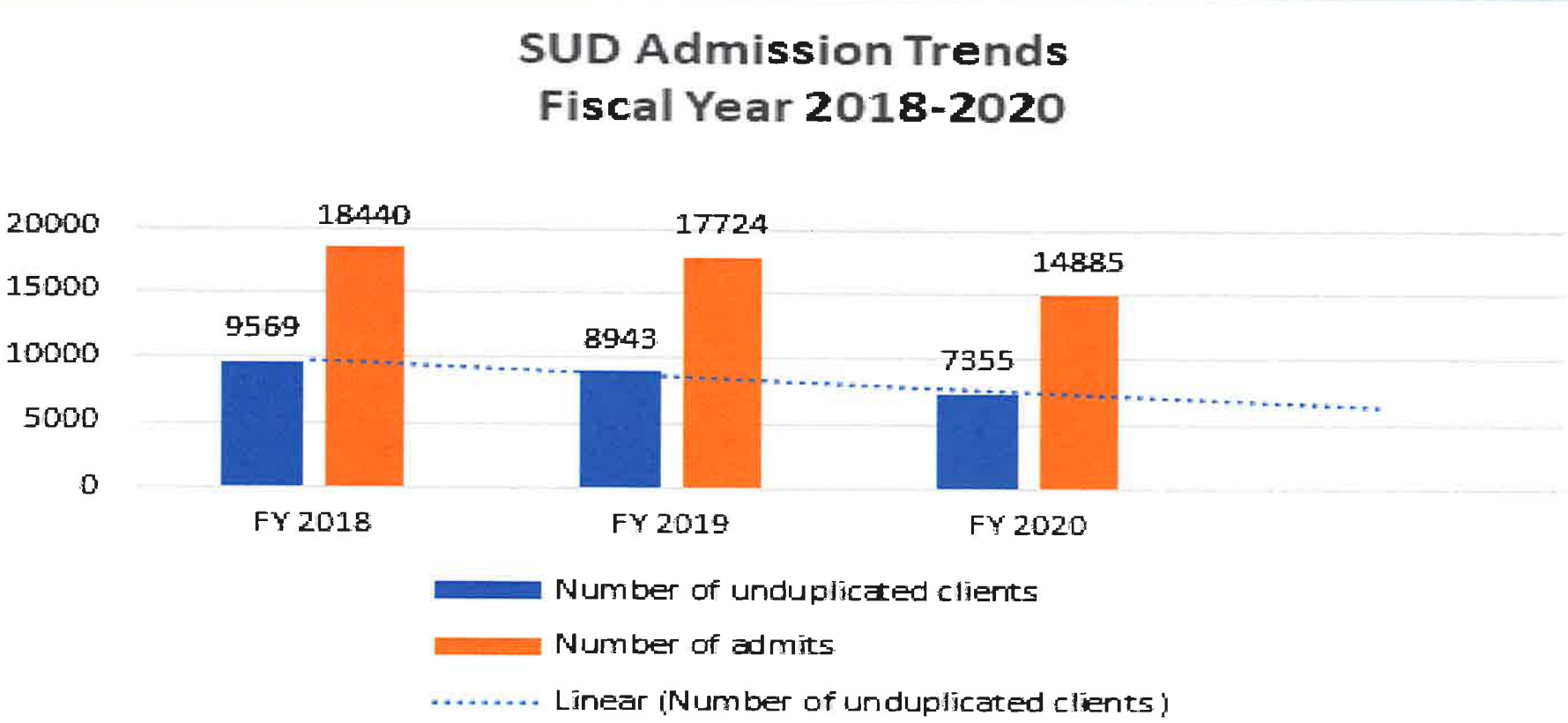
Source: Claims database 11/2/2020. New Oakland served 933 consumers in FY 20. This was a 25% reduction from FY 19, with 1245 consumers served. Reduction in most probability is due to COVID. Average length of stay for Partial in FY 20 was 9.4 days.

Finance Pillar - Key Utilization Metric, Intensive Crisis Residential



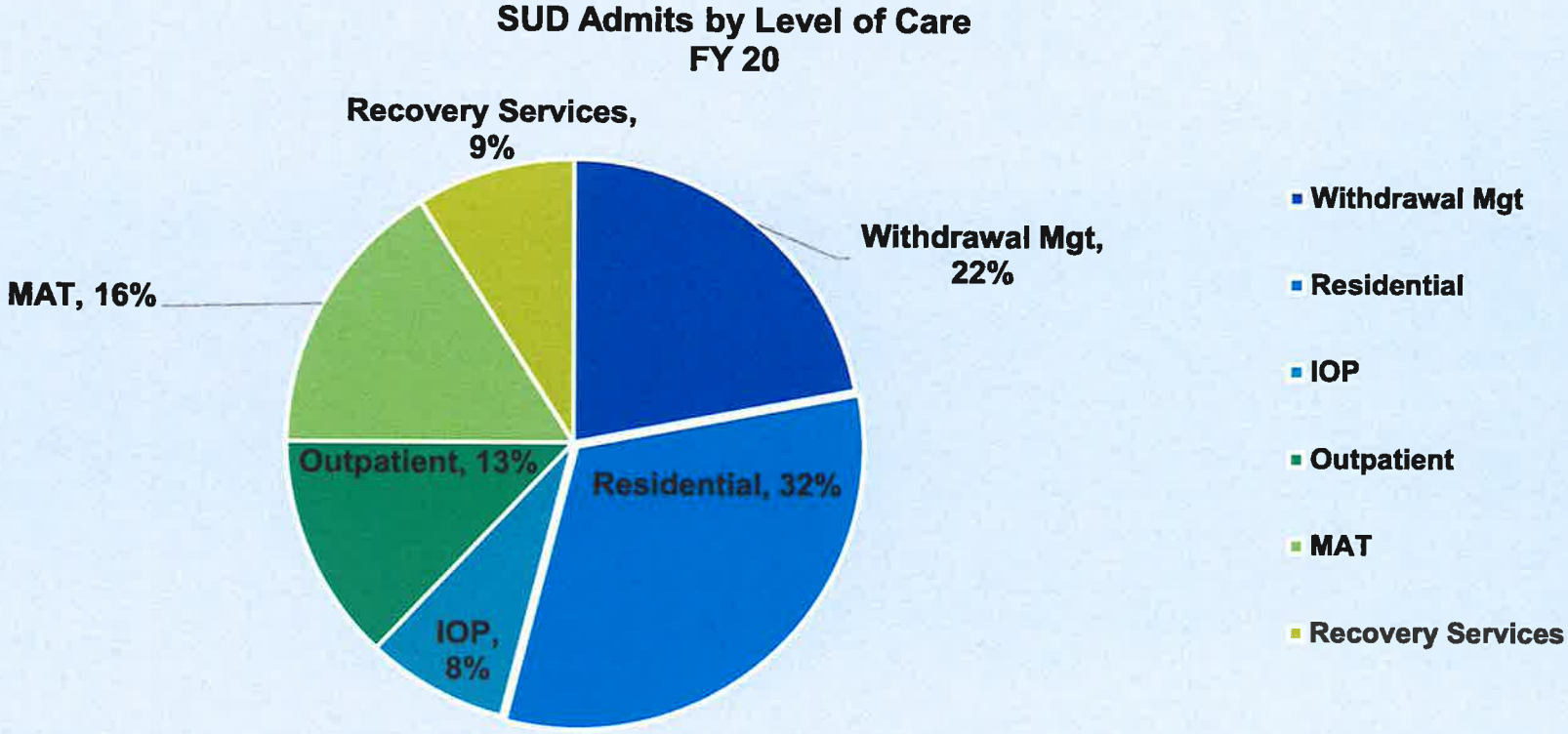
- Source: DWIHN Claims database as of 11/2/2020 . The number of consumers who received Intensive Crisis Residential Services decreased 38% from 791 consumers served in FY 19 to 489 served in FY 20. Likewise, the number of days utilized decreased 28% from 6614 in FY 19 to 4406 in FY 20. This decrease is directly related to the number of beds taken off-line during the COVID-19 pandemic. Average LOS was 9 days, up from 8 days last FY.

Finance Pillar - SUD Admission Trends



The bar graph shows the trend of admissions and the number of unique individuals served for the past 3 fiscal years. From FY 19 to FY 20, there has been a 18% decrease in the number of individuals served. FY 20, 14,885 admissions reduced by 16% from FY 19. A large portion of the reduction can be attributed to COVID. *Source: MH-WIN Admit and Discharge Records 10/23/2020.*

SUD Admissions by Level of Care – FY 20



The percentage served in each category remains relatively consistent over the years, 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.

Quality and Workforce Pillar - Assure fair and consistent UM review decisions

Continued use of Millman Care Guidelines (MCG)Criteria network wide for higher levels of care and Inter-rater reliability(IRR) of staff making UM decisions:

- In FY 20, MCG/Indicia integrated into MH-WIN versus standalone software. Staff no longer need separate log ins.
- Use of MCG Behavioral Health Guidelines by following entities: DWIHN, Screening Entities and ACT teams as they screen consumers for hospitalization.
- In FY 20, 152 staff received and passed interrater reliability studies.

Quality Pillar-Provide oversight of delegated UM functions

- Monitoring of compliance with UM timeframes for decision making
  - Delegated entities at or above 90% threshold
  - DWIHN SUD determinations did not meet timeliness threshold of 90% in the first quarter of FY 20. Urgent concurrent timeliness measure was 85% and non-urgent preservice was 76%. This was primarily due to staff vacancy. Position filled , December, 2019.
  - Subsequent quarters achieved 90% benchmark.

Customer Pillar - Utilizing Provider and Practitioner Satisfaction Surveys to make recommendations for improvement

- Provider Network Satisfaction with UM was conducted in FY 20. Eight questions pertained specifically to UM and the authorization process.
- Findings were recently released. Preliminary reviews indicate many Completely Satisfied or Somewhat Satisfied; but some areas in need of improvement in the authorization processes.
- Recommend task force to address areas requiring improvement. More thorough analysis may result in Performance Improvement Plans or Corrective Action as warranted.

New Technology Recommendations and other

- Report Development
  - Inpatient Recidivism & Other Reporting

  Continue work with IT and UM staff to enhance metrics utilizing standardized measures and reporting benchmarks. Compare DWIHN performance against national databases or local and state entities when available.
- Keep improving workflow of UM review process including hospitals documenting patient progress within MH-WIN to support UM continued stay reviews.
- Continue work with Service Utilization Management Guidelines and ability of staff and provider network to review over and under utilization of identified services.
- Continue monitoring impact of COVID-19 on overall utilization of services.

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

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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 Chief Medical Officer has substantial involvement in the development, implementation, supervision and evaluation of the UM program. 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 dedicated tremendous time to activities surrounding Systems Transformation. 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.

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.

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

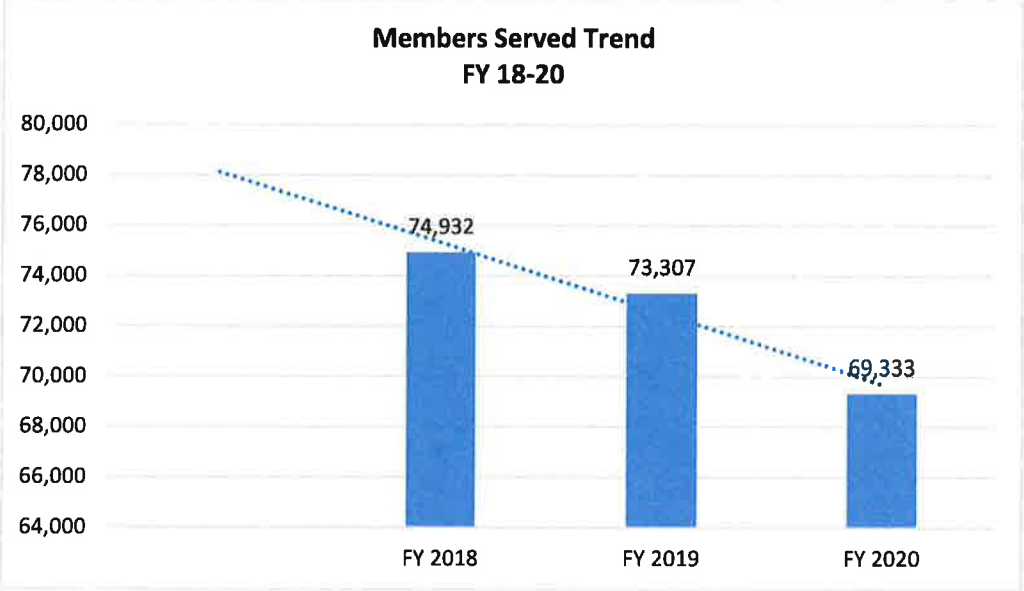
I. Populations Served

II. Status of Utilization Management Program Strategic Plan Goals

III. Status of UM Department Technology Recommendations/Initiatives

I. Population Served

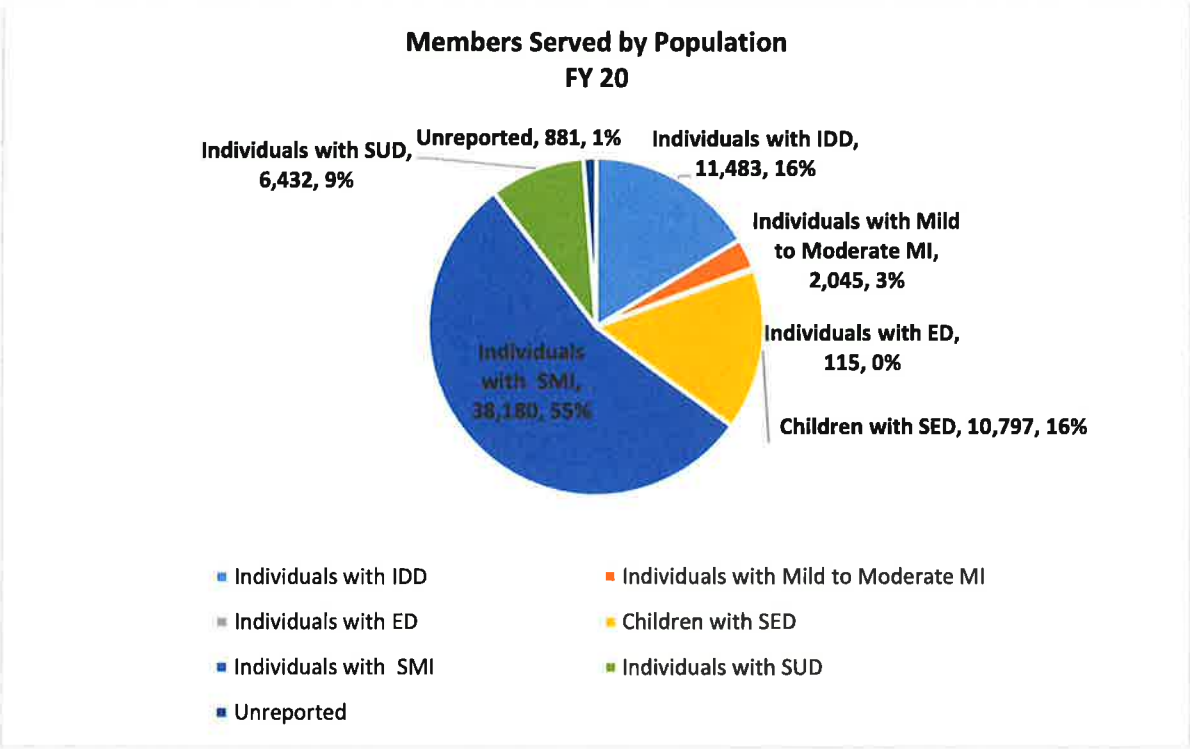
The chart below indicates the trend of unique members served based on the past three (3) Fiscal Years (FY). As can be seen from the chart, there has been a decrease in the number of unique individuals served since FY 18 in both FY 19 and FY 20. Further investigation is necessary to determine potential 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.

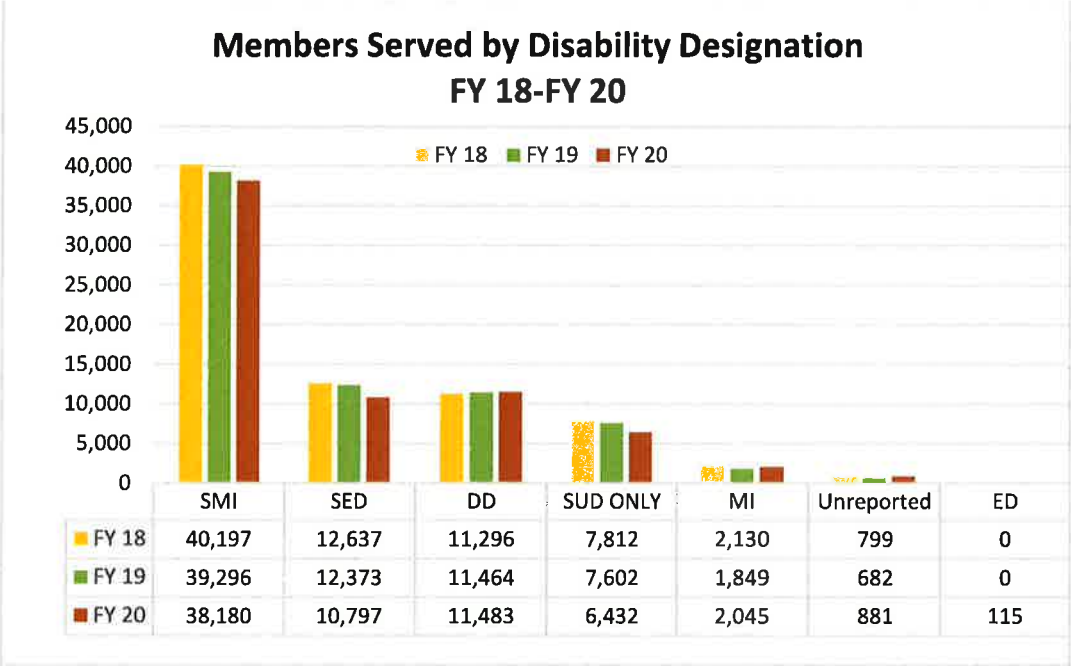


Source: Agency Profile Dashboard 11/23/2020

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. The Quality Department is required to follow through with improvements and recommendations made by the Member Experience Reports. Like other survey recommendations, Quality may direct other departments to have ownership of those Performance Improvement Plans.

DWIHN Report on Practitioner Network Satisfaction Survey

During FY 18, FY 19 and FY 20, DWIHN 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 methodology for this survey is under the auspices of the DWIHN's Customer Service division. There were 33 practitioner respondents for the FY 18 survey, 146 for the FY 19 and 180 practitioner respondents for the FY 20 survey. The detailed report is listed as Attachment A in this document.

Results and Analysis

The surveys have identified several opportunities for improvement. It is recommended the UM Program Evaluation for FY 20 Plan of Correction include the provider experience survey goal of achieving the 80% standard on *each* of the ten measures for the FY 21 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 to monitor progress and achieve the targeted goal. Additionally, delegates submitting UM Program Evaluations were requested to provide narrative in their reports regarding UM experiences. These will be reviewed and if indicated, will be included when developing the Plan of Correction for FY 21.

Planned Interventions for FY 2020

Source: Plan of Correction

- 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, the monthly "universes" or data runs from I.T. show the timeliness of the authorization process. The UM Department uses this data to track the time of receipt and response of authorization requests.*
  Create Authorization 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.

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, implemented on June 1, 2020, are in place and 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.

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)

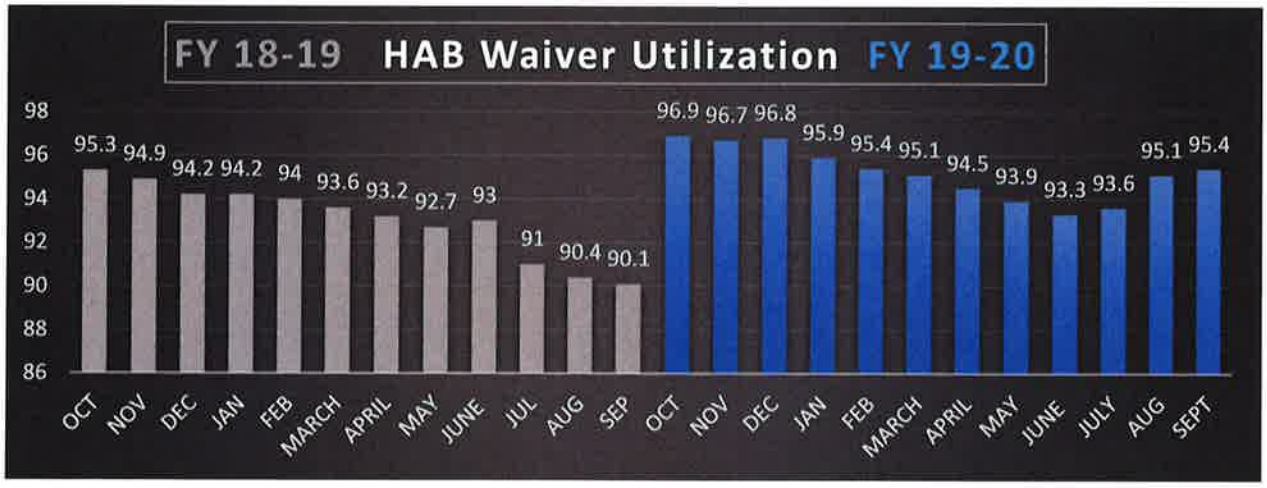
Detroit Wayne Integrated Health Network (DWIHN) receives enhanced funding for participants enrolled in the 1915(b) Habilitation Supports Waiver (HSW) ranging from $3,500.00 to $5,500.00 per member/per month from the Michigan Department of Human Services (MDHHS). In order to be enrolled in the HSW program,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

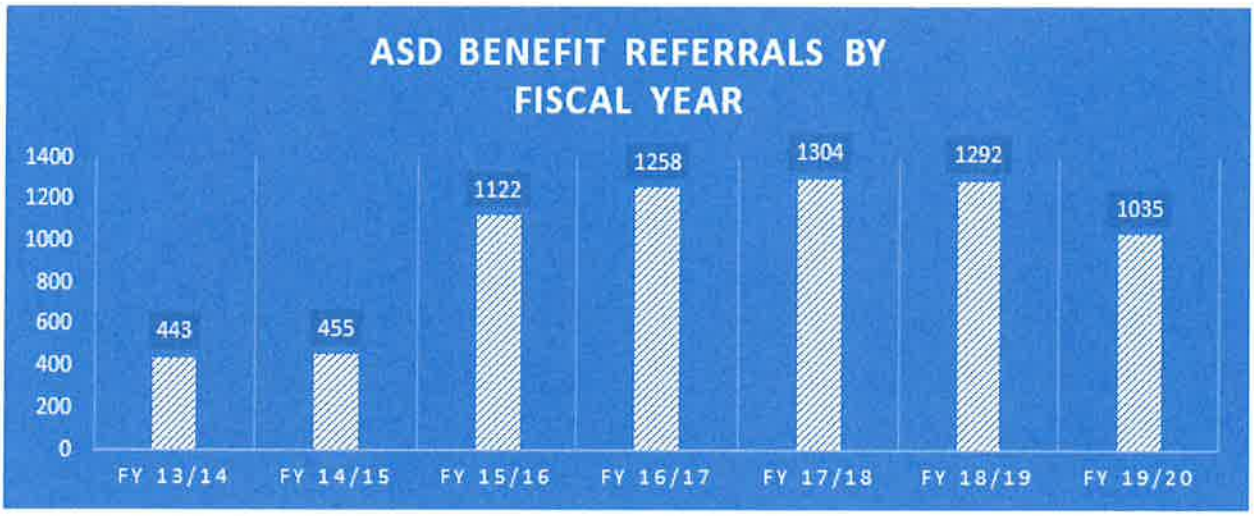
Coordinators; follow-ups and additional training provided upon request or apparent need.

- 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 wishing to have 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 who determines if the consumer is eligible for the benefit. DWIHN brought in review of medical necessity denials for ABA services in October, 2020 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.

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 meets criteria for the benefit. Consumers may be evaluated and found not eligible 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.

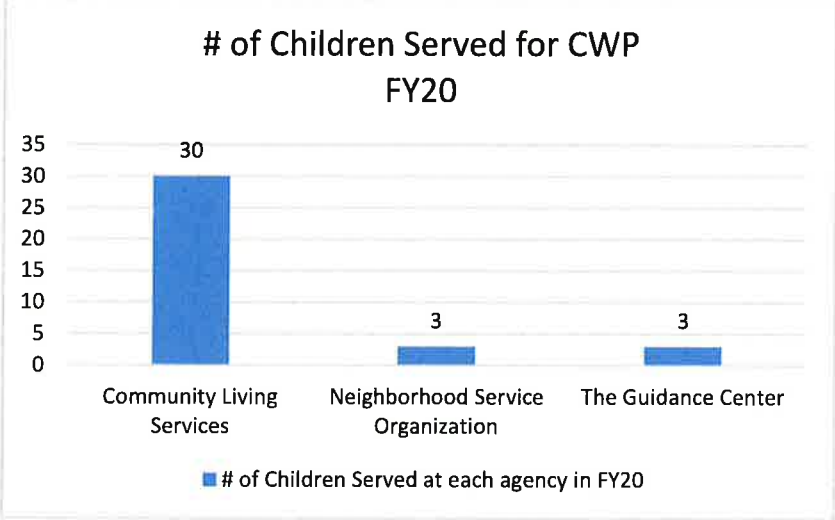
After the onset of the pandemic, MDHHS quickly made adjustments to allow nearly all ABA services to be administered via telehealth when clinically appropriate while also being more flexible on evaluation date requirements. While these changes were a tremendous help to the

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

Due to a mandate from MDHHS and CMS to have standardized medical necessity criteria to ensure parity of behavioral health services statewide, a consortium of the Prepaid Inpatient Health Plans called the Michigan Consortium for Health Excellence (MCHE) in FY 19 purchased the use of MCG Behavioral Health Guidelines and interactive software called Indicia. 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.

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. 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.

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 152 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 and retraining.

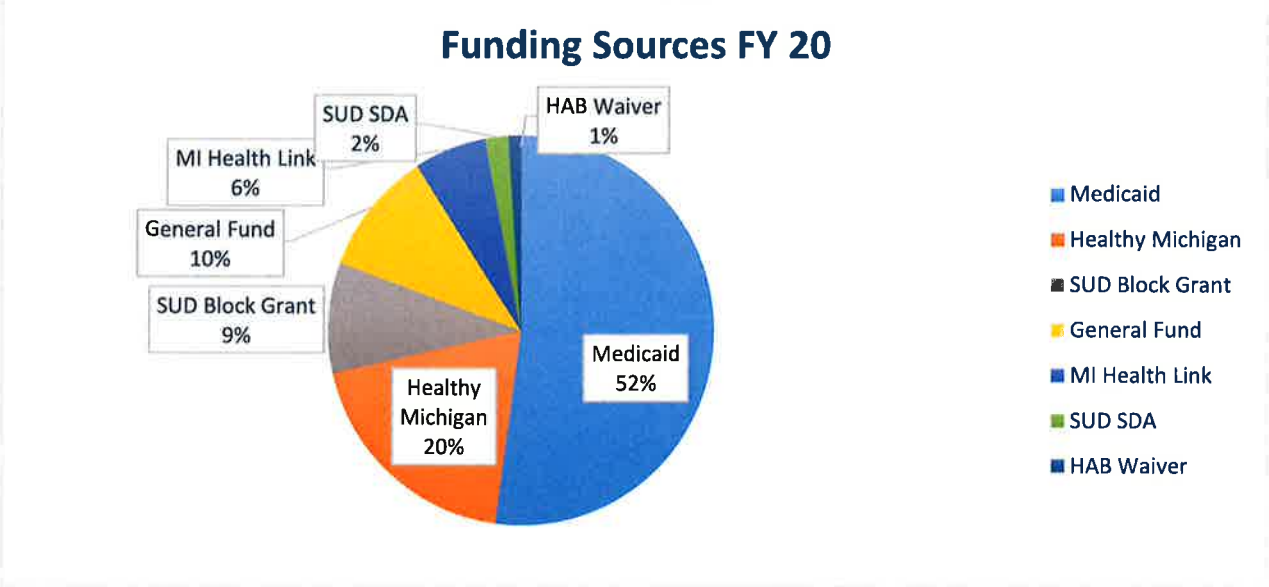
Finance Pillar– Commitment to financial stewardship and to the optimal prioritized allocation of scarce resources across a plethora of growing and competing needs to best fulfil its mission, vision and values.

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.

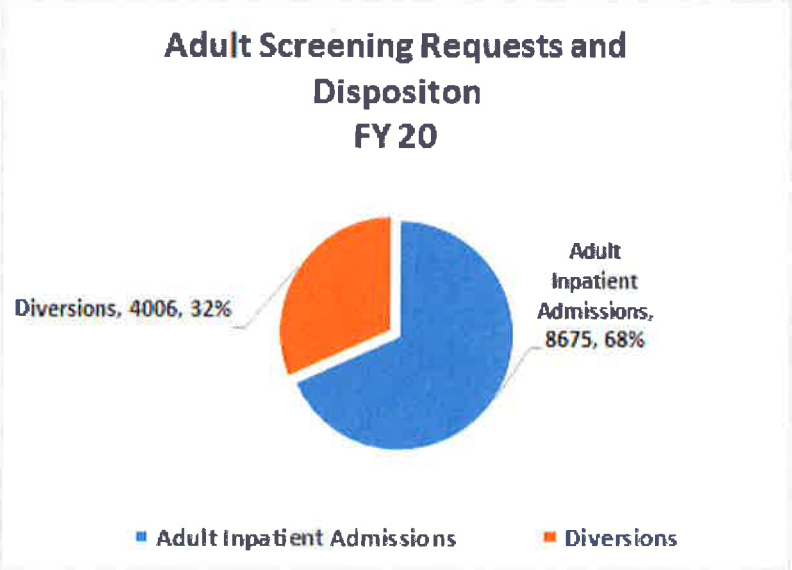
Evidenced Based Supportive Employment

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

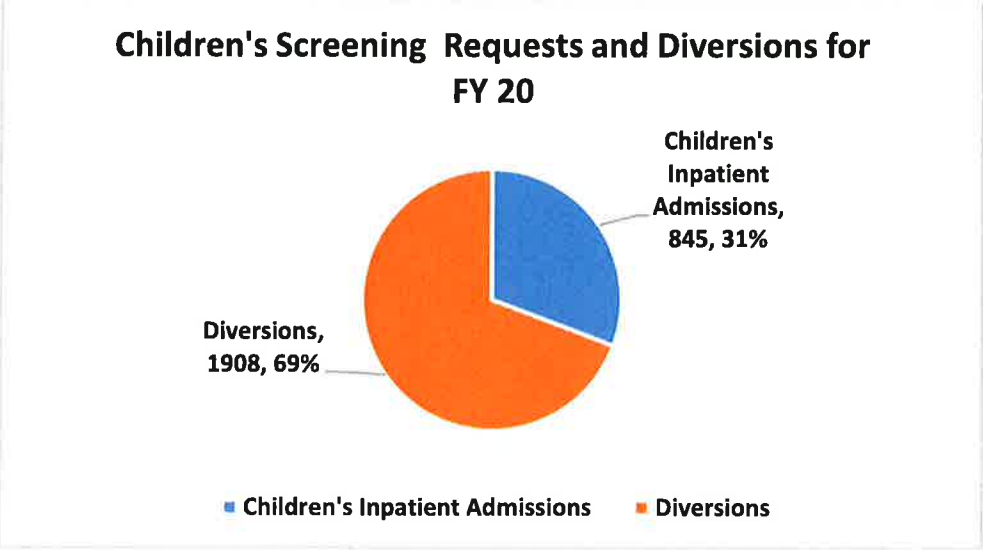
The following pie charts indicate the volume of requests for service received by COPE and the Children's Screening Entities. The screeners for children and adolescents are The Children's Center, The Guidance Center, and New Oakland Family Services. A preadmission review is conducted to determine need 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.



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.

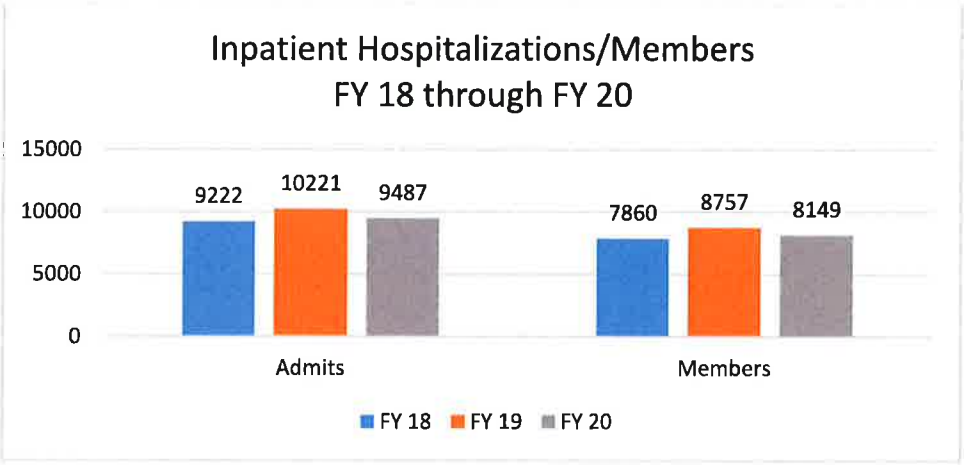


Source: MH-WIN Reports, 11/4/2020

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.

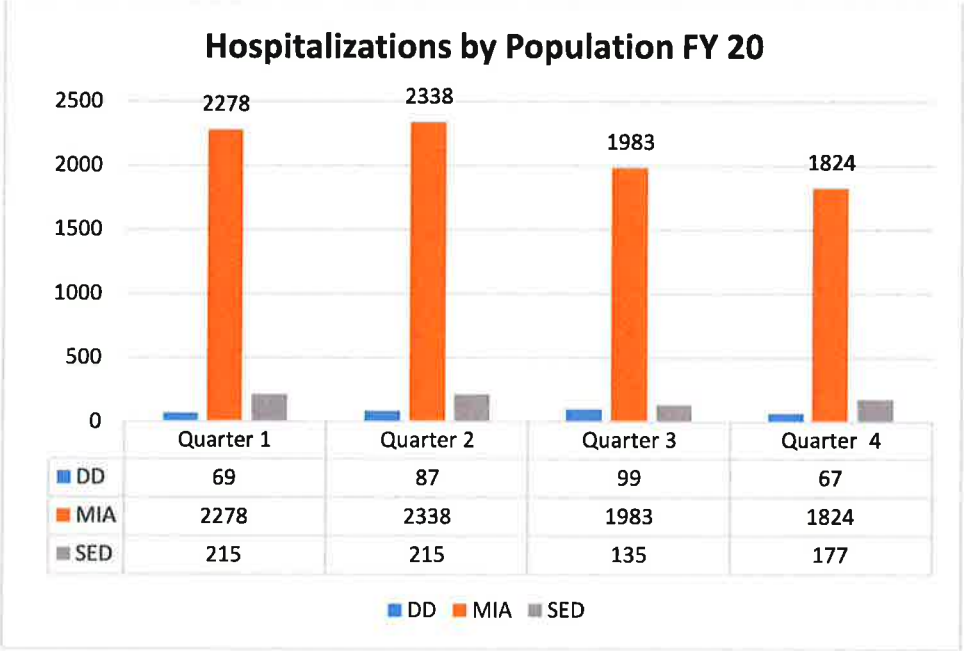


Note: The data was pulled from the hospitalization dashboards on 11/23/20. The data includes Dual Eligible. Figures from FY 2018 and 2019 are from last year's report.

Results and Analysis

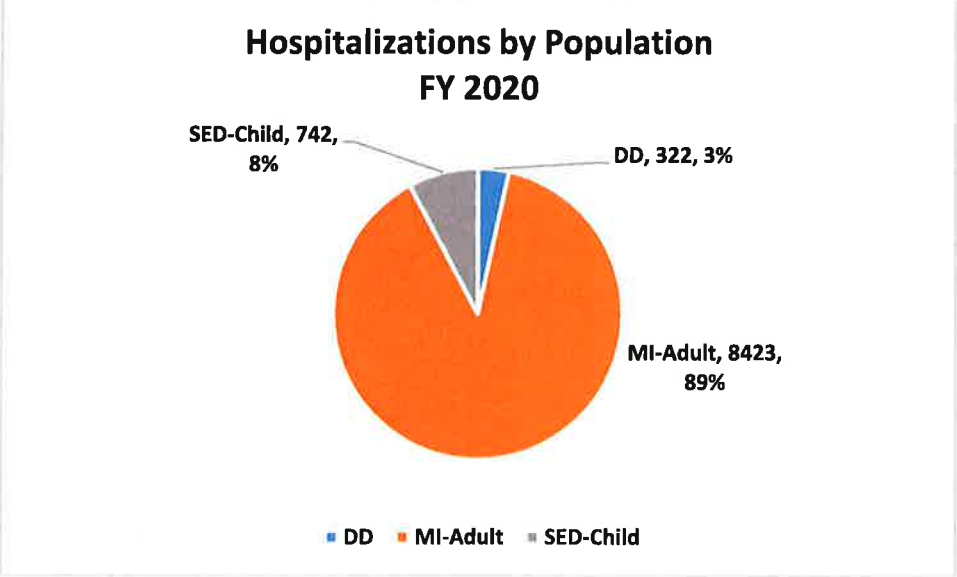
The data for Inpatient Hospitalizations indicate a decrease in number of admissions and unique members hospitalized during FY 20 compared to FY 19.. This is consistent with decrease in overall members served this FY.
When reviewing the percentage of Admissions per the number of members served for the 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%.



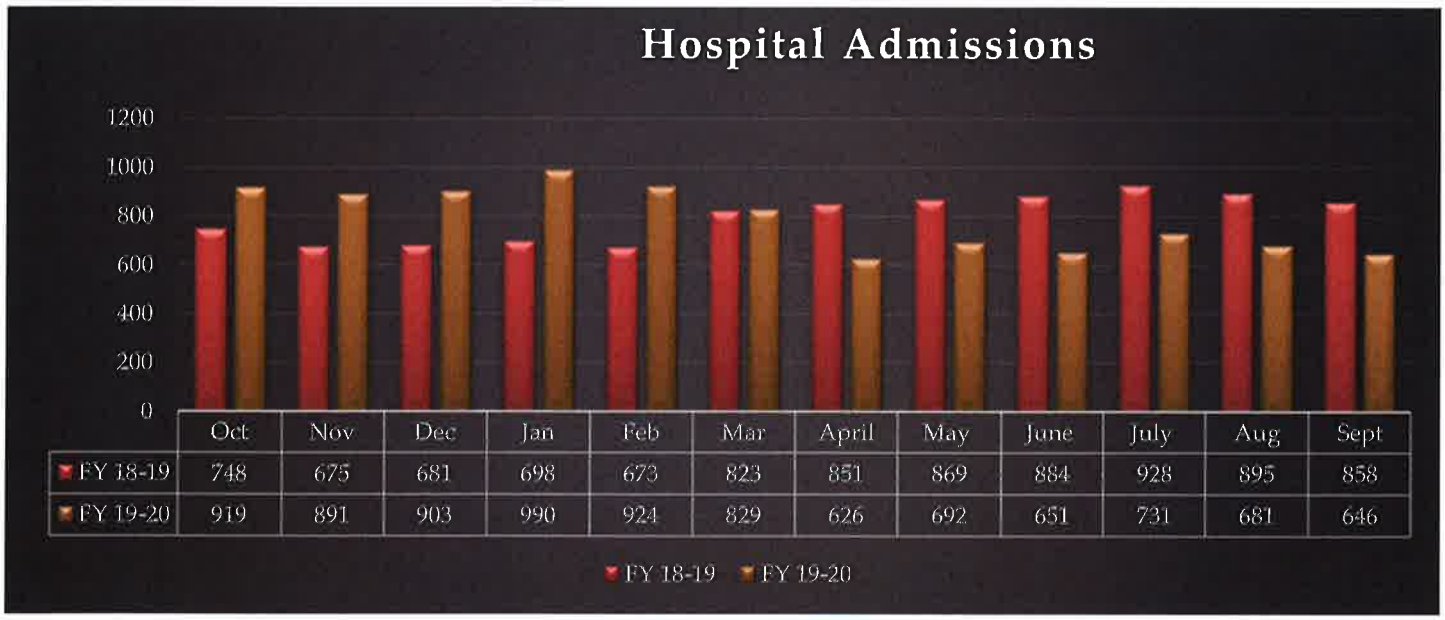
	Quarter 1	Quarter 2	Quarter 3	Quarter 4
DD	69	87	99	67
MIA	2278	2338	1983	1824
SED	215	215	135	177

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.



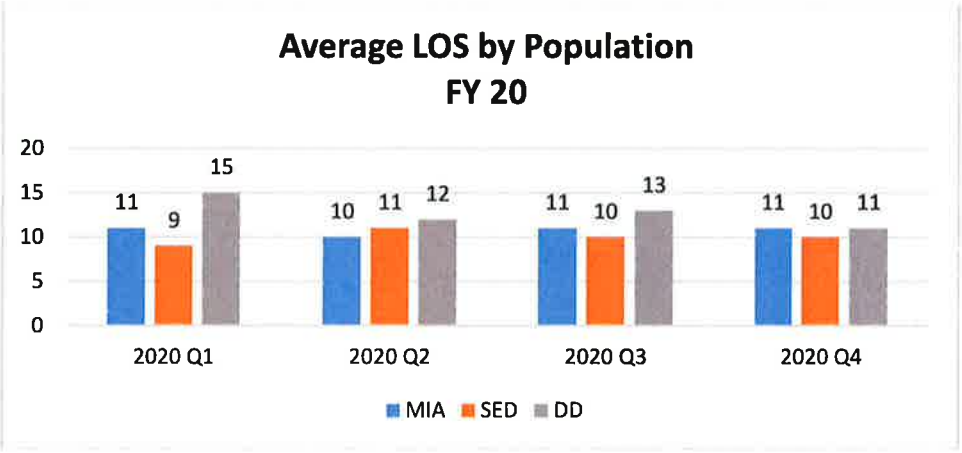
	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept
FY 18-19	748	675	681	698	673	823	851	869	884	928	895	858
FY 19-20	919	891	903	990	924	829	626	692	651	731	681	646

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.

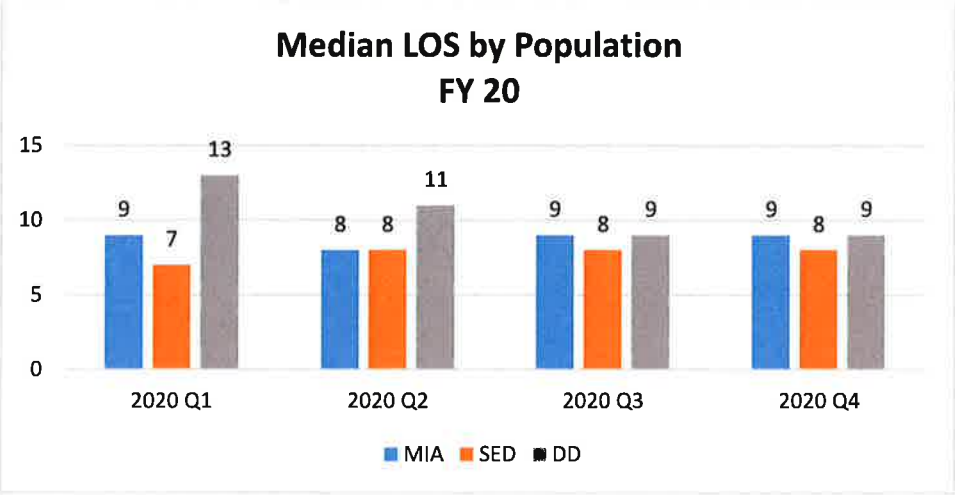
At the onset of COVID, hospitals decreased capacity to allow for single rooms and social distancing. Units were also created for individuals who tested positive or asymptomatic. Additionally, staff were tested to ensure the health and safety of the consumers.



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

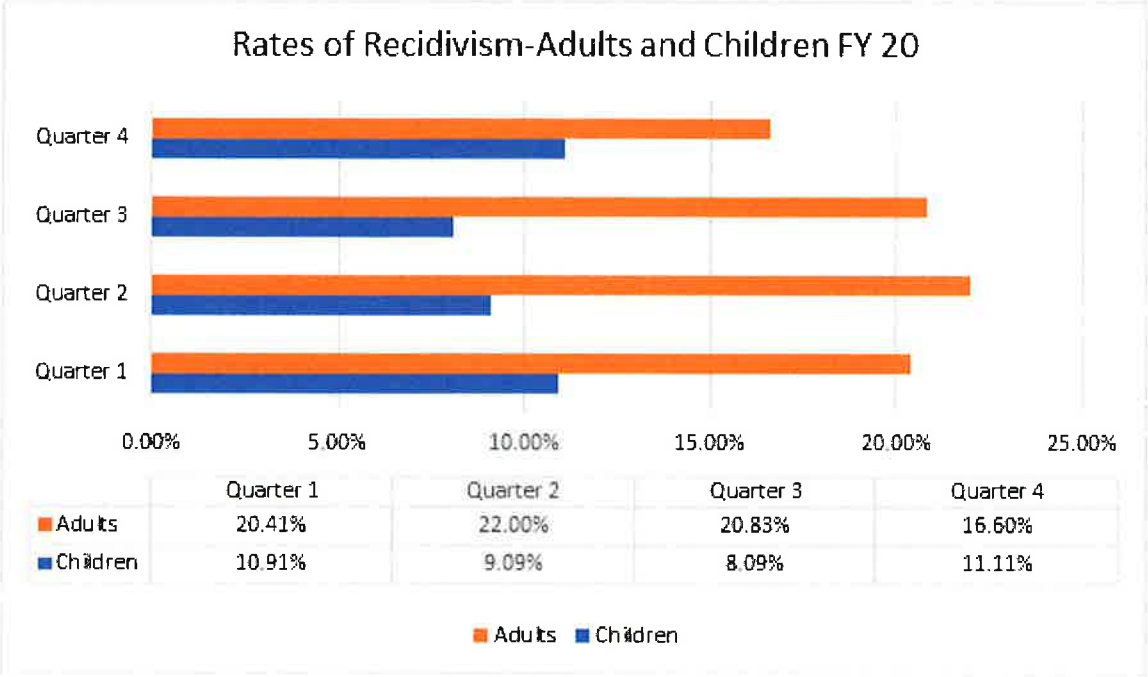
Source: 2019 SAMHSA Uniform Reporting System.

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



	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Adults	20.41%	22.00%	20.83%	16.60%
Children	10.91%	9.09%	8.09%	11.11%

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

Results and Analysis

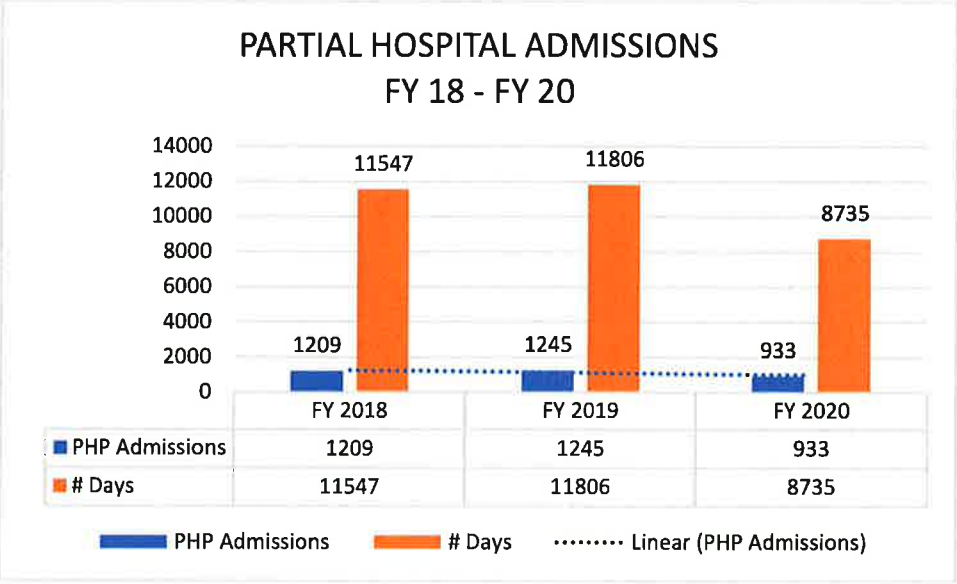
As part of the Michigan Mission Based Performance Indicator System, the Quality Department tracks hospital recidivism. Performance Indicator #10 tracks the percentage of consumers readmitted within 30 days of discharge from hospital and the data is compiled and analyzed by the Quality Department. The 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

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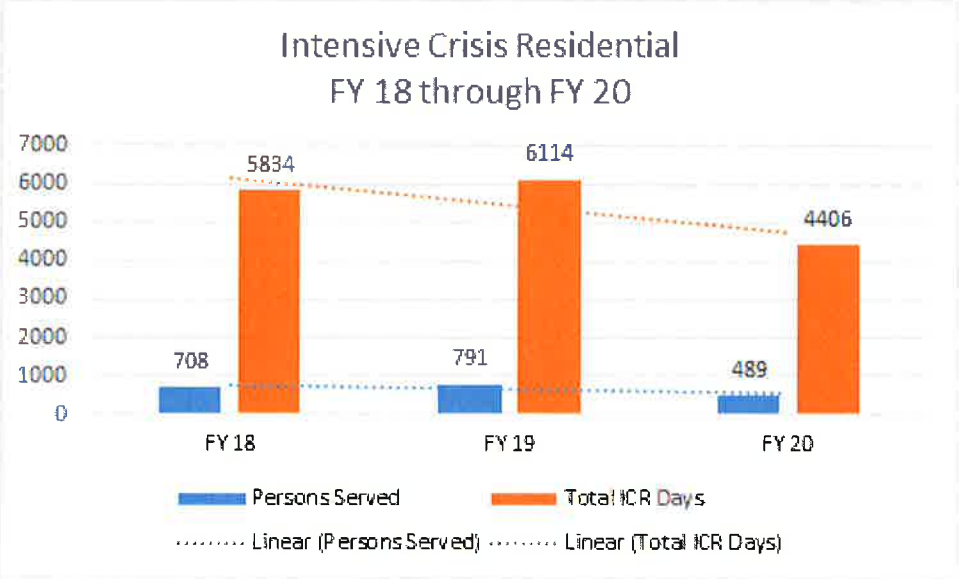
Intensive Crisis Residential



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.

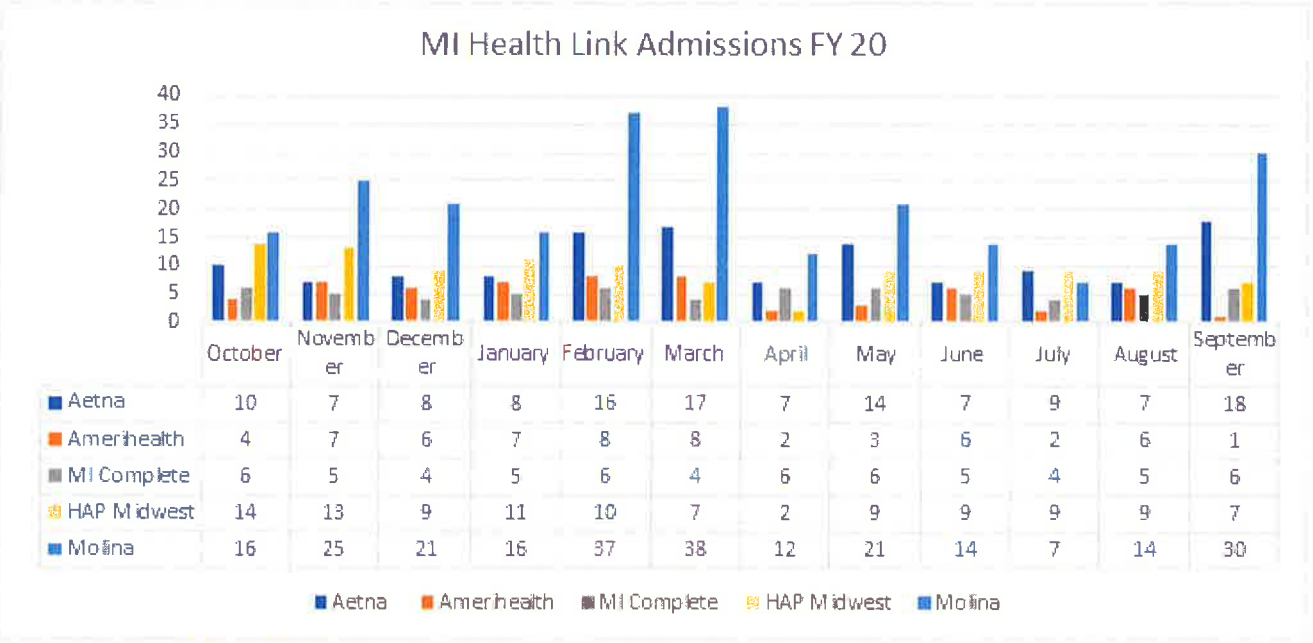
The length of stay across all state hospitals for members referred from community inpatient settings averaged 438 days, a significant decrease from 816 days in FY 18-19. This is more reflective of the rates in previous years and is attributed to the decrease in community referrals for state hospital 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)



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

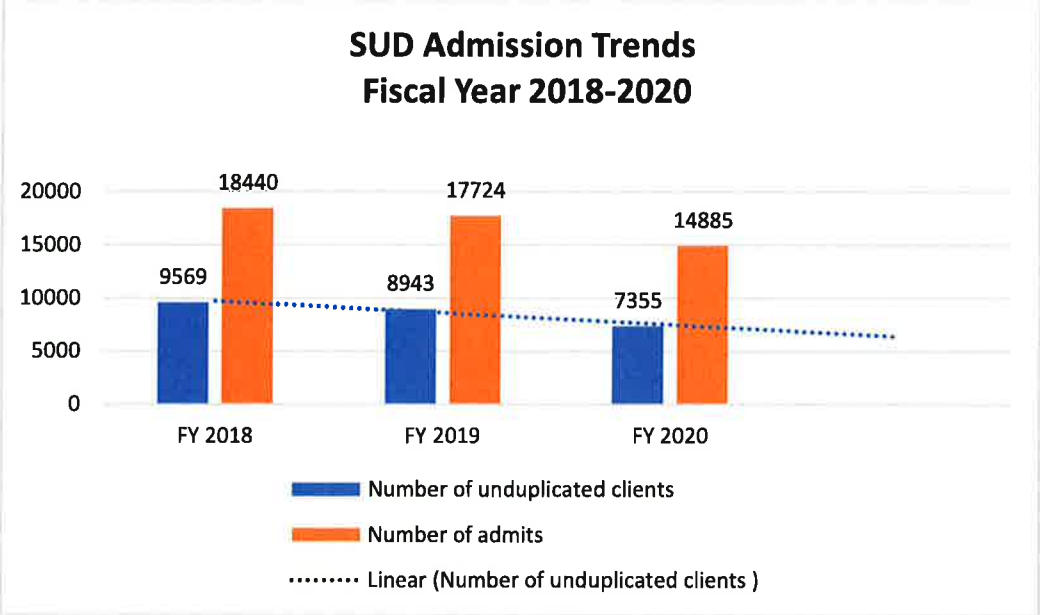
Substance Use Disorder Services

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

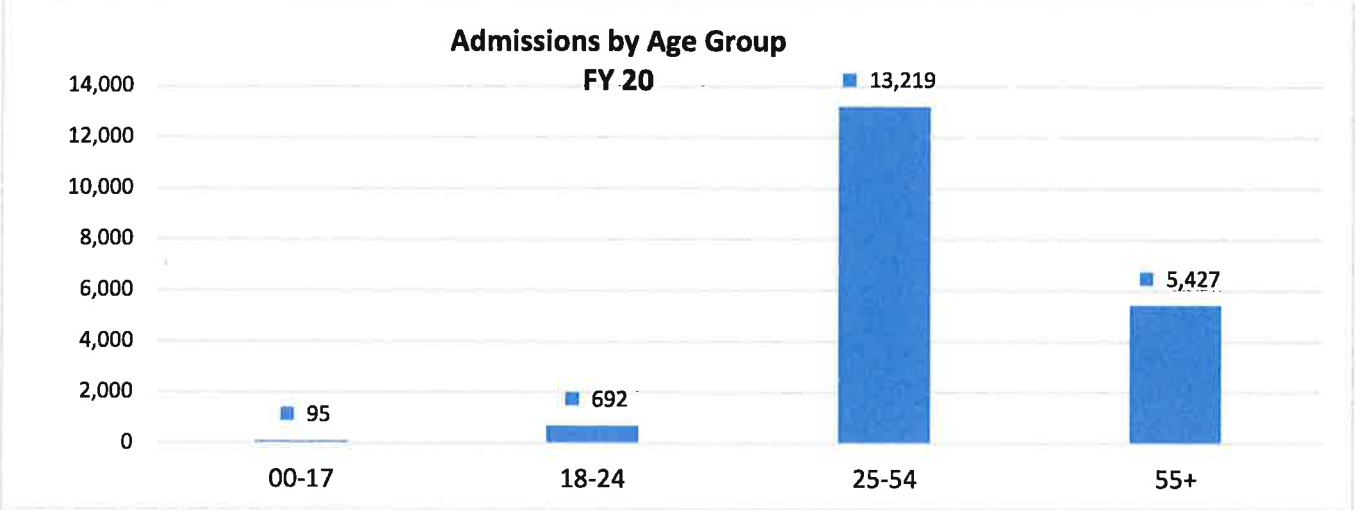
The bar graph below shows the trend of admissions and the number of unique individuals served for the past 3 fiscal years. From FY 18 to FY 20, there has been a decrease in the number of individuals served. A large portion of the reduction in FY 20 can be attributed to COVID. Each change in level of 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

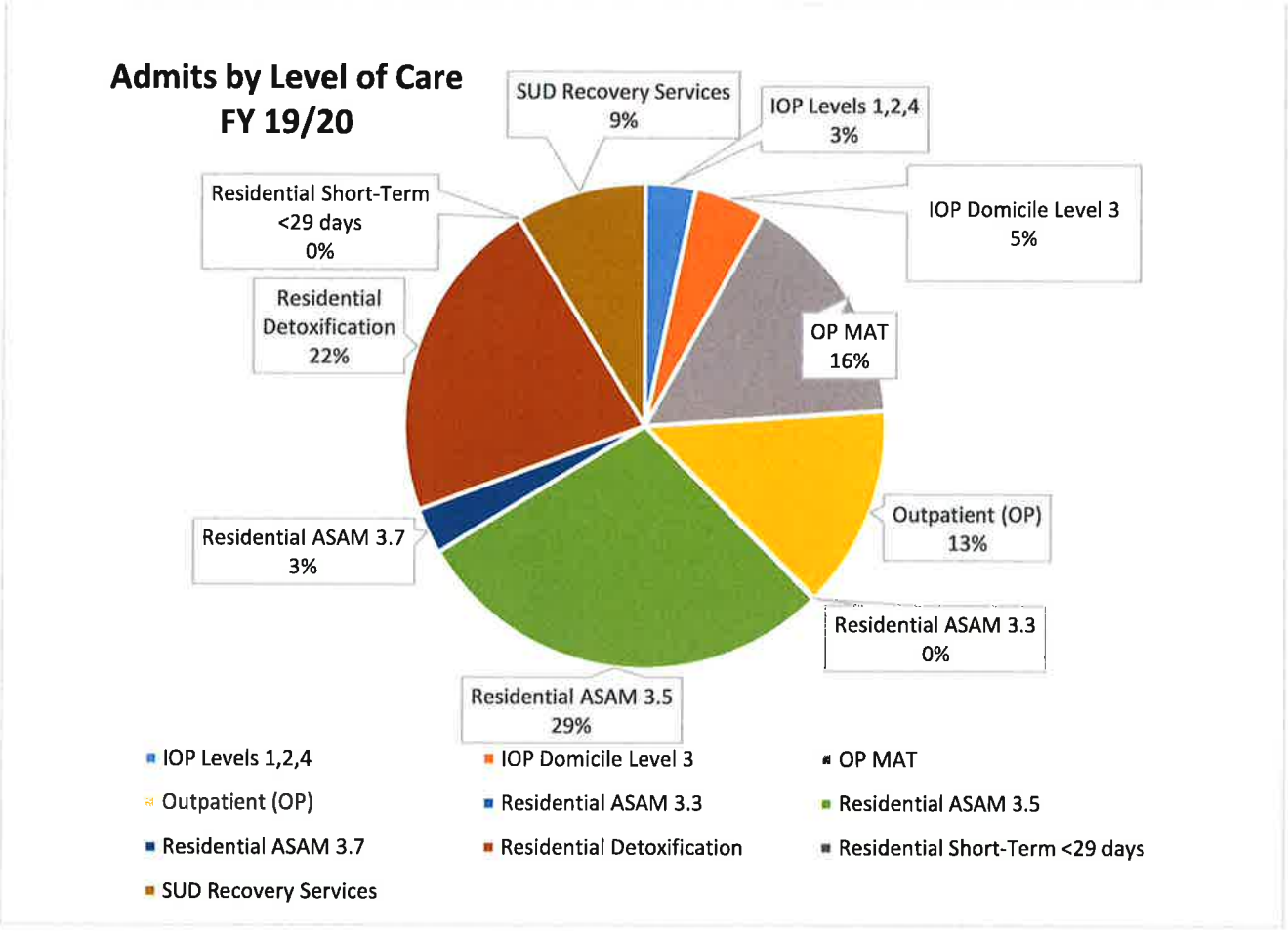
Results and Analysis

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.

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.

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 lines 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 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.

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

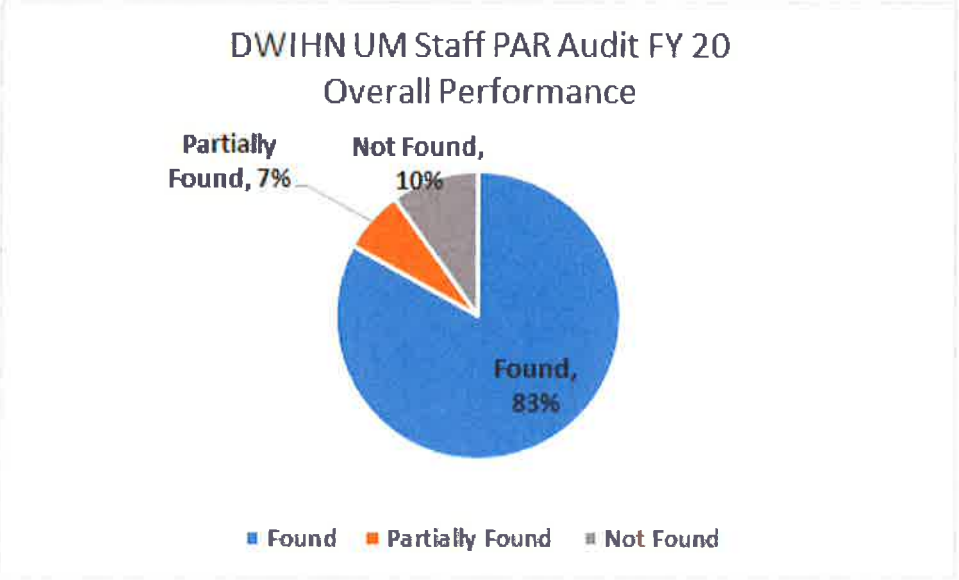
Source: DWIHN Dashboard 12/16/2020

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 (such as LOCUS and CAFAS) 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

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 table training's 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.

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

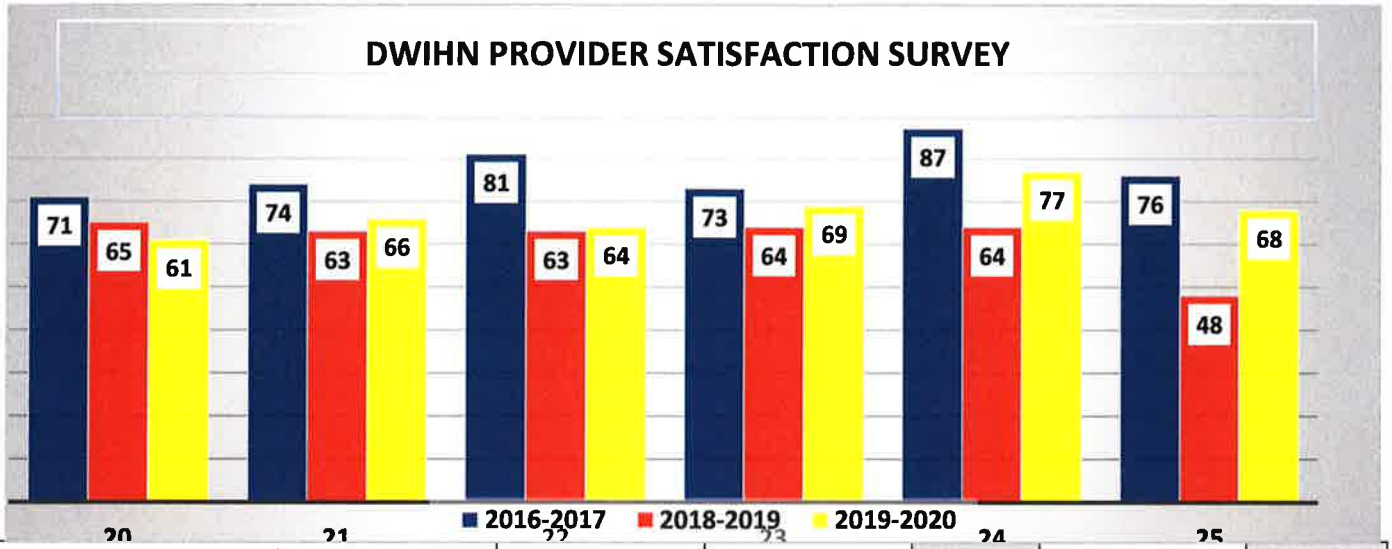
PART A: Participants were anonymous and were given the following options for scoring **Questions 20-25**: Completely Satisfied, Somewhat Satisfied, Neither Dissatisfied or Satisfied, Somewhat Dissatisfied, Completely Dissatisfied, Not Applicable. For the purposes of this report, the level of satisfaction 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	74%	63%	-11%	66%	-3%



authorizations through COPE*, SUD, Autism Spectrum Disorder, and/or MI Health Link?					
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 improvement/stabilization of level of functioning?	73%	64%	-9%	69%	+5%
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

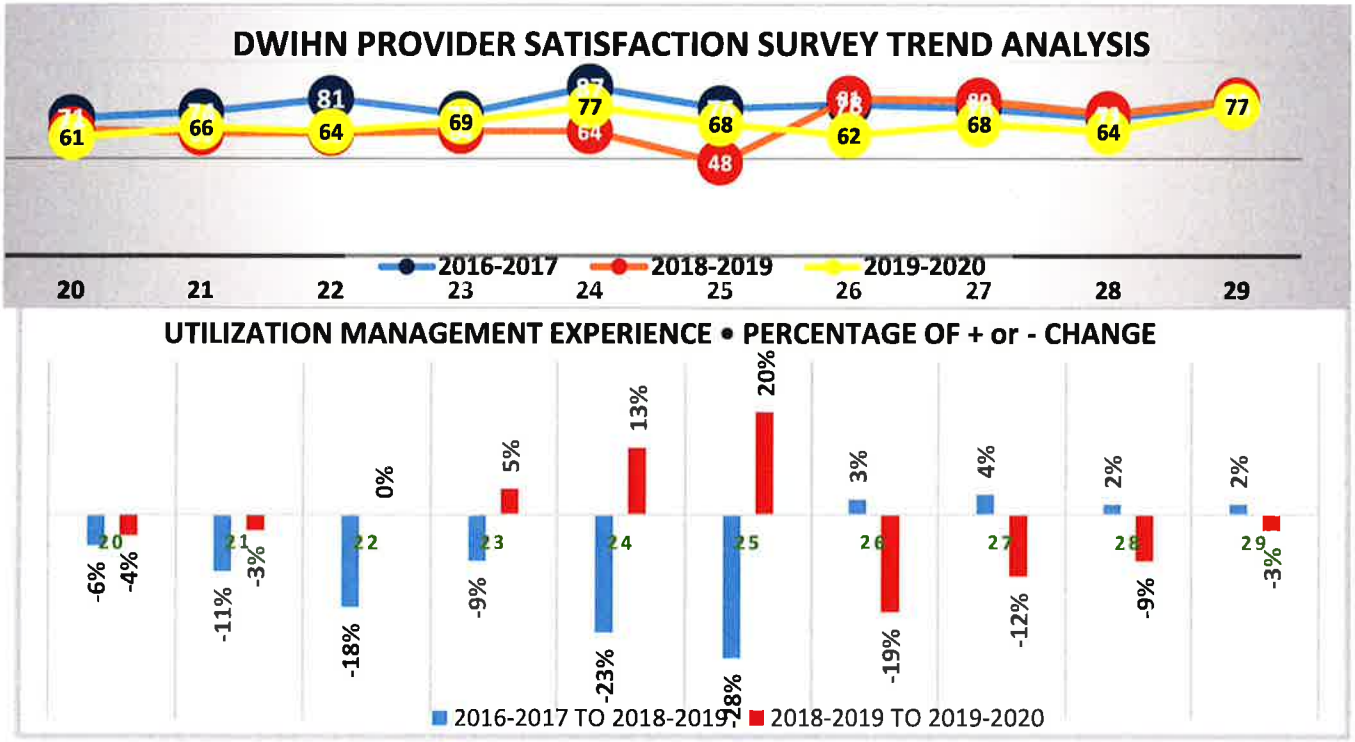
QUESTION	2016-2017 %Satisfaction	2018-2019 %Satisfaction	Rate of Change	2019-2020 %Satisfaction	Rate of Change
26. Access to knowledgeable DWIHN Utilization Management staff.	78%	81%	+3%	62%	-19%
27. Procedures for obtaining pre-certification/referral/authorization information.	76%	80%	+4%	68%	-12%
28. 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

RFP/RFQ WORK PLAN QUESTIONNAIRE

Departments are required to submit a Work Plan to the Detroit Wayne Integrated Health Network Board ("Board") for review **prior** to the issuance of a competitive solicitation (i.e. request for proposals, request for qualifications etc.) for the procurement of services that exceed a cumulative contract amount of $250,000.

Instructions: Please fill out completely for Board approval. If needed you may attach additional documentation.

Request for Proposals/Qualifications for the procurement of services for: Applied Behavior Analysis (ABA) Services

Anticipated Budget Amount: Approximately $60 million

Proposed Contract Term: 10/1/21 through 9/30/22 with option for renewal

Type of Program: ☐ **New** ☒ **Continuation**

Questions:

1. Statement of Need: Please summarize the purpose of the procurement including the technical and contractual history of the services. Applied Behavior Analysis (ABA) services have 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. Therefore, there is a need to procure these services to ensure Detroit Wayne Integrated Health Network (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.

   If applicable, please reference the federal or requirements. ABA services provided must adhere to best practice standards and established interventions for Autism Spectrum Disorder (ASD). Interventions that are identified as "Established Treatments" through the National Standards Project (NSP) or other ABA "established treatments" that focus on teaching specific adaptive skills.

2. Proposed Scope of Work: Provide a description of the services being procured. Applied Behavior Analysis (ABA) intervention for autism is to be customized to each consumer's skills, needs, interests, preferences, and family situation. ABA services are to be provided to consumers diagnosed with Autism Spectrum Disorder (ASD) when medically necessary, in the least restrictive environment where the ultimate goal of treatment is to focus on improving core deficits in communication, social interaction, or restricted behaviors; all of which will impact fundamental

deficits and help consumer develop greater functional skills and independence. The behavioral intervention should be provided at an appropriate level of intensity in an appropriate setting(s) for an appropriate period of time, depending on the needs of the consumer and their family within their community. Clinical determinations of service intensity, setting(s), and duration are to be designed to facilitate the consumer's goal attainment. These supports may serve to reinforce skills or lessons taught in school, therapy or other settings, but are not intended to supplant services provided in school or other settings or to be provided when the consumer would typically be in school but for the parent's choice to home-school the consumer or parent's choice to decline school supports. ABA service providers are required to establish a system that ensures that services can be provided with no disruption to the consumer's scheduled school day. ABA providers must coordinate with schools to ensure collaborative care is provided that will result in the best outcomes for the child, this may include attendance in school meetings and including school staff in provider meetings, etc. The provider should be skilled in implementing person-centered planning processes, which will include coordinating with other service provider entities, as well as coordinating with available community and natural supports. Provider should be in contact with Case Manager/Supports Coordinator on a minimum of monthly basis to ensure service plan is accurate to meet current needs of family and collaborative treatment team is established. ABA Plan updates on goals, objectives, progress and changes to amount/scope/duration/frequency must be communicated to the Individual Plan of Service (IPOS) case holder prior to the completion of the required 90-Day IPOS Review by the CRSP.

3. Budget and Funding: How was the budget estimate(s) derived? Review of previous funding for claims regarding services delivered.

4. Impact: What is/are the potential impact(s) of the procurement on Consumers and current Authority operations? Ensure children and youth who need ABA services, are receiving them and they are evenly distributed throughout Wayne County. This would give children and youth an opportunity to select a provider that meets their needs. Another impact could be if a current provider of ABA services is not selected, then a consumer would have to change providers.

5. Metrics: How will the success or failure of the vendor be measured? ABA Direct Services and Supervision must be provided at a rate of at least 75%, but not more than 125% of amount, scope, duration, and frequency identified and agreed upon in Individual Plan of Service (IPOS) per fiscal year quarter. Delivered at least 10% of ABA Direct Deliver on a monthly basis.

6. Public Hearings: Is there a need for public hearings to obtain Consumer and/or Provider input?
   ☐ **Yes** ☒ **No**

   If yes, what are the proposed dates for the hearings? Click here to enter text.

7. Local Community Impact: What is/are the positive or negative impacts of the procurement on existing local businesses? It will give an opportunity for providers to evenly be distributed throughout Wayne County. It will give the opportunity to publish DWIHN rates so providers are informed if this a service their organization can provide. Smaller organizations may close or may not be interested in providing the services if they determine the rates are not sustainable for their organization.

   Describe the potential for new local employment opportunities? If new organizations are selected, then there is a potential for employment opportunities.

8. Was a Request for Information (RFI) previously requested for these services? ☐ **Yes** ☒ **No**
   If yes, when? _____

Work Plan Submission Information and Board Approval:

Work Plan Submitted to Committee (Finance / Program): **Click here to enter text.**

Work Plan Submitted to Full Board on: **Click here to enter text.**

Work Plan Approved by Full Board on: **Click here to enter text.**

Board Action Taken:

☐ Approved

☐ Denied

Signature: _____ Date: _____
Board Liaison

CHIEF CLINICAL OFFICER'S EXECUTIVE SUMMARY - Program Compliance Committee Meeting
Wednesday, January 13, 2021

During the months of November and December, clinical operations continued to focus on continuity of services and supports during the COVID-19 pandemic. The following programs have been implemented and continue to operate with periodic monitoring by DWIHN staff.

COVID-19 Response Plan includes maintaining and creating an infrastructure to support a holistic care delivery system, with access to a full array of services. Planning will continue for COVID-19 to ensure access, placement and specialized programs for individuals served by DWIHN.

COVID-19 & INPATIENT PSYCHIATRIC HOSPITALIZATION

	# of Inpatient Hospitalizations
October 20	635
November 20	**704**
December 20	**613**

Inpatient Hospital Admission Authorization data as of 1/31/2021

Hospitalizations data showed an increase in admissions for the month of November by approximately 11%, but then a decrease in December by 13%. There were 6 reported Cases of COVID-19- Inpatient in November and an additional 6 reported cases of COVID-19 Inpatient in December.

COVID-19 INTENSIVE CRISIS STABILIZATION SERVICES - At the request DWIHN and due to the shortage of Mental Health Resources, particularly, crisis services, MDHHS granted provisional approval of the Team Wellness Center (TWC) application to perform Intensive Crisis Stabilization Services. Intensive Crisis Stabilization Services are structured treatment and support activities provided by a multidisciplinary team and designed to provide a short-term alternative to inpatient psychiatric services. Services may be used to avert a psychiatric admission or to shorten the length of an inpatient stay when clinically indicated. We continue to see an increase in both hospitalizations and crisis services within the last month.

Crisis Stabilization Service Provider	Services	Capacity	November 2020- # Served	December 2020- # Served
Community Outreach for Psychiatric Emergencies (COPE)	**Intensive Crisis Stabilization Services (MDHHS Approved)**	9	**212** **(Oct. report- 210)**	**219**
Team Wellness Center (TWC)	**Intensive Crisis Stabilization Services (MDHHS Approved)**	18	**34** **(Oct. report- 60)**	**57**

*There was a 10% decrease in crisis stabilization services in November, followed by a subsequent increase of 12% in Dec. (comparable to November rates).

COVID-19 PRE-PLACEMENT HOUSING - Pre-Placement Housing provides Detroit Wayne Integrated Health (DWIHN) consumers with immediate and comprehensive housing and supportive services to individuals who meet DWIHN admission criteria and eligibility. Pre-Placement Housing provides funding to residential providers contracted to provide short-term housing for a maximum stay of 14- days, meals, transportation and supportive services that promote stable housing and increase self-sufficiency. Due to the COVID-19 emergency, DWIHN Credentialing Department provisionally impaneled the following residential providers, to provide services for those persons identified as COVID-19 positive or symptomatic (mild to moderate).

Provider	Services	# Beds	Nov. 2020- # Served	Dec. 2020 - # Served
Detroit Family Homes	Licensed Residential Home- Adults	4	5	6
Novis-Romulus	Licensed Residential Home- Adults	3	1	11
Kinloch	Licensed Residential Home- Adults	3	0	0
Detroit Family Home- Boston	Licensed Residential Home- Adults	6	2	3

Residential Department Report of COVID-19 Impact:

Total # of COVID-19+ Cases in Residential Placement	Cumulative (Dates 3/30/20 to 10/31/2020)	Cumulative (Dates 3/30/20 to 12/31/20
	169	221
# of Deaths Reported	34	35

COVID -19 RECOVERY HOUSING/RECOVERY SUPPORT SERVICES

These individuals must be receiving outpatient services from a licensed SUD provider in DWIHN's network via telehealth or telephone communications. The providers may provide up to 14 days for this specific recovery housing service for individuals who are exhibiting COVID-19 symptoms and/or tested for COVID-19 and positive.

COVID-19 Recovery Homes Utilization Update

Provider	# Beds	# Served- November	# Served- December
Quality Behavioral Health (QBH)	36	9 (Oct- 7)	13
Detroit Rescue Mission Ministries (DRMM)	86	8 (Oct- 2)	9

COVID -19 URGENT BEHAVIORAL HEALTH URGENT CARE SITES

Effective April 3, 2020, providers listed below began offering Urgent Behavioral Health Care Service. The available services include Same-Day Access Services for assessment/intake, crisis services for existing DWIHN members, psychiatric evaluations, medication reviews, crisis stabilization, Peer Support Specialists, nursing assessments, medication injections, and non-ER transport.

Provider	Population	Hours of Operations	# Served November 2020	# Served December 2020
Community Care Services	Children ages 6-17 Adults ages 18 & older	Mon. -Fri. 8:30am – 6:00pm	**9 Adults** (7 in October)	**10 adults**
Northeast Integrated Health	Adults ages 18 & older	Mon.- Fri.9am – 9pm Saturdays 9am- 1pm	**10 Adults** (18 in October)	*
The Children's Center	Children SED ages 6-17	Monday thru Friday 8:00am – 8:00pm	**15 Youth** (15 in October)	**15 Youth** (no change)

*Data not available at time of report

COVID-19 OPERATIONAL Plans

Michigan COVID-19 Cases Increase: January 6, 2020 update: The total number of confirmed COVID-19 cases in Michigan is 508,736 with 12,918 deaths. Wayne County is reported to have 56,346 confirmed cases and 1,805 deaths, Detroit is listed with 26,364 confirmed cases with 1,708 deaths reported. (Source: www.michigan.gov/Coronavirus)

Michigan COVID-19 Updates:

More than 140,000 of Moderna and Pfizer COVID-19 vaccines have been administered to health care workers (8,000 of those doses went to nursing home residents).

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 1A: Paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials and are unable to work from home as well as residents in long term care facilities.
- Phase 1B: Persons 75 years of age or older and frontline essential workers in critical infrastructure.
- Phase 1C (Group A): Person 65- 74 years of age and pre-k teachers & childcare providers
- Phase 1C (Group B): Individuals 16 years of age or older at high risk of severe illness due to COVID-19 infection and some other essential workers whose position impacts life, safety and protection during the COVID-19 response.
- Phase 2: Individuals 16 years of age or older

CHIEF CLINICAL OFFICER'S REPORT
Program Compliance Committee Meeting
Wednesday, January 13, 2021

ACCESS AND CRISIS SERVICES – Director, Jacquelyn Davis

Access

The Access Center (Wellplace) services are currently being transitioned to be performed by DWIHN. Offers have been made and staff are scheduled to begin working the first week in January. The new Director started December 14, 2020.

Access Center Call Volume for the month:

Month	Total Call Volume	Clinical Eligibility total	SUD Eligibility total	Crisis Calls	Children's Inpatient Screening
December	16,239	3342	1328	1209	164

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Month	RFS	Unique consumer	Inpatient admits	% Admitted	# Diverted	% Diverted	Crisis Stab Cases
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- There was a total of 15 cases served The Children's Center- Crisis Center. The same as last month.

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- The Crisis Stabilization Team provided services to 121 cases, eleven cases more than reported last month.

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COMMUNITY/LAW ENFORCEMENT LIAISON REPORT

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Complex Case Management

The Annual Population Assessment and Analysis of Complex Case Management (CCM), and the Annual Review and Evaluation of CCM program were completed this month. Findings from both documents will be presented to the Improving Practices Leadership Team committee in December and the Quality Improvement Steering Committee in January. There are currently 13 active CCM cases. 2 new CCM cases were opened in November and there are 2 pending cases. 3 CCM cases were closed in November, all due to the members achieving their Plan of Care goals. As a means of proactively identifying members for CCM services, IHC staff engaged in outreach calls to 47 additional members to offer CCM services. IHC staff spoke with 10 members regarding receiving CCM services, but the members declined CCM services. Information regarding CCM services was also provided to staff at an adult foster care home. Care Coordination services were provided to 20 additional members in November who either declined or did not meet eligibility for CCM services.

MANAGED CARE OPERATIONS – Director, June White

MCO DEVELOPMENT MISSION:

As we start the new fiscal year, we are striving to become a major competitor with other Health Plan Agencies by creating an effective and efficient provider network of services that enhances the quality of life for all of our consumers.

Although there have been some challenges with the COVID-19 pandemic in FY19-20 we strive to provide continuous support to the network through training, webinars and emailing providers to ensure compliance with state and federal regulations.

Manage Care Operations:

COVID- 19 continues to be the center of the concerns with providers, however some have been able to make changes to the way they operate for the best interest of their staff and our members. As we open this new year, with 1 site closing.

Fiscal Year 20/21 Closure Summary: The summary Includes licensed and unlicensed homes

Downsized / Closure Summary by Provider Type

Provider T	Count of Providers
Outpatient	4
(blank)	
Residential	10
Grand Total	**14**

Downsized/closure summary by closure Type

Closure Type	Count of Provi
(blank)	
Contract Non- renewal	1
Closed line of Business an	2
Closed site(s)/home	8
Closed home/Provider Co	2
Temporary closure of ser	1
Grand Total	**14**

Downsized / Closure Summary by Closure Service Type

Service Type	Count of Providers
Licensed home/provider Personal Care and CLS services	7
Outpatient- supported employment due to low attendance C	1
(blank)	
Skill Building Services	1
Unlicensed home-- closing business	1
unlicensed homes --provider consolidating to another unlicer	1
Unlicensed home-- owner of the home is selling the house	1
IDD intake services	1
Autism Center Services	1
Grand Total	**14**

Year 2021	Count of Provider
1st Qtr	14

Although COVID-19 has affected our network at every level, we continue to receive new requests to become part of our network daily. To date we have over 105 providers in our pool that can be potential providers ranging from private clinicians, therapy services, outpatient and residential providers if approved through our credentialing process.

Our 11 contract managers continue to keep in touch with the provider network assisting with questions surrounding closing sites, general questions regarding PPE or assisting new providers becoming part of the network.

Provider and Practitioner Survey 2020

Detroit Wayne Integrated Health Network (DWIHN) Customer Service Department administered the DWIHN Annual Provider/Practitioner Survey for FY20 during the month of September 2020. The Provider Survey was distributed on 9/17/2020 and closed on 10/1/2020.

The Provider Survey was distributed to approximately 400 provider organizations and had a 50% more response rate than FY19, this is a success in itself and was accomplished by the team encouraging the providers to take the survey to promote change in our system where needed. The survey was comprised of 76 questions and covered all areas of DWIHN's operation inclusive of the following departments: Utilization Management, Claims, Residential, Managed Care Operations, Quality Management and Credentialing.

The survey is design to gain a sense on how well we are doing in terms of our individual practitioners and our provider organizations. The survey covered 5 components:

1. Measured DWIHN's effectiveness in meeting our contractual obligations to the providers
2. Measured our support of providers in meeting the needs of our consumers or members
3. Measure DWIHNs responsiveness to providers
4. Uncover gaps and/or deficiencies in DWIHN's operation
5. Identify opportunities for improvement and /or for corrective actions needed

The Practitioner Survey was be distributed on October 16th and will close on October 29th a complete analysis of both surveys will be completed late January 2021.

Provider /Training Meetings Held:

We have scheduled out for the rest of the calendar year and beyond the Outpatient and Residential Provider Meetings: October 2nd, November 13th, February 5th and March 19th (10am-12:30pm) Virtual meeting.
Meetings will be held every six weeks for Outpatient and Residential providers going forward.
All meetings going forward until further notice will be Virtual with the providers.

RESIDENTIAL SERVICES – Director, Shirley Hirsch

Please see attached October and November 2020 Reports

SUBSTANCE USE DISORDER – Director, Darlene Owens

Project or Goal 1: Naloxone Initiative

Status Overview: To support the Governor's initiative to respond to the increase in opioid overdose related deaths and to save lives in the Detroit Wayne County area. DWIHN began providing free training and distributing Naloxone kits March 22, 2016 to Wayne County law enforcement, the prevention and treatment networks, and finally the community. Naloxone blocks or reverses the effects of opioid medication, including extreme drowsiness, slowed breathing, or loss of consciousness.

Work in progress: DWIHN continues to train first responders, its providers, drug court staff, inmates/jail staff and the community on how to reverse an opioid overdose. DWIHN is increasing the number of providers that can train and distribute Naloxone in the community. DWIHN Naloxone trainings are conducted via zoom meetings or in person.

Planned Key Milestones, Activities and/or Events: DWIHN's Naloxone Initiative program has saved **674** lives since its inception. Again, the saved lives are under reported, especially during this time of COVID pandemic. The logs are coming in slowly from law enforcement and the community. DWIHN only reports those saves that we have documentation to support this initiative.

Project or Goal 2: Prescription and Heroin Efforts

Status Overview: DWIHN continues to provide telehealth services in various behavioral health settings.

Work in progress: DWIHN had its 5th annual Opioid/Heroin Summit held virtually November 12th and 13th with a host of excellent speakers. There were 285 in attendance daily. The summit was held from 8:00 am to noon each day.
DWIHNs providers continue to hold virtual meetings on opioids for the community. The mobile units have expanded services in Wayne County.

DWIHN Opioid Use Disorders (OUD) programs have increased services in emergency rooms in some hospital's others continue to be suspended due to COVID-19: drug courts, and jails/prisons. Due to the Governors order admittance into some schools have stopped.

Planned Key Milestones, Activities and/or Events:

DWIHN is in the process of receiving additional State Opioid Response (SOR) dollars to expand our Opioid efforts. The Mobile care units continue to serve Wayne County providing SUD and COVID-19 testing.

DWIHN prevention providers continue to use evidence-based practices (EBPs) prevention curriculum for students via remote.

Project or Goal 3: Synar Update

Status Overview: Synar education is still being provided via remote to tobacco retailers.

Work in progress: DWIHN had an Electronic Nicotine Delivery System (ENDS presentation for our prevention providers in November. It was a great presentation from MDHHS tobacco staff.

Planned Key Milestones, Activities and/or Events: The providers are continuing to train the community and tobacco retailers virtually and in person on not to sell tobacco products to underage youth. Providers are wearing their personal protection equipment (PPEs) and staying socially distant while conducting their presentations in person.

UTILIZATION MANAGEMENT – Director, John Pascaretti

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IHC staff continued to meet with each Integrated Care Organization (ICO) on a monthly basis as scheduled. IHC staff also attended and participated in the monthly MI Health Link Operations and sub-workgroup meetings that are facilitated by MDHHS. Integrated Care staff also continued to participate in quarterly Member Advisory groups for each ICO. IHC staff continued to assist in the response to the Hap CMS audit as well as participated in the annual audits from ICOs Molina and AmeriHealth. 292 requests for Level II referrals were received in November, and of those referrals, behavioral health care was coordinated with the ICO for 36 of the members thus far and 77 of the referrals are still in process. Transition of Care Coordination services was provided to 38 MI Health Link members in November and other Care Coordination activities were completed for 20 additional members. IHC staff also completed 10 LOCUS assessments for Mild to Moderate MI Health Link members in November. IHC staff participated in two Integrated Care Team meetings with two ICOs.

Complex Case Management

The Annual Population Assessment and Analysis of Complex Case Management (CCM), and the Annual Review and Evaluation of CCM program were completed this month. Findings from both documents will be presented to the Improving Practices Leadership Team committee in December and the Quality Improvement Steering Committee in January. There are currently 13 active CCM cases. 2 new CCM cases were opened in November and there are 2 pending cases. 3 CCM cases were closed in November, all due to the members achieving their Plan of Care goals. As a means of proactively identifying members for CCM services, IHC staff engaged in outreach calls to 47 additional members to offer CCM services. IHC staff spoke with 10 members regarding receiving CCM services, but the members declined CCM services. Information regarding CCM services was also provided to staff at an adult foster care home. Care Coordination services were provided to 20 additional members in November who either declined or did not meet eligibility for CCM services.

MANAGED CARE OPERATIONS – Director, June White

MCO DEVELOPMENT MISSION:

As we start the new fiscal year, we are striving to become a major competitor with other Health Plan Agencies by creating an effective and efficient provider network of services that enhances the quality of life for all of our consumers.

Although there have been some challenges with the COVID-19 pandemic in FY19-20 we strive to provide continuous support to the network through training, webinars and emailing providers to ensure compliance with state and federal regulations.

Manage Care Operations:

COVID- 19 continues to be the center of the concerns with providers, however some have been able to make changes to the way they operate for the best interest of their staff and our members. As we open this new year, with 1 site closing.

Fiscal Year 20/21 Closure Summary: The summary Includes licensed and unlicensed homes

Downsized / Closure Summary by Provider Type

Provider T	Count of Providers
Outpatient	4
(blank)	
Residential	10
Grand Total	**14**

Downsized/closure summary by closure Type

Closure Type	Count of Provi
(blank)	
Contract Non- renewal	1
Closed line of Business an	2
Closed site(s)/home	8
Closed home/Provider Co	2
Temporary closure of ser	1
Grand Total	**14**

Downsized / Closure Summary by Closure Service Type

Service Type	Count of Providers
Licensed home/provider Personal Care and CLS services	7
Outpatient- supported employment due to low attendance C	1
(blank)	
Skill Building Services	1
Unlicensed home-- closing business	1
unlicensed homes --provider consolidating to another unlicer	1
Unlicensed home-- owner of the home is selling the house	1
IDD intake services	1
Autism Center Services	1
Grand Total	**14**

Year 2021	Count of Provider
1st Qtr	14

Although COVID-19 has affected our network at every level, we continue to receive new requests to become part of our network daily. To date we have over 105 providers in our pool that can be potential providers ranging from private clinicians, therapy services, outpatient and residential providers if approved through our credentialing process.

Our 11 contract managers continue to keep in touch with the provider network assisting with questions surrounding closing sites, general questions regarding PPE or assisting new providers becoming part of the network.

Provider and Practitioner Survey 2020

Detroit Wayne Integrated Health Network (DWIHN) Customer Service Department administered the DWIHN Annual Provider/Practitioner Survey for FY20 during the month of September 2020. The Provider Survey was distributed on 9/17/2020 and closed on 10/1/2020.

The Provider Survey was distributed to approximately 400 provider organizations and had a 50% more response rate than FY19, this is a success in itself and was accomplished by the team encouraging the providers to take the survey to promote change in our system where needed. The survey was comprised of 76 questions and covered all areas of DWIHN's operation inclusive of the following departments: Utilization Management, Claims, Residential, Managed Care Operations, Quality Management and Credentialing.

The survey is design to gain a sense on how well we are doing in terms of our individual practitioners and our provider organizations. The survey covered 5 components:

1. Measured DWIHN's effectiveness in meeting our contractual obligations to the providers
2. Measured our support of providers in meeting the needs of our consumers or members
3. Measure DWIHNs responsiveness to providers
4. Uncover gaps and/or deficiencies in DWIHN's operation
5. Identify opportunities for improvement and /or for corrective actions needed

The Practitioner Survey was be distributed on October 16th and will close on October 29th a complete analysis of both surveys will be completed late January 2021.

Provider /Training Meetings Held:

We have scheduled out for the rest of the calendar year and beyond the Outpatient and Residential Provider Meetings: October 2nd, November 13th, February 5th and March 19th (10am-12:30pm) Virtual meeting.
Meetings will be held every six weeks for Outpatient and Residential providers going forward.
All meetings going forward until further notice will be Virtual with the providers.

RESIDENTIAL SERVICES – Director, Shirley Hirsch

Please see attached October and November 2020 Reports

SUBSTANCE USE DISORDER – Director, Darlene Owens

Project or Goal 1: Naloxone Initiative

Status Overview: To support the Governor's initiative to respond to the increase in opioid overdose related deaths and to save lives in the Detroit Wayne County area. DWIHN began providing free training and distributing Naloxone kits March 22, 2016 to Wayne County law enforcement, the prevention and treatment networks, and finally the community. Naloxone blocks or reverses the effects of opioid medication, including extreme drowsiness, slowed breathing, or loss of consciousness.

Work in progress: DWIHN continues to train first responders, its providers, drug court staff, inmates/jail staff and the community on how to reverse an opioid overdose. DWIHN is increasing the number of providers that can train and distribute Naloxone in the community. DWIHN Naloxone trainings are conducted via zoom meetings or in person.

Planned Key Milestones, Activities and/or Events: DWIHN's Naloxone Initiative program has saved **674** lives since its inception. Again, the saved lives are under reported, especially during this time of COVID pandemic. The logs are coming in slowly from law enforcement and the community. DWIHN only reports those saves that we have documentation to support this initiative.

Project or Goal 2: Prescription and Heroin Efforts

Status Overview: DWIHN continues to provide telehealth services in various behavioral health settings.

Work in progress: DWIHN had its 5th annual Opioid/Heroin Summit held virtually November 12th and 13th with a host of excellent speakers. There were 285 in attendance daily. The summit was held from 8:00 am to noon each day.
DWIHNs providers continue to hold virtual meetings on opioids for the community. The mobile units have expanded services in Wayne County.

DWIHN Opioid Use Disorders (OUD) programs have increased services in emergency rooms in some hospital's others continue to be suspended due to COVID-19: drug courts, and jails/prisons. Due to the Governors order admittance into some schools have stopped.

Planned Key Milestones, Activities and/or Events:

DWIHN is in the process of receiving additional State Opioid Response (SOR) dollars to expand our Opioid efforts. The Mobile care units continue to serve Wayne County providing SUD and COVID-19 testing.

DWIHN prevention providers continue to use evidence-based practices (EBPs) prevention curriculum for students via remote.

Project or Goal 3: Synar Update

Status Overview: Synar education is still being provided via remote to tobacco retailers.

Work in progress: DWIHN had an Electronic Nicotine Delivery System (ENDS presentation for our prevention providers in November. It was a great presentation from MDHHS tobacco staff.

Planned Key Milestones, Activities and/or Events: The providers are continuing to train the community and tobacco retailers virtually and in person on not to sell tobacco products to underage youth. Providers are wearing their personal protection equipment (PPEs) and staying socially distant while conducting their presentations in person.

UTILIZATION MANAGEMENT – Director, John Pascaretti

Please see attached October and November 2020 Reports

Children's Initiatives Monthly Report – November 2020

SERIOUS EMOTIONAL DISTURBANCE WAIVER (SEDW)/CHILDREN'S WAIVER PROGRAM (CWP) NUMBERS SERVED - Please see tables below:

Serious Emotional Disturbance Waiver Cases – October 2020	
Cases Served to Date (FY20-21)	53
Active Cases	53
New Referrals	7
Renewals/Approved	4
Terminated Cases	1
Transferred to Another County	0

Detroit Wayne Integrated Health Network (DWIHN) has committed to serve 65 children and youth in the Serious Emotional Disturbance Wavier (SEDW) for FY20-21. During the month of November 2020, DWIHN has served 53 cases and currently has 53 active cases. There were seven (7) new referrals and four (4) cases were approved/renewed by the Michigan Department of Health and Human Services (MDHHS). No cases were terminated during this month.

Children's Waiver Program Cases – November 2020	
Active Cases	35
Agency Breakdown	
Community Living Services	29
Neighborhood Services Organization	3
The Guidance Center	3

During the month of November, the Children's Waiver Program remained the same; 35 children on the waiver. There were no prescreens submitted to DWIHN for review in November.

WORKFORCE DEVELOPMENT – The Children's Initiatives Department in collaboration with the Workforce Development Department hosted the following event during the month of October:

- This month, the Children's Mental Health Lecture Series featured a training titled "Working with Young Children and Parents Using Telehealth: What Does It Look Like?" During this event, Dr. Jennifer DeSchryver, a licensed Clinical Psychologist and Infant Mental Health Mentor, provided a framework for how to assess the appropriate use of Telehealth for young clients and their parents as well as presented ideas for how to engage them in the therapeutic process. Additionally, the discussion provided an invitation for social workers to reflect on their own attitudes towards Telehealth and the importance of self-care. There were 71 participants present.

Additionally, the first Quarterly Peer-to-Peer Training Series event took place on November 12th, 2020. The training focused on working with Transition Age Youth and was a panel discussion providing insight into different engagement techniques, advocacy models and

ancillary services that can be provided to transition age youth to help them be successful as they move into adulthood. There were 20 participants present.

There were three CAFAS/PECFAS trainings in November. The first was a CAFAS Initial Training, in which all 19 participants successful became reliable raters, completing the course. The second training was a CAFAS Booster with 18 participants who all renewed their CAFAS certification by passing the course. The third training was a PECFAS Initial Training with 12 participants who passed to become reliable raters.

SCHOOL SUCCESS INITIATIVE: During the month of November, the Children's Initiatives Team sent out a survey to all the Children's Community Mental Health Providers to determine what services are provided in the schools beyond the School Success Initiative. The Children's Redesign Committee has developed curriculum for the 4 risk areas and are developing a plan to implement it to the system. Additional, DWIHN has been working with Wayne RESA and Detroit Public Schools Community District regarding implementation of the curriculum. Lastly, the Children's Initiatives Director is collaborating with the Chief Information Officer on data collection for this project.

YOUTH UNITED/YOUTH MOVE DETROIT (SYSTEM OF CARE BLOCK GRANT): This month, Youth United's Central Region continues hosting their Youth MOVE Detroit Facebook live video streams. Youth MOVE Detroit went live on November 25th, 2020. This month Youth MOVE Detroit brought Crystal Hepburn BSN, RN, CCM the Team Lead for Children's Special Health Care Services at the Detroit Health Department on as a guest. The guest speaker, shared with the viewers more information about COVID and why it is important to continue to maintain the public health measures that DHD, MDHHS and CDC have recommended. There were approximately 30 viewers for the live session.

ANNUAL REPORT TO THE COMMUNITY: Connection's Wayne County System of Care hosted their Annual Report to the Community virtually on December 3rd virtually via the BlueJeans platform. The event showcased the accomplishments of the Children's System of Care along with acknowledging the key stakeholder, caregiver, father, and youth via an award. The Keynote Speaker was Dr. Iris Taylor, DWIHN Board Member and DPSCD Board President, who spoke on the needs of our children in the current state we are living in. Also, special speaker, Jasmine Boatwright, spoke on her personal experience and how she continues to overcome challenges in her life. This year's theme is "Grow through what you go through." There were 100 attendees.

INTELLECTUAL/DEVELOPMENTAL DISABILITIES (I/DD) SERVICES: This month, the Children's Initiatives Department collaborated with the Michigan Developmental Disabilities Council and Wayne RESA to co-host a series of virtual trainings to inform educators and school administrators about alternatives to guardianship for children and youth diagnosed with an I/DD. This series is focused on supported decision making and various topics that parents and educators historically are concerned about when it comes to youth turning 18 and making

decisions for themselves. The proposal at this time is to have a tri-county collaboration with Wayne, Oakland, and Macomb counties to present this information virtually via Zoom and Facebook Live. Michigan Developmental Disabilities Council will present this information on their platform allowing for greater attendance. The counties will each advertise and encourage individuals to attend. Although a specific date has yet to be set, the first of these presentations is tentatively scheduled to be held in January 2021.

Children's Initiatives Monthly Report – December 2020

SERIOUS EMOTIONAL DISTURBANCE WAIVER (SEDW)/CHILDREN'S WAIVER PROGRAM (CWP) NUMBERS SERVED - Please see tables below:

Serious Emotional Disturbance Waiver Cases – December 2020	
Cases Served to Date (FY20-21)	57
Active Cases	51
New Referrals	6
Renewals/Approved	9
Terminated Cases	2
Transferred to Another County	2

Detroit Wayne Integrated Health Network (DWIHN) has committed to serve 65 children and youth in the Serious Emotional Disturbance Wavier (SEDW) for FY20-21. During the month of December 2020, DWIHN has served 57 cases and currently has 51 active cases. There were six (6) new referrals and nine (9) cases were approved/renewed by the Michigan Department of Health and Human Services (MDHHS). No cases were terminated during this month.

Children's Waiver Program Cases – December 2020	
Active Cases	37
Agency Breakdown	
Community Living Services	29
Neighborhood Services Organization	3
The Guidance Center	5

During the month of November, the Children's Waiver Program remained the same; 37 children on the waiver. There was one (1) prescreen submitted to DWIHN for review in December.

WORKFORCE DEVELOPMENT – The Children's Initiatives Department in collaboration with the Workforce Development Department hosted the following event during the month of December:

The first Quarterly Leadership Training event took place on December 10th, 2020. The learning event discussed the needs for effective feedback, evidenced based models for feedback delivery and management, and the use of tools to streamline and analyze both quantitative and qualitative feedback. There were 22 participants present.

There were two Preschool and Early Childhood Functional Assessment Scale (PECFAS)/Child and Adolescent Functional Assessment Scale (CAFAS) Trainings in December. The first was a PECFAS Booster December 7, 2020 with 23 in attendance and all passing to renew their rater reliability for two more years. The second was a CAFAS booster, later that week on December 9, 2020 with 18 participants present and all passing. Also, four (4) staff from within the DWIHN provider network attended a PECFAS Train the Trainer this month and are now certified to provide PECFAS trainings to the clinical staff.

Children's Initiatives Monthly Report – December 2020

SCHOOL SUCCESS INITIATIVE: To date, the Children's Redesign Task Force has completed the established Phase 1 of the project which focuses on Increasing Accessibility and Prevention Services. The Task Force has finalized the training modules and accompanying syllabi. To ensure that the Michigan Model for Health is reflective in the curriculum, Detroit Wayne Integrated Health Network (DWHIN) is in the process of purchasing the material for the community mental health agencies participating in the School Success Initiative. In addition, once the purchase is completed. Training will be scheduled with Wayne RESA for the providers and staff who directly participate in the School Success Initiative program.

A letter communicating DWIHN services was distributed to district superintendents by Dr. Daveda Colbert Wayne RESA's Associate Superintendent. School representatives have started reaching out to schedule meetings to gain more insight to the School Success Initiative's purpose, goals, and services. In total, nine (9) providers are interested in expand services in a variety of ways within Detroit Public Schools Community District. These agencies are: Starfish Family Services, Southwest Counseling Solutions, Northeast Integrated Health, Arab-American Chaldean Council, Team Wellness, Black Family Development Inc., Development Centers, ACCESS, and Assured Family Services.

YOUTH UNITED/YOUTH MOVE DETROIT (SYSTEM OF CARE BLOCK GRANT): Detroit Wayne Integrated Health Network collaborated with Detroit Public Schools Community District to host a Mental Health Town Hall on December 17, 2020. During the event, a 60 second recording was played which featured Destinee Dale, a Youth United East Region Youth Advocate, Destinee Dale. Ms. Dale described her self-care for managing stress during the COVID pandemic.

TRANSITION AGE YOUTH SERVICES: Youth receive Transition Age Youth Services through the Cornerstone Program. This allows youth to successfully transition out of Children's Services to their next level of care.

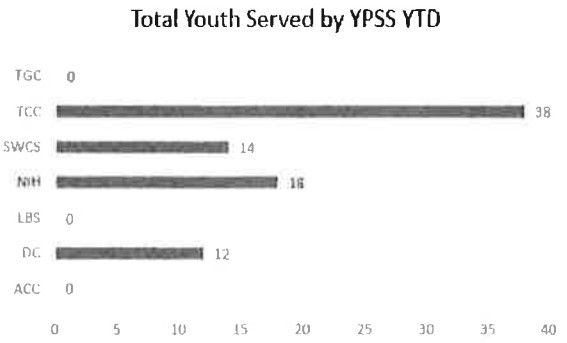
The Annual Cornerstone and Youth Peer Support Services (YPSS) report for FY 2019-2020 was finalized this month, with reporting from seven (7) providers within the network that either have an active Cornerstone program or YPSS. Some highlights from the report are shared below:

Children's Initiatives Monthly Report – December 2020

Youth Peer Support Services:

- 82 youth received Youth Peer Support Services

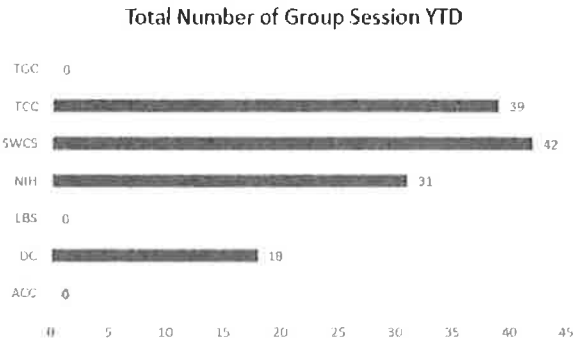
Total number of youth served by YPSS Year to Date:



Cornerstone:

- 130 Cornerstone group sessions held across providers

Total number of group sessions Year to Date:



Additionally, Detroit Wayne Integrated Health Network's Children's Initiatives Team hosted a virtual Wayne County Youth Peer Support Roundtable event on December 16, 2020 with four of the YPSS from across the provider network present. The roundtable focused on effectively creating boundaries as a YPSS, importance of self-care and self-advocacy in the role of a YPSS and plans for the next YPSS event during which a guest speaker from Youth MOVE Detroit (topic/presenter chosen by the group) to speak on engaging youth as well as to provide resources that the YPSS can incorporate into their work with youth.

+EXECUTIVE SUMMARY REPORT

Reporting Department:
Clinical Practice Improvement

For the Month of November, 2020

Evidence Based Supported Employment

- DWIHN's program manager continues to provide support to EBSE providers through technical assistance to help individuals living with a behavioral health condition in their effort to achieve meaningful work in mainstream community-based jobs of their choosing. EBSE providers report that although many of their employment staff have returned back to providing face to face services in the community, there are still some staff members who continue to fear for their health and safety as the pandemic continues. All indicate despite the recent spike in Covid-19 cases their EBSE staff remains committed to the needs of individuals served while keeping them safe through following the Center for Disease Control (CDC) guidelines by wearing a mask and social distancing during in-person contacts.
- According to Team Wellness Center and Central City Integrated Health, their EBSE program continues to struggle with filling vacant employment specialist positions. They report that some candidates have expressed that they still have concerns for their health and safety in the community. All providers shared as a positive unintended consequence of the pandemic, that individuals served who were often overlooked in the past are now receiving multiple job offers and perceived by employers as highly valued employees who are both hardworking and reliable.
- EBSE program manager also worked with Central City Integrated Health to successfully submit FY20-21 claims for EBSE services through the coordinated effort of DWIHN's Claims Department, Procedure Code Workgroup and authorization staff.
- An EBSE Supervisors meeting was held this reporting period. Agenda items of discussion: 1) Success Stories/Challenges, 2) MDHHS virtual training in FY20-21 for new employment staff and staff needing a refresher in Job Development and the EBSE/IPS Model, 3) Technical Assistance Requests- to address areas identified by provider needing improvement, 4) Scheduling of Monthly 30-minute Power Hour Meeting per provider- various areas of interest will be discussed, including program status, the IPS fidelity scale/anchors, as well as other concerns/issues.
- EBSE/IPS staff participated in the following training and job fairs: Dispelling Benefit to Work Myths Zoom Workshop (11/18/2020), Careers & the Disabled Virtual Job Fair (11/20/2020), Michigan Works Hiring Event (11/21/2020). Upcoming scheduled training: EBSE/IPS Job Development Virtual Training (December 3-22, 2020).

Dual Diagnosis Capability in Addiction Treatment (DDCAT)

- National Committee for Quality Assurance Performance Improvement Project (NCQA-PIP) – During the month of November, CPI clinical specialist investigated possible elements resulting in possible errors with the PHQ-9 at the initial intake appt with new members. The current data indicates that the completion rate of the PHQ-9 is between 71.8% to 74.6% for Quarter 4 FY19-20. CPI Clinical Specialist has been working to resolve the issue in error admission with IT. DWIHN contacted five agencies that reflected a 29% or greater rate of PHQ-9 completion to intake ratio during Q3. Those organization were:
    - Mariner's Inn
    - Quality Behavioral Health Medbury & Sterling Heights
    - SHAR House – Main
    - Southwest Solutions – Waterman
    - Team Wellness – Russell & East
- The five agencies represent 73% of the missing PHQ-9 screens at intake (500 of 680). CPI worked with 4 of the 5 organizations to identify irregularities. Ongoing problem solving will continue to occur until the data errors are resolved.
- DWIHN staff participated in MDHHS Co-occurring Leadership Committee meeting. The committee developed some initial framework to conduct fidelity visits and workforce training for FY 2021. All FY 2021 fidelity reviews and training will be virtual.
- A Person-Centered Planning module had been developed and placed on Improving MI Practices website
- Co-occurring Disorders (COD) College is set for June 16, 2021. Focus this year will be on contact level facilitation skills for practitioners working with individuals who have both a serious mental illness (SMI) and substance use disorders (SUD)

Project – WC Jail – IST – Probate Court – Returning Citizens

- The Returning Citizens meeting was held. The upcoming change of DWIHN absorbing the access function was discussed. Kelly George stated it will be a smooth transition and policies and procedures are being readied for the transfer of services.
- CCS reported success with its Med-drop program. Returning Citizens are being signed-up for it because it allows for autonomy and is helpful for anyone having issues with medication adherence.
- The fourth quarter review was held with the Wayne County Jail. The meeting was postponed due to a COVID outbreak amongst staff. Precautions were taken to ensure the health and safety of staff.

- The Jail received an increase in its per diem rate to $135 due to COVID-19. The Clinician is working on a revision of the Jail Bulletin to reflect the increase and change of the actual code to H2016.
- The Jail population is currently at 800 members; that number is down from 1800 in past years. Daily bookings average 35-40 persons. Although there would normally be 90 or more individuals on the in-patient unit, there are currently 72-74 individuals on average as of recent.
- Wellpath has hired a new director to replace Dr. Restum. Bridie Johnson will begin the end of November.
- The FY 19/20 contract has been signed and now needs to be approved by the Wayne County Commission. The FY 20/21 contract is still currently under review.
- Clinical Officer and CPI Clinical Specialist held a meeting to discuss and finalize with Dr. Rinnas and Dr. Pinals, providers allowing for video evaluations to be conducted at the provider site. The providers had previously agreed to do so for their own members.
- Until the Forensic Center has Connect 360 running, the Clinician will review the wait-list on a weekly basis to determine what members are in the DWIHN system.
- The IST meeting was held. There was discussion regarding community restoration. The group concluded that for it to actually work, there needs to be viable options. Caro Hospital is going to have regional IST Liaisons.

Project - Jail Diversion/ ACT Reviews/DDCAT Reviews

- Mental Health Court began the new fiscal year with the change that CCIH is not the primary provider for the court. CCIH will only continue to participate as the provider for any CCIH member who is a participant in the program.
- The court is discussing re-opening in January.
- All Wellbeing Services ACT review was completed. The review provided the opportunity for the team to build upon the recommendations made by DWIHN.
- A Jail Diversion meeting was held to discuss the transition and role of Wellplace regarding Returning Citizens; Jail Mental Health; and the Administrative Jail Release. All the programs use Wellplace to enroll persons involved in a criminal justice program.
- Processes are being finalized with Team; NIH; and CCIH for the Jail Diversion programs in the Programs of Homelessness and Co-Responder Teams.

- The Wayne County Domestic Violence Fatality Review Board is finishing it's 2020 case review and has chosen an in-depth and lengthy case for the upcoming year.

Assertive Community Treatment (ACT)

- CPI Monitored ACT program admissions and discharges of Lincoln Behavioral Services, Community Care Services, Northeast Integrated Health, Hegira, All Well Being Service, Central City Integrated Health, Development Centers, Team Wellness Center, and The Guidance Center including the appropriateness of level of care determinations and technical assistance ensure program eligibility requirements were met.
- CPI Conducted a fidelity review of Hegira and All Well Being Service. Where Hegira scored 89% and AWBS scored 75% out of 100%.
- On November 4 CPI conducted a follow up meeting with Med Drop where the current admission, discharges and referrals for LBS and CCS were discussed. Expected outcomes for December were discussed as well as any concerns.
- November 5 2020, CPI participated in COPE hospital liaison meeting. CPI also host monthly ACT forum with all 9 ACT providers. Topics discussed were, ACT fidelity reviews completed, Telehealth/ Telemedicine Consent, ACT on call list updated and sent to COPE, Pre-Admission Screenings (PARS), clinical summary/ disposition, and providers Transition plan for seeing members face to face.
- On November 4 and 18 and 25th, CPI participated in the Wellplace Transition meeting with crisis services as well as with an ACT delegation meeting with legal and Utilization management department.
- On November 5, CPI participated in the recidivism workshop with quality department.
- November 10, CPI participated in IPLT where topics discussed were revision of the Telemedicine Policy and Procedure.
- On November 13 CPI participated is a meeting hosted by the State regarding ACT providers, completion of ACT fidelity reviews, ACT providers current staff and member roster. It was noted that CPI will send all information requested by the State on Friday November 20, 2020.
- On November 19, CPI had a meeting with director at CCS regarding ACT fidelity review score and processed recommendations for improvement.

+EXECUTIVE SUMMARY REPORT

Reporting Department:
Clinical Practice Improvement
December 2020

Evidence-Based Supported Employment

- For the month of December, DWIHN's EBSE program manager provided support/guidance to providers delivering services to individuals diagnosed with a behavioral health condition in their recovery journey to obtain and maintain meaningful community-based employment. Providers indicated their staff continue to utilize telemedicine services to deliver EBSE services for individuals that express health and safety concerns. EBSE providers have reported some staff related challenges with delivering face to face services with members. DWIHN will continue to provide support to EBSE providers and support recommendations to eliminate barriers and increase safe delivery of services.

- Providers reported satisfaction in knowing that employers of members served are adhering to the CDC guidelines to ensure their members can safely perform their work duties in the workplace amid the pandemic. Some providers report an increased demand for EBSE services and are finding far fewer individuals who view the pandemic as a barrier to achieving their employment goals. However, some providers report their organizations to continue to struggle filling open Employment Specialist positions in their EBSE programs due to the pandemic, but remain hopeful this will be less of an issue in the upcoming new year as job seekers' confidence improves when the vaccine becomes available. Central City Integrated Health shared their EBSE program is currently utilizing case managers to fill the staffing gap in the short-term to avoid disruptions in service delivery.

- No reported provider billing issues this reporting period as claims submissions for EBSE services were successfully processed.

- MDHHS initiated the first of its virtual monthly technical assistance meetings facilitated by MIFAST team members and includes, DWIHN EBSE providers. The assigned MIFAST team member along with each DWIHN EBSE provider will review each of the (25) fidelity item anchors in-depth and provide support as needed. DWIHN EBSE program manager will offer support as well as needed.

- EBSE/IPS staff and DWIHN program manager participated in the following webinars/training: EBSE/IPS Job Development Virtual Training Series (December 3-22, 2020), Leveraging Protective Factors to Help Mitigate Racial Trauma in 2021 (December 3, 2020), Identifying and Treating Compassion Fatigue in Healthcare Professionals (December 4, 2020). Upcoming scheduled

training: IPS (EBSE)-An Introduction Virtual Training (January 19th & 26th, 2021), Dispelling Benefit to Work Myths (January 12 & 28, 2021)

CPI Policy Review

- Reviewed and revised draft DWIHN Integrated Biopsychosocial Assessment Procedure for its provider network's use as well as in preparation for DWIHN's NCQA site review for reaccreditation.

- DWIHN CPI staff assisted in revising the Self-Management Procedure for co-occurring disorder members as well as other services populations, informal support systems, system professionals, first responders, advocates, and staff.

Project – WC Jail – IST – Probate Court – Returning Citizens

- The Wayne County Steering Committee was held. COVID has affected programming in the prisons, and the ability to see parolees in-person. Parole offices will remain closed until March.
- Clinician attended the Procedure Work Code Group regarding the changes of the Jail Bulletin for the per diem code and increase in the per diem rate. Bulletin has been published on the DWIHN website.
- The clinician received the bond list from the Forensic Center. The list was reviewed, and the providers were contacted to inquire as to the feasibility of having a video evaluation at their location starting in January. The clinician suggested that those bonders whose record is closed in MHWIN should be re-evaluated for services. Monitoring of this list will continue ongoing to ensure proper linking a coordination of eligible members.

Project - Jail Diversion/ ACT Reviews/DDCAT Reviews

The Veterans Court will be graduating two participants. Judge Elizabeth Mullins has taken over the program from Judge Kandrevas who has retired.

- A status update meeting was held for the Detroit Wayne Co-Response teams, Northeast Integrated Health (NIH) and Team Wellness. Although still tentative, beginning January 11, Team will work in the 9th Precinct and Downtown Services. NIH will be at the 3rd and 12th Precincts. Detroit Police Department (DPD) will finalize these precinct assignments.
- Both providers were asked to be flexible with staff hours even though most issues occur during the day.
- Central City Integrated Health (CCIH) is piloting a program for homeless individuals with the Homeless Outreach Team (H.O.T.). Individuals can be taken to CCIH or their agency. H.O.T. should be on each provider referral list.
- Incompetent to Stand Trial (IST) Meeting: Judge Milton Mack reported that Assisted Outpatient Treatment (AOT) orders are being used with regularity. He also reported that the Wayne County Prosecutor's Office is more committed to AOT's and diversion.
- Judge Laura Mack stated that it would be better for misdemeanants to get an AOT instead of going to the Forensic Center. The Forensic Center is working

on out-patient competency restoration, using a liaison between the Forensic Center and CMH.

- The clinician reviewed and updated the Sequential Intercept Model.
- The Wayne County Diversion Council spent its monthly meeting reviewing the identified gaps and on-going programming of the Sequential Intercept Model. The outcomes from this analysis will be reported at the next meeting.

Assertive Community Treatment (ACT)

- CPI Monitored ACT program admissions and discharges of Lincoln Behavioral Services, Community Care Services, Northeast Integrated Health, Hegira, All Well Being Service, Central City Integrated Health, Development Centers, Team Wellness Center, and The Guidance Center including the appropriateness of the level of care determinations and technical assistance ensure program eligibility requirements were met.
- On December 1, 2020, CPI participated in Improving Practices Leadership Team (IPLT) to discuss policy updates as well as new policies and procedures.
- On December 1 and 3, CPI met with finance, Chief Clinical Officer to discuss MDHHS ACT requirements that were updated by MDHHS on 11/20/2020. CPI also met to discuss ACT Fidelity Reviews Recommendation.
- On December 2, CPI met with internal staff for Procedure Code Work Group Meeting and to discuss coding updates.
- On December 2, CPI met with internal staff to discuss Wellplace Transition and offered support on the transition of services for DWIHN members.
- On December 2, CPI met with Genoa Pharmacy via teams to discuss the outcome, barriers, strengths, and future goals. Please see the attached Genoa outcome measure report that will reflect March 2020- November 2020.
- December 3, CPI participated in the COPE hospital liaison meeting. CPI also hosts a monthly ACT forum with all 9 ACT providers. Topics discussed were, ACT fidelity reviews completed, Telehealth/ Telemedicine Consent, ACT on-call list updated and sent to COPE, Pre-Admission Screenings (PARS), clinical summary/ disposition, and providers Transition plan for seeing members face to face.
- CPI met with Med Drop pilot provider Community Care Service to confirm the process of providing ACT transition Readiness tool for the ACT Step Down/Med Drop program.

genoa healthcare

MED DROP™ Program
Program Outcome Report-Site Name: Wayne County (DWIHN)
Reporting Period: 3/1/20 to 11/30/20

Total # of Clients Served[1]	Ages 18-19	Ages 20-29	Ages 30-39	Ages 40-49	Ages 50-59	Ages 60-69	Ages 70+
22	12	2	2	6	4	4	2

[1]This includes current and discharged clients

Total # of Clients Served	# of Clients in Program < 1 Year	# of Clients in Program 1 Year to 2 Years	# of Clients in Program 2 Years to 3 Years	# of Clients in Program 3 Years to 4 Years	# of Clients in Program 4 Years to 5 Years	# of Clients in Program 5 Years to 6 Years
22	22	0	0	0	0	0
Average Length of Stay (LOS) per Category	99 days					

# of Clients who had a Psychiatric Hospital Admission within the 12 months prior to entering the Med Drop Program	# of Psychiatric Hospital Admissions by Clients who had a Psychiatric Hospital Admission within the 12 months prior to entering the Med Drop Program	# of Psychiatric Hospital Days used by Clients who had a Psychiatric Hospital Admission within the 12 months prior to entering the Med Drop Program
10 **(45% of the 22 clients served)**	25*	253* Cost = $219,921
# of Clients who had a Psychiatric Hospital Admission within the 12 months prior to entering the Med Drop Program AND had a Psychiatric Hospital Admission while in the Med Drop Program	**# of Psychiatric Hospital Admissions by Clients while in the Med Drop Program, who had a Psychiatric Hospital Admission within the 12 months prior to entering the Med Drop Program**	**# of Psychiatric Hospital Days used by Clients while in the Med Drop Program, who had a Psychiatric Hospital Admission within the 12 months prior to entering the Med Drop Program**
2	2	23 Cost = $12,425

*Outlier = 1 client had 14 prior admissions for 88 days

Individual Outcomes for Med Drop Participants:

- **80% reduction in the number of Med Drop clients admitted to a psychiatric hospital,** who had a psychiatric hospital admission within the 12 months prior to entering the Med Drop Program
- **92% reduction in psychiatric hospital admissions** for Med Drop clients who had a psychiatric hospital admission within the 12 months prior to entering the Med Drop Program
- **91% reduction in psychiatric hospital days** for Med Drop clients who utilized hospital days within 12 months prior to entering the Med Drop Program

94 % Reduction in Hospitalization costs - $219,921 to $12,425

# of Clients who had a Psychiatric Hospital Admission within the 12 months prior to entering the Med Drop Program	# of clients with 1 prior admissions	# of clients with 2 prior admissions	# of clients with 3 prior admissions	# of clients with 4 prior admissions	# of clients re-admitted within 30 days of discharge	# of clients re-admitted within 60 days of discharge	# of clients re-admitted within 90 days of discharge
10	8	0	1**	1***	2	2	1
# of Clients who had a Psychiatric Hospital Admission within the 12 months prior to entering the Med Drop Program AND had a Psychiatric Hospital Admission while in the Med Drop Program	**# of clients with 1 prior admission who were admitted while in the program**	**# of clients with 2 admissions who were admitted while in the program**	**# of clients with 3 admissions who were admitted while in the program**	**# of clients with 4 admissions who were admitted while in the program**	**# of clients admitted while in the program that were re-admitted within 30 days of discharge**	**# of clients admitted while in the program that were re-admitted within 60 days of discharge**	**# of clients admitted while in the program that were re-admitted within 90 days of discharge**
2	1 (87% reduction in # of clients admitted)	0	0 (100% reduction in # of clients admitted)	1***	0 (100% reduction in # of clients re-admitted)	0 (100% reduction in # of clients re-admitted)	0 (100% reduction in # of clients re-admitted)

**1 client had 3 admissions in the 12 months prior to entering the program. The client was readmitted to the hospital within 30 days of discharge on 1 occasion and was readmitted within 60 days of discharge on 1 occasion.

***1 client had 13 admissions in the 12 months prior to entering the program. The client was readmitted to the hospital within 30 days of discharge on 4 occasions; was readmitted within 60 days of discharge on 3 occasions; and was readmitted within 90 days of discharge on 5 occasions

# of Clients who had a Crisis Home Admission within the 12 months prior to entering the Med Drop Program	# of Crisis Home Admissions by Clients who had a Crisis Home Admission within the 12 months prior to entering the Med Drop Program	# of Crisis Home Days used by Clients who had a Crisis Home Admission within the 12 months prior to entering the Med Drop Program
1 (4% of the 22 clients served)	1	10 Cost = $3,204
# of Clients who had a Crisis Home Admission within the 12 months prior to entering the Med Drop Program AND had a Crisis Home Admission while in the Med Drop Program	**# of Crisis Home Admissions by Clients while in the Med Drop Program, who had a Crisis Home Admission within the 12 months prior to entering the Med Drop Program**	**# of Crisis Home Days used by Clients while in the Med Drop Program, who had a Crisis Home Admission within the 12 months prior to entering the Med Drop Program**
0	**0**	**0** **Cost= $0**

Individual Outcomes for Med Drop Participants:

- 100% reduction in the number of Med Drop clients admitted to the crisis home, who had a crisis home admission within the 12 months prior to entering the Med Drop Program
- 100% reduction in crisis home admissions for Med Drop clients who had a crisis home admission within the 12 months prior to entering the Med Drop Program
- 100% reduction in crisis home days for Med Drop clients who utilized crisis home days within the 12 months prior to entering the Med Drop Program

100 % Reduction in Crisis Home costs - $3204 to $0

Total # of Discharges from the Med Drop Program	Average LOS in Med Drop Program for clients discharged from the Med Drop Program
4	58 days

Total # of Discharges[1] from the Med Drop Program	Discharge Category: **Program Completed: Client was able to independently adhere to his/her medication regimen with assistance[2] or without assistance[3]**	Discharge Category: **Client moved out of the Med Drop Service Area**	Discharge Category: **Client transferred to a Different Program**	Discharge Category: **Client Died**	Discharge Category: **Client incarcerated for 30 days or more**	Discharge Category: **Client dropped out of program; cannot be located; ATO ended; MHC ended and client did not continue services**	Discharge Category: **Other Reasons**
4	# of Discharges: 0	# of Discharges: 0	# of Discharges: 2 (50% of the 4 discharges)	# of Discharges: 0	# of Discharges: 0	# of Discharges: 2 (50% of the 4 discharges)	# of Discharges:
Average LOS in Med Drop Program for Discharges by Category	0	0	102 days	0	0	14 days	

[1] The number of discharges represents the number of "exits" from the program versus the number of clients that "exited" the program.
[2] "With assistance" is defined as the client needs coaching to maintain his or her medication regimen.
[3] "Without assistance" is defined as the client does not need coaching to maintain his or her medication regimen.

Department Monthly Report: **November 2020**

Residential Assessment Productivity

# of Referral Requests RECEIVED*	**333**
Assessment Not Needed/Referral Cancelled	24
Cases Requiring Placement/Brokering Only	64
Assessments Awaiting Completion	54
Total Completed Assessments	**210**

Per Disability Designation	
AMI Referrals	231
IDD Referrals	102

Referral Sources*

Inpatient Hospitals	102
Emergency Departments	*24*
CRSP	63
Youth Aging Out (DHHS)	*2*
Pre-placement (C.O.P.E.)	2
Crisis Residential	9
Nursing Homes	1
In-Home Assessments (via Teleconference)	129
Total Received Referrals	**333**

Residential Service Authorizations

Total Received Authorizations	**600**
Authorizations Completed	**464**
Requests Returned to CRSP	136

Authorization Submission Type	
Internal Requests Submitted by Residential Care Specialists	122
Requests Processed Through MHWIN Queues	478

***Authorization** (Per Disability Designation)*	
AMI Authorizations	365
IDD Authorizations	247

30-Day/Emergency Consumer Discharge Notifications

Total Received Consumer Notifications	**22**
30-Day Notices for Licensed Facilities	9
Emergency Discharges	9
Consumer Relocation Requests	4
Rescinded Requests/Self-Discharges	0

COVID-19

For the month of November 2020, Residential Services is noticing an uptick in reporting of COVID-19 positive cases from contracted residential providers; however, no related deaths since September 2020 reporting.

# of Positive Cases Reported (11/1/20 – 11/30/20): 14

Per Designation	AMI	I/DD
Males	3	3
Females	1	7

# of Deaths Reported (11/1/20 – 11/30/20): 0 *(No Change since 9/30/20)*

Per Designation	AMI	I/DD
Males	0	0
Females	0	0

Residential Facility Closures

The following residential facility closures were processed during November 1-30, 2020 to relocate all consumers to alternate specialized placements (No residential facility closures reported this month due to COVID-19 issues; i.e. lack of staff, consumer exposure, etc.).:

# of FACLITY CLOSURE NOTIFICATIONS	11
RECEIVED in NOVEMBER 2020*: ON GOING	2
Requests ON-HOLD / PENDING	1
Completion of Facility Closure	8

We Care Home: Lappin – 26102 & Corbett – 26099
Notification received: 10/28/20 via MCO
Closure Effective Date: 12/18/20
Confirmed Closure Date: 11/27/20
All 10 AMI consumers successfully relocated to alternate DWIHN facilities; with
(1) consumer refusing to relocate (awaiting CRSP placement status or APS case involvement)
Current Status: COMPLETED

Westbrook SIL – 26271
Notification received: 10/27/20 via MCO
Closure Effective Date: 11/30/20
Confirmed Closure Date: 11/20/20
14 AMI consumers successfully relocated to alternate DWIHN facilities; with
(1) consumer remaining at facility under general services
Current Status: COMPLETED

Comfort Care Home – 31378
MCO Notice of Contract Non-Renewal, received: 10/9/20
Confirmed Closure Date: 11/20/20
3 AMI consumers successfully relocated to alternate DWIHN facilities.
Current Status: COMPLETED

Haggerty Group Home – 25709
Notification received: 10/8/20
CRSP Confirmation of Consent to Relocate: 10/15/20
Confirmed Closure Date: 11/18/20
5 (Wayne Center) DD consumers successfully relocated to alternate DWIHN facilities.
Current Status: COMPLETED

Green II Home – 25701
Provider Notification received: 8/27/20
Lease Termination Date: 10/31/20
3 (CLS) DD consumers successfully relocated
Current Status: COMPLETED

Samaritan Care – 26367
MCO Notice received: 7/7/20
Closure Effective Date: ASAP
DWIHN experienced difficulty with residential provider in attempting to relocate all consumers from facility due to MCO directive.
Confirmed Closure Date: 11/23/20
3 AMI consumers successfully relocated to alternate DWIHN facilities; with (1) consumer returning home to live with family
Current Status: COMPLETED

Ellen II Home – 25635
MCO Notification received: 9/22/20
Provider issued 60-day discharge notice, Effective 11/22/20
Confirmed Closure Date: 11/30/20
All 3 (Wayne Center) DD consumers successfully relocated to alternate DWIHN facilities
Current Status: COMPLETED

Margie's Castle – 25859
MCO Suspension of Services, effective 7/7/20
MCO Contract Reinstatement : 10/15/20
Current Status: COMPLETED

Country Club Home – 25105
Notification received: 11/12/20
Lease Termination Date: 12/15/20
1 (CLS) DD consumer pending relocation date from CRSP confirmation
Current Status: ON GOING

West Creek Home – 25851
Relocation Request received: 9/15/20
Lease Termination Date: 12/10/20
3 CLS (DD) consumers pending relocation
Current Status: ON GOING

Lakepointe II Home – 14844
Notification received: 10/22/20
Lease Termination Date: 10/31/20
3 (CLS) DD consumers pending relocation
Current Status: *PENDING*

Department Project Summaries

Referral Trends

IDD Consumers under Self-Determination – The noted trend tends to continue with the department receiving ED and CRSP referrals for placement of IDD (Self Determined) consumers transitioning into specialized residential services without banner being removed from MHWIN. During the month of November, we received 7 additional SD referrals, totaling 12 for the current fiscal year. All SD verifications are forwarded to MCO Liaison Lucinda Brown to follow up with the designated CRSP of their current statuses.

Children's Initiatives – DWIHN Children's Initiatives has implemented a community living supports policy and in-home community living supports (H2015) tool for IDD and SED children, per their meeting held on November 16, 2020. It is our understanding that the practice and application of their assessment tool has been sporadic and not a mandated requirement. A meeting has been requested with Clinical management to outline a process suggesting that Children's Inititatives take responsibility for the children H2015 assessment reviews, informing Residential Services of authorization entry which would streamline the process.

Authorizations

The Authorization Team continues to work in collaboration with assigned residential staff and IT to make significant changes to the MHWIN residential assessment/SPG for the H2015 conversion process (effective 10/1/20). The team works daily to make sure that all related authorizations for each consumer are appropriately entered, assigned to correct (contracted) residential facilities, and continue to report identifed errors and barriers within PCE through this process, such as:

- "U" modifier errors with H2015 authorizations for specialized unlicensed seetings due to lack of accurate and timely vacancy reporting
- HIE transitioned IPOS without clinical signature from CRSP staff
- PCE-automatic authorization approvals
- CRSP approving entered authorizations without DWIHN review

Staffing

The Residential Care Coordinator started on November 30, 2020. We await the finalization of the hiring process for the second qualified candidate issued an offer letter last month.

Department Meetings & Trainings

- ***CRSP Presentation Review Sessions of Residential Assessment/SPG, H2015 Service Authorizations, & Standardized Progress Note*** – Selected residential staff completed 4 of 6 scheduled two-hour review sessions to refamiliarize the CRSP clinical staff of the updates and/or changes to the service authorization entry process, assessment/SPG, and review of the standardized progress note; which included a total of ***127 attendees*** (IDD-92; AMI-35). Our last scheduled session is Thursday, December 3rd with the IDD CRSP (10 AM) and the AMI CRSP (2 PM) via Microsoft TEAMs.

- ***Residential/CRSP Monthly Meetings*** – We are pleased to announce our department has established monthly CRSP meetings to enhance to support their understanding in current residential policies, processes, and updates. We have completed meetings with ACC, ACCESS, AWBS, Southwest Solutions, PsyGenics, Hegira Programs, and S.T.E.P.; continuing to extend the meeting offer to the remaining CRSP throughout next month. They have reported their satisfaction with the opportunity given to gain better understanding of their responsibilities and duties.

DWIHN Residential Assessments/SPGs

AMI Assessment Barriers

- Residential providers are reporting no WI-FI for internet access to complete telemedicine assessments after appointments have been scheduled. This causes the RCS to reschedule appointments several times until the provider has made accommodations to make consumers virtually accessible as needed. They continue to report they are working on a resolution to address the issue.
- Residential provides still delay in downloading their selected telehealth option (i.e. Zoom, Teams, etc.) prior to scheduled appointment, causing rescheduling of appointments.

IDD Assessments Barriers

- All assessments/SPGs for unlicensed settings have been temporarily suspended as the H0043-to-H2015 transtion continues through to 12/31/20. Although residential providers have been directed to submit claims without a current service authorization in MHWIN, the timeline of assessment/SPG completion is delayed until further notice.
- CRSP case managers and supports coordinators cofntiunue to need a lot of guidance although gaining better understanding of the assessment/SPG process.
- Changes to the authorization process are causing CRSP and residential providers to have more related questions that need to be addressed. We continue to refer to submit all inquries to the department email address to be addressed by the authorizations team.
- As changes are completed, the assessment/SPG grows to be a more user-friendly document for both licensed and unlicensed specialized settings.

Department Goals

Automated Productivity Reporting

- In coordination with IT's Suzanne Henson, the department began implementation to automate productivity reporting through the development of Smartsheets. The process began with the Residential Care Specialists in their reporting assigned cases and the timeline to completion into specialized placement.

Residential Review Committee

- We are in the process of creating a interdepartmental committee to conduct comprehensive reviews of contested assessments/SPGs. We hope the committee will reduce the number of grievances and allow for a process to address residential providers and/or CRSP inquiries and concerns.

Department Monthly Report: **December 2020***

*Reporting Date Range: December 1-21, 2020**

Residential Assessment Productivity

Pending Assignments PRIOR to December 1st	***54***
# of Referral Requests RECEIVED for December 2020*	**234**

Assessment Not Needed/Referral Cancelled	18
Cases Requiring Placement/Brokering Only	76
Assessments Awaiting Completion	23
Total Completed Assessments	**140**

Per Disability Designation	
AMI Referrals	184
IDD Referrals	50

Referral Sources*

Inpatient Hospitals	56
Emergency Departments	*3*
CRSP	112
Youth Aging Out (DHHS)	*2*
Pre-placement (C.O.P.E.)	0
Crisis Residential	2
Nursing Homes	5
In-Home Assessments (via Teleconference)	53
Total Received Referrals	**234**

Residential Service Authorizations

Total Received Authorizations	**588**
Authorizations Completed	**503**
Requests Returned to CRSP	85

Authorization Submission Type	
Internal Requests Submitted by Residential Care Specialists	165
Requests Processed Through MHWIN Queues	342

***Authorization** (Per Disability Designation)*	
AMI Authorizations	319
IDD Authorizations	269

30-Day/Emergency Consumer Discharge Notifications

Total Received Consumer Notifications	**14**
30-Day Notices for Licensed Facilities	6
Emergency Discharges	5
Consumer Relocation Requests	3
Rescinded Requests/Self-Discharges	0

COVID-19

During December 2020, Residential Services continues to see an uptick in COVID-19 positive cases; receiving our first reported death since 3/30/20. ***This number indicates increase/decrease from last month's reporting***.

# of Positive Cases Reported (12/1/20 – 12/21/20*): 26 ***(+12)***

Per Designation	AMI	I/DD
Males	5	15
Females	1	5

# of Deaths Reported (12/1/20 – 11/20/20*): 1 ***(+1)***

Per Designation	AMI	I/DD
Males	0	1
Females	0	0

Residential Facility Closures

The following residential facility closures were processed during December 1-21, 2020* to relocate all consumers to alternate specialized placements (No residential facility closures reported this month due to COVID-19 issues; i.e. lack of staff, consumer exposure, etc.).:

# of FACLITY CLOSURE NOTIFICATIONS	4
RECEIVED in DECEMBER 2020*: **ON GOING**	1
Requests ON-HOLD / PENDING	0
Completion of Facility Closure	3

Shining Starr SILs #3 (28391), #4 (29392), #5 (28393), & #6 (28394-VACANT)
MCO Notification received: 12/1/20
Scheduled Contract Termination Date: 12/31/20
2 (Team Wellness) AMI consumers successfully relocated to alternate DWIHN facilities; 1 remaining (AWBS) AMI consumer pending relocation
Current Status: ON GOING

Country Club Home – 25105
Notification received: 11/12/20
Confirmed Closure Date: 12/16/20
1 (CLS) DD consumer successfully relocated to alternate DWIHN facility
Current Status: COMPLETED

Lakepointe II Home – 14844
Notification received: 10/22/20
Confirmed Closure Date: 11/30/20
3 (CLS) DD consumers successfully relocated to alternate DWIHN facilities
Current Status: COMPLETED

West Creek Home – 25851
Relocation Request received: 9/15/20
Confirmed Closure Date: 12/11/20
3 (CLS) DD consumers successfully relocated to alternate DWIHN facilities
Current Status: COMPLETED

Department Project Summaries

Referral Trends

IDD Consumers under Self-Determination – The noted trends to continue with the department receiving ED and CRSP referrals for placement of IDD (Self Determined) consumers transitioning into specialized residential services without banner being removed from MHWIN. During the month of December*, we received 2 additional SD referrals, totaling 14 for the current fiscal year. As SD referral are forwarded to MCO Liaison Lucinda Brown to follow up with the designated CRSP of their current SD statuses, only 1 case was returned to Residential Services due to consumer no longer being under SD services.

Authorizations

The Authorization Team completed the remaining H2015 Outpatient/Staffing Agent authorizations from the original spreadsheet created by Jeff White in Finance. Finance Department also requested the review of an outstanding authorization spreadsheet to send identified CRSPs lists of expired authorizations to input into MHWIN. The Authorization Team reviewed the spreadsheet and summary of numbers is below.:

# of Authorizations Under Review	**1,336**
Active Auths (No work required)	175
Auths Confirmed ***Consumers No Longer in the Facility***	709
Consumers Confirmed ***Deceased***	110
Consumers Confirmed ***No Longer Qualify for Specialized Services***	21
CRSP Needing to Enter Additional Auth into MHWIN	241
Expired IPOS, Auth to be entered upon IPOS Completion	50
Miscellaneous Auths	30

Authorization Team continues to attend meetings between IT and Finance to determine updates needed to the MHWIN Residential Assessment (SPG) for unlicensed settings; continuing to share input regarding the impact of the assessment on authorizations.

Department Meetings & Trainings

- ***CRSP Presentation Review Sessions of Residential Assessment/SPG, H2015 Service Authorizations, Standardized Progress Note, & (revised) Residential Vacancy Notification Form*** – Selected residential staff completed the last 2 of 6 scheduled two-hour review sessions with DWIHN CRSP clinical staff on Thursday, December 3rd; totaling ***198 attendees*** (IDD-141; AMI-68) to all 6 sessions consisting of:
    - Updates/changes to the MHWIN Residential Assessment (SPG)
    - Service Authorization entry process updates relating to H2015 conversion for unlicensed settings
    - Standardized progress note and guidelines
    - Newly revised residential vacancy notification form

The staff also confirmed with attendees that training materials will be electronically issued to all CRSP supervisors upon final revisions and completion of the MHWIN residential assessment changes once finalized by Finance, IT, and PCE.

Department Meetings & Trainings (continued)

- ***DWIHN Residential Providers Review Sessions*** – Residential Services also extended the invitation to review the aforementioned processes, additions, and changes to the DWIHN Residential Providers at 10 AM and 2 PM each day: IDD Sessions held December 10th, and AMI Providers held on December 17th via Bluejeans. A total of ***174 attendees*** (IDD-111; AMI-63) attended all 4 sessions. The assigned staff will complete a FAQ Sheet to be published on the company website to respond to all inquiries submitted during the review sessions.

DWIHN Residential Assessments/SPGs

Residential Assessment (SPG) Development Team

In addition to completing assessments, the assigned team members supervised CRSP staff in completion of trainings to assist supports coordinators in understanding the residential assessment/SPG and how to address each category to report accurate services that reflects the consumer's treatment plan. Team members continue to collect and report data to Finance and IT to redefine the residential assessment/SPG that will be utilized for both licensed and unlicensed facilities.

Department Goals

Automated Productivity Reporting

- Residential Services received licensing for access to develop Smartsheet reporting from the IT department this month to continue to develop productivity reporting throughout the department as needed. To date, the staff utilizes the Residential Care Specialist Assessment reporting and Facility Closure sheets with additional revised reporting forthcoming.

Residential Review Committee

- We are in the process of creating an interdepartmental committee to conduct comprehensive reviews of contested assessments/SPGs. We hope the committee will reduce the number of grievances and allow for a process to address residential providers and/or CRSP inquiries and concerns.

Residential Task Log

- Attached for review.

Residential Department Task Log

Received Date	Originated From	Assigned To	Assignment Date	Task Name	Task Requirements
09/28/20	Shirley Hirsch	Sherri Watson	09/28/20	CRSP Case Management Responsibilities	Review prior (CRL) documents to convert for DWIHN documentation
09/28/20	Shirley Hirsch	Kelly McGhee	09/21/20	Residential Provider/CRSP Review for Assessment	Process and Work flow development
09/28/20	Shirley Hirsch	Darryl Smith; Sheila Jones; Megan Latimer; Michael Jackson		Department Workflows/Process Development for CRSP	Urgent/Emergent Residential Assessment/SPG Process Flow
09/28/20	Shirley Hirsch	Darryl Smith; Sheila Jones; Megan Latimer; Michael Jackson		Department Workflows/Process Development for CRSP	Residential Assessment/SPG Process Flow and changes
10/01/20	Shirley Hirsch	Kelly McGhee		Department Workflows/Process Development for CRSP	Internal (Res) Provider Consumer Transfers
10/01/19	June White; Rai Williams	Shirley Hirsch, Kelly McGhee, Sherri Watson		Internal Department Notifications	(CRSP) Outpatient Provider Meetings
10/01/19	June White; Rai Williams	Shirley Hirsch, Kelly McGhee, Sherri Watson		Internal Department Notifications	Hospital Liaison Provider Meetings
10/01/19	June White; Rai Williams	Shirley Hirsch, Kelly McGhee, Sherri Watson		Internal Department Notifications	Residential Provider Meetings
09/17/20	Shirley Hirsch	Sherri Watson	09/23/20	CRSP Monthly Meetings with DWIHN Residential Services	CRSP Invite DRAFT from Director Shirley Hirsch
09/23/20	Shirley Hirsch	Sherri Watson	09/23/20	CRSP Monthly Meetings with DWIHN Residential Services	ACC
09/23/20	Shirley Hirsch	Sherri Watson	09/23/20	CRSP Monthly Meetings with DWIHN Residential Services	ACCESS
09/23/20	Shirley Hirsch	Sherri Watson	09/23/20	CRSP Monthly Meetings with DWIHN Residential Services	All-Well Being Services
09/23/20	Shirley Hirsch	Sherri Watson	09/23/20	CRSP Monthly Meetings with DWIHN Residential Services	Hegira Programs Inc.
09/23/20	Shirley Hirsch	Sherri Watson	09/23/20	CRSP Monthly Meetings with DWIHN Residential Services	Southwest Solutions
09/23/20	Shirley Hirsch	Sherri Watson	09/23/20	CRSP Monthly Meetings with DWIHN Residential Services	STEP
09/23/20	Shirley Hirsch	Sherri Watson	09/23/20	CRSP Monthly Meetings with DWIHN Residential Services	PsyGenics
09/23/20	Shirley Hirsch	Sherri Watson	12/21/20	CRSP Monthly Meetings with DWIHN Residential Services	Spectrum Community Services
09/23/20	Shirley Hirsch	Sherri Watson	09/23/20	CRSP Monthly Meetings with DWIHN Residential Services	CCIH
09/23/20	Shirley Hirsch	Sherri Watson	09/23/20	CRSP Monthly Meetings with DWIHN Residential Services	CCS
09/23/20	Shirley Hirsch	Sherri Watson	09/23/20	CRSP Monthly Meetings with DWIHN Residential Services	DCI
09/23/20	Shirley Hirsch	Sherri Watson	09/23/20	CRSP Monthly Meetings with DWIHN Residential Services	Goodwill-Detroit
09/23/20	Shirley Hirsch	Sherri Watson	09/23/20	CRSP Monthly Meetings with DWIHN Residential Services	CNS Healthcare
09/23/20	Shirley Hirsch	Sherri Watson	09/23/20	CRSP Monthly Meetings with DWIHN Residential Services	JVS Human Services
09/23/20	Shirley Hirsch	Sherri Watson	09/23/20	CRSP Monthly Meetings with DWIHN Residential Services	Lincoln Behavioral Services
09/23/20	Shirley Hirsch	Sherri Watson	09/23/20	CRSP Monthly Meetings with DWIHN Residential Services	MORC
09/23/20	Shirley Hirsch	Sherri Watson	09/23/20	CRSP Monthly Meetings with DWIHN Residential Services	NSO
09/23/20	Shirley Hirsch	Sherri Watson	09/23/20	CRSP Monthly Meetings with DWIHN Residential Services	The Guidance Center
09/23/20	Shirley Hirsch	Sherri Watson	09/23/20	CRSP Monthly Meetings with DWIHN Residential Services	Team Wellness
09/23/20	Shirley Hirsch	Sherri Watson	09/23/20	CRSP Monthly Meetings with DWIHN Residential Services	Wayne Center (Sheila Jones)
09/23/20	Shirley Hirsch	Sherri Watson	09/23/20	CRSP Monthly Meetings with DWIHN Residential Services	Northeast Integrated Health
10/01/18	Stacie Durant	Shirley Hirsch	10/01/20	Title XIX (19)	Review and grant auth requests through ASAP System for CRSP/CMH workers
08/20/20	Shirley Hirsch	Sherri Watson; Lezlee Adkisson; Megan	08/20/20	Temporary COVID-19 Quarantine facilities	Detroit Family Home-Southfield
08/20/20	Shirley Hirsch	Sherri Watson; Lezlee Adkisson; Megan	08/20/20	Temporary COVID-19 Quarantine facilities	Forever Care-Taylor
08/20/20	Shirley Hirsch	Sherri Watson; Lezlee Adkisson; Megan	08/20/20	Temporary COVID-19 Quarantine facilities	Angel Patience
08/20/20	Shirley Hirsch	Sherri Watson; Lezlee Adkisson; Megan	08/20/20	Temporary COVID-19 Quarantine facilities	Novus Living 1
08/20/20	Shirley Hirsch	Sherri Watson; Lezlee Adkisson; Megan	08/20/20	Temporary COVID-19 Quarantine facilities	Detroit Family Home-Boston
08/20/20	Shirley Hirsch	Sherri Watson; Lezlee Adkisson; Megan	08/20/20	Temporary COVID-19 Quarantine facilities	Infinity Care-Kinloch Home
08/20/20	Shirley Hirsch	Sherri Watson; Lezlee Adkisson; Megan	08/20/20	Temporary COVID-19 Quarantine facilities	Novus Living 1
08/20/20	Shirley Hirsch	Sherri Watson; Lezlee Adkisson; Megan	08/20/20	Temporary COVID-19 Quarantine facilities	Detroit Family Home-Boston
08/20/20	Shirley Hirsch	Sherri Watson; Lezlee Adkisson; Megan	08/20/20	Temporary COVID-19 Quarantine facilities	Infinity Care-Kinloch Home
11/27/20	Shirley Hirsch	Sherri Watson; Amelia Answorth	11/27/20	SMARTSHEET for Residential Facility Home Closures	For automated reporting
12/08/20	Shirley Hirsch	Kathryn Mancani; Meaghan Karafa; Christie Oaved	12/07/20	Missing Auths for Licensed Settings	Auth team to review spreadsheet from IT and Finance to determine if auths are outstanding.
09/15/20	Shirley Hirsch	Authorization Team, Darryl Smith; Sheila Jones	09/15/20	CRSP Process for PC/CLS Worksheet Entry	CRSP Notification of H2015 worksheet suspension, effective 9/15/20 thru 10/15/20
09/15/20	Shirley Hirsch	Authorization Team, Darryl Smith; Sheila Jones	09/15/20	CRSP Service Authorization Entries thru MHWIN	CRSP to complete all active service auths at least 30 days in advance of the authorization expiration
09/15/20	Shirley Hirsch	Authorization Team, Darryl Smith; Sheila Jones	09/15/20	CRSP Interim IPOS for service date gaps	Auth team to enter interim IPOS for initial placement requests when needed; CRSP notifications sent w CRSP has updated IPOS upon submitting request through MHWIN.
	Shirley Hirsch	Darryl Smith, Kathryn Mancani; Annetta McClain	11/19/20	CRSP Refresher Sessions-IDD CRSP Providers	Confirmed dates and times for CRSP refresher sessions on service auth process (K Mancani), resident assessment/SPG updates/changes (D Smith), and standardized progress notes (A McClain)
	Shirley Hirsch	Darryl Smith, Kathryn Mancani; Annetta McClain	11/19/20	CRSP Refresher Sessions-AMI CRSP Providers	Confirmed dates and times for CRSP refresher sessions on service auth process (K Mancani), resident assessment/SPG updates/changes (D Smith), and standardized progress notes (A McClain)

Residential Department Task Log

Received Date	Originated From	Assigned To	Assignment Date	Task Name	Task Requirements
11/12/20	Finance Department (J White)	Kathryn Mancani; Meaghan Karafa	11/13/20	AMI CRSP Focus Group Meeting	HPI, LBS, & TEAM (AMI Focus Group) invited to review our PowerPoint Presentation with RS Auth Te discuss real-life scenarios to assist with modifying CRSP Training materials. Auth team will then sched meeting with Jeff White to discuss findings.
11/12/20	Finance Department (J White)	Kathryn Mancani; Meaghan Karafa	11/13/20	IDD CRSP Focus Group Meeting	MORC & PsyGenics (IDD Focus Group) invited to review our PowerPoint Presentation with RS Auth T discuss real-life scenarios to assist with modifying CRSP Training materials. Auth team will then sched meeting with Jeff White to discuss findings.
11/12/20	Finance Department (J White)	Kathryn Mancani; Meaghan Karafa	11/13/20	AMI/IDD Focus Group Review with Jeff White (Finance)	Auth Team to discuss AMI/IDD CRSP Focus Group findings with identified scenarios.
12/16/20	MCO	Amelia Answorth; Andrea Guilbault; Sherri Watson	12/16/20	Res Provider Suspension for Tender Heart Care AFC	RS Director advise MCO reporting 6-month contract suspension for residential provider of all DWIHN s until February 2021.
12/01/20	Shirley Hirsch	Kelly, McGhee, Sherri Watson, Amelia Answorth, Jessica Wright, Megan Latimer	12/18/20	Hope Network Discharge Notification for TR-439221	Residential Services case review timeline for designed consumer at Hope Network's Westlake V facilit
12/16/20	Shirley Hirsch	Kelly McGhee, Sherri Watson, Kate Mancani, Meaghan Karafa	12/16/20	Suspension of H2015 Continued Assessments-Directions to the CRSP	Email communication developed and sent out to DWIHN CRSP Supervisory to notify of continued susp H2015 entries into MHWIN through 3/31/2021.
12/16/20	Shirley Hirsch	Residential Staff	12/16/20	Identifying Difficult Case Referrals in Residential Department	Identify RS staff to review severe cases and placement history under longer-than-normal timeframe du extenuating circumstances, etc..
12/21/20	Shirley Hirsch	Sherri Watson	12/18/20	Self Determination Tracking and Process Flow	Residential referrals of consumer under SD Services, forwarded to MCO Lucinda Brown to confirm cur financial status. Residential Admin Specialist to develop process flow for specified referrals types and r tracking
12/21/20	Shirley Hirsch	Jessica Wright	12/18/20	30-Day Discharge Reporting Updates/Revision	Reporting grid review/update to track length-of-time for discharge notifications, carry-overs from previo and process barriers (extending past 30-day or Emergency discharge timeframe).
12/21/20	Shirley Hirsch	Kelly McGhee, Amelia Answorth, Andrea Guilbault	12/18/20	Residential Consumer Timeline for Facility	RS Manager to review with RCC the redevelopment of reporting facility closures and specific complexit reported during the process: i.e.. template letter/communications, consumer/guardian consents, referra alternate placements, final decisions, etc.
12/18/20	Shirley Hirsch	Kelly McGhee, Sherri Watson, Amelia Answorth	12/18/20	Timeline for Samaritan Care Inc. Facility Closure	Residential timeline for Samaritan Care Inc. Facility Closure to be completed ASAP

DWIHN UTILIZATION MANAGEMENT MONTHLY REPORT
November 2020

I. Executive Summary

- **Autism:** There were 269 authorization requests manually approved during the month of November. There were approximately an additional 157 authorizations approved via the new auto approval process for a total of 426 approved authorizations. There are 1749 cases currently open in the benefit.
- **Evidence Based Supported Employment:** There were 71 authorization requests approved during the month of November for Supportive Employment.
- **Habilitation Supports Waiver:** There are 1,084 slots assigned to the DWMHA. As of the end November, 1,061 slots (97.9%) were filled.
- **County of Financial Responsibility:** The total number of COFR cases decreased by two (2) resulting in a 2% of total open cases.
- **Denials and Appeals:** There were a total of five (5) medical necessity Denials and four (4) Appeals for the month of November.
- **General Fund:** There were 253 General Fund Authorization approvals for the month of November.
- **MI Health Link:** There were 63 inpatient admissions and 51 discharges in November. There were 11 recidivistic consumers.
- **Provider Network:** **Preliminary numbers for NOV. There were 785 consumers managed within the provider network during the month of November including MI Health Link. The 645 Inpatient Admissions, shows an 9.41% decrease from October (i.e., 712). There were 96 Partial Hospital Admissions in Nov shows a 36% decrease from October (i.e., 150) and 44 Crisis Residential Admissions is an 8.33% decrease from October (i.e., 48).
- **State Facilities:** There were 4 state hospital admissions and 1 discharge for the month. 68 NGRI consumers are currently managed in the community.
- **SUD:** There was a total of 2043 SUD authorizations approved during the month of November compared to 2970 approved in October, a decrease of 31%. UM reviewed 1349 authorizations in November, a 35% decrease from October's 2069. Wellplace generated the remaining 694, a 15% decrease from 814 authorizations approved in October.
- **SUD Administrative Denials**: During the month of November, the SUD team issued 35 administrative denials compared to 43 the previous month.
- **MCG:** For the month of November, there were 1024 individuals screened in Indica which is an average of 34 case per day screened

using the MCG Behavioral Health Guidelines. This was a small increase from last month that averaged 31 cases screened per day.

II. General Report

Autism Spectrum Disorder (ASD) Benefit

In addition to the 269 manual approvals, approximately 157 more requests were approved via the auto new approval process. The authorizations that are automatically approved are then reviewed manually to ensure that the new system is working and that required documentation is complete and without errors. The UM specialist then has to enter all authorizations into the WSA.

In last month's report it was noted that a substantial number of auto approved authorizations had to be voided due to requestor mistakes or lack of supporting documentation. In November, there was a decrease in voided authorizations, potentially due to DWIHN providing additional training and support to the provider network.

ASD Referrals by Month 1st Quarter	Number
October	107
November	Pending update from the WSA
December	

	Number of Auths Approved Per Month (Manual + auto = total) *	Number of Open Cases Per Month
October	473+135=608	1718
November	269+157=426	1747
December		

*numbers are approximate as they are pulled for this report prior to when all data for the month is available.

Evidence Based Supportive Employment (EBSE)

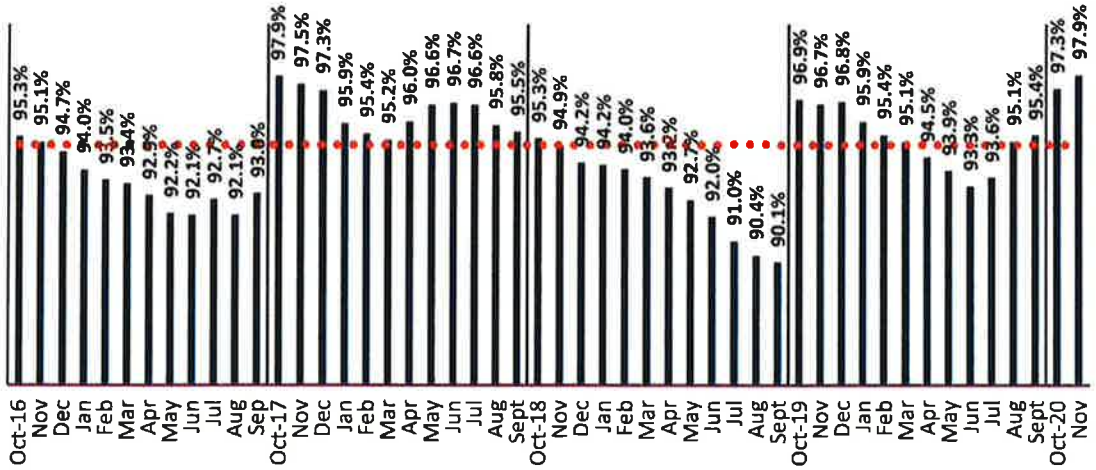
In the month of November, DWIHN approved 71 authorization requests for EBSE. The Dashboard indicates that at this time last year, 121 authorizations were approved.

Month	Number
October	82
November	71
December	
Total for Quarter 1	

Habilitation Support Waiver (HAB

Outcome Measurement	Oct	Nov
# of applications received	16	2
# of applications reviewed	16	2
# of app. Pended PIHP level for more information	9	1
#of pended app. resubmitted	9	1
# of app. withdrawn	0	0
Total of application sent to MDHHS.	16	2
Technical Assistants contacts	5	8
# of deaths/disenrollment's (recertification forms reviewed & signed)	1 death	4 all deaths
# of recertification forms reviewed and signed	91	77
# of recertification forms pended	16	16
# of dis-enrollments (not meeting HSW criteria)	0	0

Utilization 2017, 2018, 2019 & 2020



	FY2020												FY2021	
	Oct-19	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct-20	Nov
Owned	1,084	1,084	1,084	1,084	1,084	1,084	1,084	1,084	1,084	1,084	1,084	1,084	1,084	1084
Used	1,050	1,048	1,049	1,040	1,034	1,031	1,024	1,018	1,011	1,015	1,031	1,034	1,055	1061
Open	34	36	35	44	50	53	60	66	73	69	53	50	29	23
Rate	96.9%	96.7%	96.8%	95.9%	95.4%	95.1%	94.5%	93.9%	93.3%	93.6%	95.1%	95.4%	97.3%	97.9%

The utilization of the HSW continues to increase following the implementation of DWIHN's Incentive Payment Program effective July 1, 2020. The number of one-time incentive payments made to CRSPs thus far is summarized below:

Month	#
July	15
August	26
September	24
October	19
November*	8

*Tentative

Submissions of new certifications continue to be received and are under review either at DWIHN or MDDHS. Outreach and the provision of technical assistance to our provider network continues. Biweekly technical assistance calls with our two largest HSW providers, Wayne Center and Community Living Services remain.

Serious Emotional Disturbance Waiver (SEDW)

November 2020

# of youth expected to serve in the SEDW for FY 20	65
# of active youth served in the SEDW, thus far for FY 19-20	53
# of youth currently active in the SEDW for the month of November	53
# of referrals received in November	7
# of youth approved/renewed for the SEDW in November	4
# of referrals currently awaiting approval at MDHHS	0
# of referrals currently at SEDW Contract Provider	5
# of youth terminated from SEDW in September	1
# of youth transferred to another County, pursuing the SEDW	0
# of youth coming from another county, receiving the SEDW	2
# of youth moving from one SEDW provider in Wayne County to another SEDW provider in Wayne County	1

County of Financial Responsibility (COFR)

The COFR Committee continued to meet weekly for one (1) hour during the month of November. Weekly meetings are expected to continue ongoing.

	Adult COFR Case Reviews Requests	Children COFR Case Reviews Requests	Resolved	Pending*
November 2020	1	0	6	129

*This is a running total. Recommendations forwarded to Administration and pending determination

Successfully transferred COFR case to St. Clair CMH effective 10/1/2020.

Previously 131 cases in October 2020.

*Note: Not all new cases referred are reviewed within the month they are received. All new cases are added to COFR Master List with date referral is received. Cases are reviewed by priority of the committee.

General Fund

There were 253 General Fund Approvals for the month of November.

Denials and Appeals

For the month of November 2020, there were a total of five (5) denials that did not meet MCG medical necessity criteria for continued inpatient hospitalization and ABA services. There were four (4) appeals.

State Hospital Liaison Activity Report

Hospital	Caro Center	Kalamazoo	Walter Reuther
Census	1	15	115
Wait List	0	0	10
Admissions	0	0	4
Discharges	0	1	0
ALS Status	0	1	67

- COVID cases are increasing among all state hospitals and mandates have been given by MDHHS to expedite discharges for the elderly and COVID negative inpatient members.
- MDHHS has initiated a new pilot program to expedite discharges from the state hospital. Selected providers are contracted with MDHHS to provide placement for 90 days with transfer to the CMHSP. Two members have been transferred through this program.
- Increased placement efforts are needed for I/DD members discharging from the state hospital as placement options are limited. Currently, 10 of 15 Kalamazoo I/DD cases are pending discharge despite multiple placement efforts.

MI Health Link

November 2020	Admissions	Discharges	Discharge days *total # of inpatient days for all discharges	Average Length of Stay (ALOS)	# Recidivistic Consumers
Aetna	9	9	107	11.8	3
AmeriHealth	5	4	54	10.8	0
Fidelis	5	5	113	22.6	1
HAP Midwest	10	7	97	9.7	4
Molina	34	26	330	12.7	3

There were 63 inpatient admissions and 51 discharges for November 2020, compared to 74 admissions and 50 discharges in October 2020. Average length of stay (ALOS) is calculated using the number of discharge days accumulated by the number of persons discharged divided by the number of persons discharged in the current month. This month's ALOS for Fidelis increased from 12.6 days in October to 22.6 days in November. DWIHN's largest ICO, Molina, had 34 admissions with a total of 330 discharge days for the month of November. The number of discharge days for Aetna showed a decrease in both admissions (9) and discharge days (107) and a significant

decrease in the average length of stay; from 17.4 to 11.8. There was also an increase in the number of discharge days for HAP Midwest from 24 to 97. Across all ICOs, there were 7 members who re-admitted more than once in the past 30 days.

Provider Network

There were 785 consumers managed within the provider network during the month of November including MI Health Link. The 645 Inpatient Admissions, shows an 9.41% decrease from October (i.e., 712). There were 96 Partial Hospital Admissions in Nov shows a 36% decrease from October (i.e., 150) and 44 Crisis Residential Admissions is an 8.33% decrease from October (i.e., 48). Please the Crisis Residential Units are still at 50% capacity due to COVID. The preliminary numbers below reflect the admissions for the month of November:

- Inpatient: 582
- MHL: 63
- Partial: 96
- Crisis Residential: 44
- Total Admissions: 785
- Average Length of Inpatient Stay: 12

- Safehaus – For November, 2020, there were 14 consumers (i.e., 2 males and 12 females). Please note: All of these consumers were at Warren location. Grand Rapids and Rose City location have been permanently closed.

Substance Use Disorder

SUD Authorizations

There was a total of 2043 SUD authorizations approved during the month of November compared to 2970 approved in October, a decrease of 31%. UM reviewed 1349 authorizations in November, a 35% decrease from October's 2069. Wellplace generated the remaining 694, a 15% decrease from 814 authorizations approved in October

(Note: The volume of Wellplace treatment referrals is larger as not all new referrals result in an authorization.)

SUD Administrative Denials

During the month of November, SUD team issued 35 administrative denials compared to 44 reported last month. The primary reason for administrative denials is failure to adhere to timeliness guidelines.

Medical Necessity Denial

There were one medical necessity denials this month, but it was reversed when additional information was received.

Appeal Requests and Appeal Determination Forms

There were no administrative appeals received during the month.

SUD Timeliness Dashboard

Overall timeliness for SUD November authorizations remains high at 99% reviewed in a timely fashion (11/997). Nonurgent authorizations (694/695) were approved within 14 days 100% of the time. Urgent authorizations (292/302) were reviewed within 24 hours 97% of the time, meeting the benchmark of 90%.

Utilization Management Committee

The monthly UMC Meeting was held on November 17, 2020 and minutes are available for review.

NCQA

Work for many of the UM Standards was completed for many of the NCQA UM folders. Not all tables of contents have been updated with pdf page numbers. Mock audit feedback has been received and continues to be addressed as needed. UM Clinical Specialists assisted in facilitating the completion of a delegate grid submitted this month.

ICO Meetings/Issues

These meetings continue with many of the ICOs on a monthly basis and UM Clinical Specialist attends and reviews audit information as requested.

MCG

For the month of November, there were 1024 individuals screened in Indica which is an average of 34 case per day screened using the MCG Behavioral Health Guidelines. This was a small increase from last month that averaged 31 cases screened per day.

A quarterly meeting was held with MCG account rep with attendance by UM administrators and IT. This is a new meeting initiated by MCG. The ability to separate report activity by organization, or attach reviewer to an organization continues to be an issue. IT and PCE do not support mapping to a random (Facility or Bed or Room #) field to include staff/provider name. Kim Mars said she would bring this back to development. The recent admit date fix doesn't appear to work for DWIHN. More research is needed to see if we can have a date the client is admitted, autofill to Indicia instead of the date of PAR initiation.

Annual UM Program Evaluation

Work has begun on completing the Annual UM Program Evaluation. The request for COPE, Wellplace and Children's entities was sent the last week in November with a due date of 12/18. Internal meetings have been held and are scheduled to address internal contributions and content by UM administrators and staff.

DWIHN UTILIZATION MANAGEMENT MONTHLY REPORT
December 2020

I. Executive Summary

- **Autism:** There were 235 authorization requests manually approved during the month of December. There were approximately an additional 153 authorizations approved via the new auto approval process for a total of 388 approved authorizations. There are 1753 cases currently open in the benefit.
- **Evidence Based Supported Employment:** There were 73 authorization requests approved during the month of December for Supportive Employment.
- **Habilitation Supports Waiver:** There are 1,084 slots assigned to the DWMHA. As of the end December, 1,058 slots (97.6%) were filled.
- **County of Financial Responsibility:** The total number of COFR cases decreased by four (4) resulting in a 3% decrease of total open cases.
- **Denials and Appeals:** There were a total of five (5) medical necessity Denials and two (2) Appeals for the month of December.
- **General Fund:** There were 402 General Fund Authorization approvals for the month of December.
- **MI Health Link:** There were 51 inpatient and 2 CRU admissions and 53 discharges in December. There were 7 recidivistic consumers across all ICOs. No MI Health Link members were admitted for Partial Hospitalization in December.
- **Provider Network:** **Preliminary number(s) for DEC. The UM Team managed 781 consumers within the provider network including MI Health Link, Partial Hospital and Crisis Residential.
- **State Facilities:** There were 3 state hospital admissions and 4 discharges for the month. 69 NGRI consumers are currently managed in the community.
- **SUD:** There was a total of 2313 SUD authorizations approved during the month of December compared to 2043 approved in November, an increase of 13%. UM reviewed 1455 authorizations in December, an 8% increase from 1349. Wellplace generated the remaining 858, a 24% increase from 694 authorizations approved in November.
- **SUD Administrative Denials**: During the month of December, the SUD team issued 12 administrative denials compared to 35 the previous month.
- **MCG:** For the month of December, there were 974 individuals screened in Indica which is an average of 32 cases per day screened using the MCG Behavioral Health Guidelines. This was a small decrease from last month that averaged 34 cases screened per day.

II. General Report

Autism Spectrum Disorder (ASD) Benefit

In addition to the 235 manual approvals, approximately more requests were approved via the auto new approval process. The authorizations that are automatically approved are then reviewed manually to ensure that the new system is working and that required documentation is complete and without errors. The UM specialist then has to enter all authorizations into the WSA.

ASD Referrals by Month 1st Quarter	Number
October	107
November	60
December	Pending update from the WSA

	Number of Auths Approved Per Month (Manual + auto = total) *	Number of Open Cases Per Month
October	473+135=608	1718
November	269+157=426	1747
December	235+153=388	1753

*numbers are approximate as they are pulled for this report prior to when all data for the month is available.

Evidence Based Supportive Employment (EBSE)

In the month of December, DWIHN approved 71 authorization requests for EBSE.

Habilitation Supports Waiver

Month	Number
October	82
November	71
December	73

Outcome Measurement	Oct	Nov	Dec
# of applications received	16	2	7
# of applications reviewed	16	2	7
# of app. Pended PIHP level for more information	9	1	0
# of pended app. resubmitted	9	1	0
# of app. withdrawn	0	0	0
Total of application sent to MDHHS.	16	2	7
Technical Assistants contacts	5	8	5
# of deaths/disenrollment's (recertification forms reviewed & signed)	1 death	4 all deaths	4 deaths 1 moved out of state
# of recertification forms reviewed and signed	91	77	121
# of recertification forms pended	16	16	23
# of dis-enrollments (not meeting HSW criteria)	0	0	0

	FY2020										FY2021		
	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct-20	Nov	Dec
Owned	1,084	1,084	1,084	1,084	1,084	1,084	1,084	1,084	1,084	1,084	1,084	1084	1084
Used	1,049	1,040	1,034	1,031	1,024	1,018	1,011	1,015	1,031	1,034	1,055	1,061	1,058
Open	35	44	50	53	60	66	73	69	53	50	29	23	26
% Used	96.8%	95.9%	95.4%	95.1%	94.5%	93.9%	93.3%	93.6%	95.1%	95.4%	97.3%	97.9%	97.6%

The utilization of the HSW remains steady at an increased level following the implementation of DWIHN's Incentive Payment Program effective July 1, 2020. The number of one-time incentive payments made to CRSPs thus far is summarized below:

Month	#
July	15
August	26
September	24
October	19
November	8
December*	6
*TENTATIVE	

We continue to meet regularly with our second largest HSW provider, Wayne Center. We also regularly respond to calls and emails from other providers regarding the HSW benefit, etc.

Serious Emotional Disturbance Waiver (SEDW)

December 2020

# of youth expected to serve in the SEDW for FY 20-21	65
# of active youth served in the SEDW, thus far for FY 20-21	57
# of youth currently active in the SEDW for the month of December	51
# of referrals received in December	6
# of youth approved/renewed for the SEDW in December	9
# of referrals currently awaiting approval at MDHHS	0
# of referrals currently at SEDW Contract Provider	11
# of youth terminated from SEDW in December	2
# of youth transferred to another County, pursuing the SEDW	2
# of youth coming from another county, receiving the SEDW	0
# of youth moving from one SEDW provider in Wayne County to another SEDW provider in Wayne County	0

County of Financial Responsibility (COFR)

The COFR Committee continued to meet weekly for one (1) hour during the month of December. Weekly meetings are expected to continue ongoing.

	Adult COFR Case Reviews Requests	Children COFR Case Reviews Requests	Resolved	Pending*
December 2020	3	0	3	125

*This is a running total. Recommendations forwarded to Administration and pending determination

Previously 129 cases in November 2020.

*Note: Not all new cases referred are reviewed within the month they are received. All new cases are added to COFR Master List with date referral is received. Cases are reviewed by priority of the committee.

General Fund

There were 402 General Fund Approvals for the month of December.

Denials and Appeals

For the month of December 2020, there were a total of five (5) denials that did not meet MCG medical necessity criteria for continued inpatient hospitalization and ABA services. There were two (2) appeals.

State Hospital Liaison Activity Report

Hospital	Caro Center	Kalamazoo	Walter Reuther
Census	1	14	117
Wait List	0	0	15
Admissions	0	1	2
Discharges	0	2	2
ALS Status	0	1	68

- Hospitals are maintaining strict guidelines to limit increasing COVID cases. Restriction of visitors, quarantined units, and daily COVID testing are all in place to prevent further transmission among patients and staff.
- Though restrictions are in place, hospitals continue to urge discharges for healthy patients and the elderly.
- Admissions remain limited as hospitals continue to shift patients to accommodate COVID protocols. Walter Reuther Psychiatric admitted 10 patients from Caro Center to provide treatment for potentially COVID positive patients due to the limited medical resources in the Caro area. Kalamazoo Psychiatric previously postponed admission as COVID cases were increasing.

MI Health Link

December 2020	Admissions	Discharges	Discharge days *total # of inpatient days for all discharges	Average Length of Stay (ALOS)	# Recidivistic Consumers
Aetna	10	10	117	11.7	1
AmeriHealth	3	5	52	17.3	1
Fidelis	8	8	117	14.6	0
HAP Midwest	8	9	147	18.3	1
Molina	24	21	250	10.4	4

Inpatient admissions decreased by 15.8% in December 2020 for all ICOs. There were 53 inpatient admissions and 53 discharges for December 2020, compared to 63 admissions in November 2020. Average length of stay (ALOS) is calculated using the number of discharge days accumulated by the number of persons discharged divided by the number of persons discharged in the current month. This month's ALOS for all ICOs was 12.8 days compared to 12.7 days in November, less than 1% increase for length of stay. Out of the 5 ICOs, 3 had significant increases and decreases to the ALOS. Specifically, there was 60% increase for AmeriHealth, a 35% decrease for Fidelis and an 88% increase for Hap Midwest. There were 7 MI Health Link members who re-admitted

more than once in the past 30 days. Of note, there was one member who required a higher level of care. After only 3 days in CRU, the member met medical necessity criteria for inpatient treatment.

Provider Network

The UM Team managed a total of 781 consumers within the provider network during the month of December. This includes Inpatient, MI Health Link, Partial Hospital and Crisis Residential. The 613 Inpatient Admissions, shows a 14.66% decrease from November (i.e., 710). There were 80 Partial Hospital Admissions in DEC, which shows a 18.18% decrease from November (i.e., 96) and 35 Crisis Residential Admissions is a 22.78% decrease from November (i.e., 44). Please note that the Crisis Residential Units are still at 50% capacity due to COVID. The preliminary numbers below reflect the admissions for the month of December:

- Inpatient: 613
- MHL: 53
- Partial: 80
- Crisis Residential: 35
- Total Admissions: 781
- Average Length of Inpatient Stay:14

- Safehaus – For December, 2020, there were 10 consumers (i.e., 1 male and 9 females). Please note: All of these consumers were at Warren location. Grand Rapids and Rose City location have been permanently closed.

Substance Use Disorder

SUD Authorizations

There was a total of 2313 SUD authorizations approved during the month of December compared to 2043 approved in November, an increase of 13%. UM reviewed 1455 authorizations in December, an 8% increase from 1349. Wellplace generated the remaining 858, a 24% increase from 694 authorizations approved in November.

(Note: The volume of Wellplace treatment referrals is larger as not all new referrals result in an authorization.)

SUD Administrative Denials

During the month of December, SUD team issued 12 administrative denials compared to 35 reported last month. The primary reason for administrative denials is failure to adhere to timeliness guidelines.

Medical Necessity Denial

There were no medical necessity denials this month.

Appeal Requests and Appeal Determination Forms

There were no administrative appeals received during the month.

SUD Timeliness Dashboard

Overall timeliness for SUD December authorizations remains high at 98% reviewed in a timely fashion (1128/1146). Nonurgent authorizations (797/797) were approved within 14 days 100% of the time. Urgent authorizations (331/349) were reviewed within 24 hours 95% of the time, meeting the benchmark of 90%.

Utilization Management Committee

The monthly UMC Meeting was held in December and minutes are available for review.

NCQA

The UM Team continues work diligently to finalize the UM Standards. The file upload to NCQA has begun and weekly meetings to finalize the process continue. The final submission date is 2/16/2021 and the is review is scheduled 4/5/2021 - 4/6/2021.

ICO Meetings/Issues

These meetings continue with many of the ICOs on a monthly basis and UM Clinical Specialist attends and reviews audit information as requested.

MCG

For the month of December, there were 974 individuals screened in Indica which is an average of 32 cases per day screened using the MCG Behavioral Health Guidelines. This was a small decrease from last month that averaged 34 cases screened per day.

Annual UM Program Evaluation

Work continues on the Annual UM Program Evaluation. With the exception of Wellplace, the external entities have submitted their reports. Wellplace encountered technical difficulties. Internal meetings have been held and are scheduled to address internal contributions and content by UM administrators and staff.

DETROIT WAYNE INTEGRATED HEALTH NETWORK
BOARD ACTION

Board Action Number: BA#21-23 R Revised: Y Requisition Number:

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

Name of Provider: DWIHN Provider Network - see attached list

Contract Title: Provider Network System

Address where services are provided: Provider List Attached

Presented to Program Compliance Committee at its meeting on: 1/13/2021

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

Amount of Contract: $ 614,327,102.00 Previous Fiscal Year: $ 579,139,150.00

Program Type: Continuation

Projected Number Served- Year 1: 68,932 Persons Served (previous fiscal year): 73,446

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).

Detroit Wayne Integrated Health Network (DWIHN) 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.

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
Multiple	$ 614,327,102.00	$ 614,327,102.00
	$ 0.00	$ 0.00
Total Revenue	$ 614,327,102.00	$ 614,327,102.00

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

Type of contract (Business/Clinical): Clinical

ACCOUNT NUMBER: VARIOUS

In Budget (Y/N)? Y

Approved for Submittal to Board:

Willie E. Brooks, President/CEO

Signature/Date:

Willie E Brooks

Signed: Thursday, January 7, 2021

Stacie Durant, Chief Financial Officer

Signature/Date:

Stacie Durant

Signed: Thursday, January 7, 2021

DETROIT WAYNE INTEGRATED HEALTH NETWORK
BOARD ACTION

Board Action Number: 21-53 Revised: Requisition Number:

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

Name of Provider: Detroit Central City C.M.H., Inc., Development Centers Inc., Southwest Counseling Solutions, Wayne Metropolitan Community Action Agen, Coalition on Temporary Shelter

Contract Title: HUD Permanent Supportive Housing

Address where services are provided: Various locations throughout Wayne County

Presented to Program Compliance Committee at its meeting on: 1/13/2021

Proposed Contract Term: 2/1/2021 to 1/31/2022

Amount of Contract: $ 2,077,406.00 Previous Fiscal Year: $ 2,049,991.00

Program Type: Continuation

Projected Number Served- Year 1: 330 Persons Served (previous fiscal year): 314

Date Contract First Initiated: 10/1/2004

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 recommends 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.

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 in the amount of $1,972,621 and the

Detroit Wayne Integrated Health Network state general fund match of $104,785 for an amount not to exceed $2,077,406.

The Providers listed in this Board Action submitted applications for renewal to the local Continuum of Care and are 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.

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

Source of Funds: General Fund,HUD

Fee for Service (Y/N): N

Revenue	FY 21/22	Annualized
Federal funds	$ 1,972,621.00	$ 1,972,621.00
General Fund	$ 104,785.00	$ 104,785.00
Total Revenue	$ 2,077,406.00	$ 2,077,406.00

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

Type of contract (Business/Clinical): Clinical

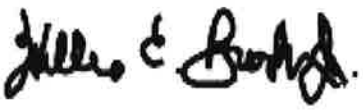
ACCOUNT NUMBER: VARIOUS

In Budget (Y/N)? Y

Approved for Submittal to Board:

Willie E. Brooks, President/CEO

Signature/Date:



Signed: Wednesday, December 23, 2020

Stacie Durant, Chief Financial Officer

Signature/Date:

Signed: Tuesday, December 22, 2020

DETROIT WAYNE INTEGRATED HEALTH NETWORK

QUALITY ASSURANCE PERFORMANCE IMPROVEMENT PLAN

(QAPIP) DESCRIPTION

FY 20-21 and FY 21-22

Approved:

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

Table of Contents

Section 1: Introduction

The Detroit Wayne Integrated Health Network (DWIHN), a National Committee Assurance (NCQA) accredited Managed Behavioral Health Organization (MBHO) 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) provides assurance that DWIHN achieves in alignment with healthcare reform. The QAPIP demonstrates to members, advocates, community organizations, health care providers and State policy makers that it has a distinct competency as a high-performing, member-focused, quality-focused, and evidence-based efficient provider of mental health and substance use disorder services and is an essential partner in helping healthcare reform to succeed. The QAPIP has the infrastructure necessary to improve the quality and safety of clinical care and services to our members and to oversee the QI program by ensuring desired member health status, quality of life and member satisfaction.

The term of the QAPIP begins October 1, 2020 and ends September 30, 2022. Upon expiration of the term, the QAPIP shall remain in effect until the DWIHN's Board of Directors approves a new QAPIP. The QAPIP incorporates by reference, any and all policies and procedures necessary to operate as a Prepaid Inpatient Health Plan and Community Mental Health Services Program. The DWIHN's Board of Directors hereby approves all current and subsequent policies and procedures through the approval of the QAPIP.

Mission, Vision and Values

The Mission and Vision Statements provide inspiration for DWIHN and describe what we aim to achieve mid-to-long term. The Values are the core principles and define DWIHN culture and identity.

Mission

We are a healthcare safety net organization that provides access to a full array of integrated services that facilitate individuals to maximize their level of function and create opportunities for quality of life.

Vision

To be recognized as a national leader that improves the behavioral and physical health status of those we serve, through partnerships that provide programs promoting integrative holistic health and wellness.

Values

- We are an *advocate*, person-centered, family and community focused organization.
- We are an *innovative*, outcome, data-driven, and evidence-based organization.
- We respect the dignity and diversity of individuals, providers, staff and communities.
- We are *inclusive*, culturally sensitive and competent.
- We are fiscally responsible and accountable with the highest standards of integrity.
- We achieve our mission and vision through partnerships and collaboration.

Quality Assurance Performance Improvement Plan (QAPIP)

The QAPIP provides the framework necessary to improve the quality, safety and efficiency of clinical care. The QAPIP provides structure and governance to guide the formal processes for evaluating and improving the quality and appropriateness of health care services and the health status of the populations we serve. It also defines the authority, scope and content of the QI program, including the roles and responsibilities of committees and individuals supporting program implementation.

The QAPIP contains the core functions of DWIHN's Board approved Strategic Plan, and the (6) pillars which serve as the foundation of the commitment of DWIHN to continuously improve the quality and safety of clinical care and quality of service. These functions will be conducted by DWIHN and its network of contracted service providers. It is the responsibility of DWIHN to ensure that the QAPIP meets applicable Federal and State laws, contractual requirements and regulatory standards.

Scope of the QAPIP

The scope of the QAPIP is board which includes DWIHN contracted service providers. It identifies the important processes and aspects of care, both clinical and non-clinical, required to ensure quality supports and services for persons in the system. DWIHN requires all contracted Clinical Responsible Service Providers (CRSP) to have a mental health and substance use disorder quality improvement plan relevant to the services they provide. DWIHN assures that all demographic groups, care settings and types of services are included in the scope of the QAPIP by including members, advocates, contracted service providers and community groups in the quality improvement process using a Continuous Quality Improvement (CQI) perspective.

DWIHN has an organizational structure which allows for clear and appropriate administration and evaluation of the QAPIP. DWIHN's Quality Improvement Steering Committee (QISC) is the decision-making body of the QAPIP and the evaluation.
There is a designated senior official and Medical Director (MD) responsible for the QAPIP implementation. There is active participation of providers and persons served in the QAPIP processes. The participating practitioners are external to the organization and part of the organization's network, providing input on process improvement, program planning, and program evaluation, through data collection and analysis. DWIHN believes the structure supports effective governance and align key strategic initiatives to ensure adequate guidance to help DWIHN reach goals and objectives.

Quality Improvement Program (QIP)

DWIHN QIP is based on the principles of Continuous Performance Improvement (CPI) which is adopted and utilized throughout the organization. The Centers for Medicare and Medicaid Services (CMS) Medicaid Bureau mandates that QIP's be a part of Pre-Paid Inpatient Health Plans (PIHP). The DWIHN has several contracts with the Michigan Department of Health and Human Services (MDHHS) for the provision of Managed Specialty Supports and Services (Medicaid), General Fund and waiver services for mental health and substance abuse and must comply with Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY19 Attachment P7.9.1 and CMHSP Managed Mental Health Supports and Services Contract FY19: Attachment C6.8.1.1 "Quality Assessment and Performance Improvement Programs for Specialty Pre-Paid Inpatient Health Plans" and the "Department of Community Health Michigan Mission Based Performance Indicators", the Balanced Budget Act, External Quality Review, and the Application for Renewal and Recommitment.

DWIHN maintains a network-wide commitment to quality and industry best practices and standards as set forth by state and federal regulations, as well as accrediting organizations. The QAPIP defines the program purpose, structure, policy and procedure for DWIHN in the framework of DWIHN's Mission and Values.

Quality Improvement Program (QIP) Governance

The DWIHN Board's Strategic Plan is an overarching process that works toward common goals, establish agreements around intended outcomes/results, and assess and adjust the organization's direction in response to a changing environment. The QIP provides a systematic approach to assessing services and improving them on a priority basis. The DWIHN's approach to quality improvement is based on the following six pillars. The six pillars are the focus areas that help realize the vision and a call to action with Information Systems as the foundation for supporting success across each of the pillars.

DWIHN's ability to understand and meet the unique health needs of our members is supported by our capabilities to effectively access, integrate, and analyze data. We have built and continue to invest in our members and technology to support industry-leading capabilities in data analytics. DWIHN's understanding of health care analytics and statistics enables us to develop and adjust standard methodologies to achieve targeted accurate results.

Cultural and Linguistic Needs

DWIHN's objectives for serving a culturally and linguistically diverse membership is a commitment to innovation, affordability, professional competence, continuous learning, teamwork and collaboration. The racial and ethnic disparities in behavioral 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 overall care of members by identifying the racial and ethnic composition so that potential health care disparities can be identified. This is accomplished by systematic monitoring and evaluation of provided services and by actively pursuing opportunities for improvement. DWIHN includes the following principles into its QIP:

- The importance of culture
- The assessment of cross-cultural relations
- Expansion of cultural knowledge, and
- The adaptation of services to meet the specific needs of our members

DWIHN and its Provider Network shall demonstrate an ongoing commitment to linguistic and cultural competence that ensures access and meaningful participation for all individuals receiving behavior health services. Such commitment includes acceptance and respect for the cultural values, beliefs and practices of the community, as well as the ability to apply an understanding of the relationship of language and culture to the delivery of supports and services. Professional competence includes a general awareness of the cultural diversity of the service area including race, culture, religious beliefs, regional influences in addition to the more typical social factors such as gender, gender identification, sexual orientation, marital status, education, employment and economic factors, etc.

DWIHN Medversant software captures the capacity to recruit providers of diverse racial and ethnic background by documenting the provider's self-identified ethnicity, culture and race (if provided). The software also includes a question about other languages spoken by providers to indicate their linguistic diversity – this information can also be found in the provider e- directory and provider directory for informational purposes to members. In addition, to ensure a competent work force of qualified practitioners, DWIHN utilizes Detroit Wayne Connect (DWC) for ongoing cultural diversity training.

DWIHN monitors the delivery of care and services in relation to the provision of culturally competent services through review of Staff Training Records, Member Satisfaction Surveys and Provider Satisfaction Surveys.

1. **F**ind a Process to Improve
2. **O**rganize to Improve
3. **C**larify Current Knowledge of the Process
4. **U**ncover Causes of Process Variation or Poor Quality
5. **S**tate Plan Do Study Act (PDSA)
    i. **P**lan the Improvement Process
    ii. **D**o the Improvement, Data Collection, and Analysis
    iii. **S**tudy the Results and Lessons Learned
    iv. **A**ct by Adopting, Adjusting, or Abandoning the Change

To ensure compliance of the QAPIP methodology, the use of quality improvement process management/improvement tools and techniques will consistently be included using the following four steps:

1. Identify - Determine what to improve
2. Analyze - Understand the problem
3. Develop - Hypothesize what changes will improve the problem
4. Test/Improvement - Test the hypothesized solution to see if it yields improvement. Based on the results, decide whether to abandon, modify, or implement the solution.

Key cultural components also ensure the success of improvement efforts include: leadership involvement, data informed practice, use of statistical tools, prevention over correction, and continuous quality improvement. Strong leadership, direction and support of quality improvement activities by the governing body and CEO are key to performance improvement and audit readiness. This involvement of organizational leadership assures that quality improvement initiatives are consistent with the DWIHN mission, vision, values and strategic plan.

Successful QI processes create feedback loops, using data to inform practice and measure results. Fact- based decisions are likely to be correct decisions, for continuous improvement of care, tools and methods needed to foster knowledge and understanding. Processes must be continually reviewed and improved. Small incremental changes do make an impact, and providers can almost always find an opportunity to make things better.

Continuous Quality Improvement Activities

The Quality Program encompasses all aspects of care and service delivery. Components of DWIHN's quality improvement activities include but not limited to:

- Clinical components across the continuum of care from acute hospitalization to outpatient care
- Organizational components of service delivery such as case management, discharge planning, prior authorizations, as well as other procedures or processes that affect care including access to care
- Processes that impact our members or providers of care such as claims, interpreter services, enrollment, customer services, credentialing/recredentialing and utilization management
- Member satisfaction
- Member safety

These quality improvement activities emerge from a systematic and organized framework for improvement. This framework, adopted by the leadership, is understood, accepted and utilized throughout the system, as a result of continuous education and involvement of staff at all levels in performance improvement. Quality Improvement involves two primary activities:

- Measuring and assessing the performance of processes and services through the collection and analysis of data.
- Conducting quality improvement initiatives and acting where indicated, including the redesign of processes, design of new services, and/or improvement of existing services.

MDHHS requires that DWIHN provide a written description of the QAPIP plan for approval by the Board of Directors. The contract with MDHHS requires DWIHN to annually conduct an effectiveness review of its QAPIP. The effectiveness review includes an analysis of whether there have been improvements in the quality of health care and services for members as a result of quality assessment and improvement activities and interventions carried out by DWIHN. The analysis takes into consideration trends in service delivery and health outcomes over time and include monitoring of progress on performance goals and objectives. The QAPIP is also reviewed for effectiveness of the methods used to implement, monitor and evaluate the quality improvement processes and for any necessary revisions and adjustments on a monthly basis. The review of the QAPIP includes members, providers, Quality Improvement Steering Committee (QISC), Program Compliance Committee (PCC) of the DWIHN's Board of Directors, and other stakeholders. Information on the effectiveness of DWIHN's QAPIP is provided annually to our stakeholders and to members upon request.

At a minimum, the QAPIP specifies the following elements:

a. An adequate organizational structure that allows for clear and appropriate administration and evaluation of the QAPIP.

b. Responsibilities of the governing body for monitoring, evaluation and making improvements to care.

c. Objectives and timelines for implementation and achievement.

d. Role of recipients of services and other stakeholders in the QAPIP plan.

e. Mechanisms or procedures used for adopting and communicating process and outcome improvements.

f. Description of a designated senior official responsible for QAPIP implementation.

g. Performance measures to address access, availability, quality, efficiency and outcome of services, using standardized indicators based upon the systematic, ongoing collection and analysis of valid and reliable data.

h. Performance improvement projects that address clinical and non-clinical aspects of care that are directed as the state and the DWIHN established aspects of care. Clinical areas include high volume services, high-risk services and continuity and coordination of care. Non-clinical areas include grievances and appeals, complaints and access to and availability of services.

i. Process from the review and follow-up of Critical/ Sentinel Events and events that place members at risk of harm.

j. Periodic quantitative (i.e., survey) and qualitative (i.e., focus group) assessments of member experiences with services. These assessments must address issues of quality, availability and accessibility of care.

k. Process for the incorporation of members receiving services into the review and analysis of the information obtained from quantitative and qualitative reviews.

l. Written procedures to determine whether physicians and other licensed health care professionals are qualified to perform their services.

m. Written procedures to ensure non-licensed providers of care or support are qualified to perform their jobs.

n. The organization's process for the initial credentialing and re-credentialing of providers.

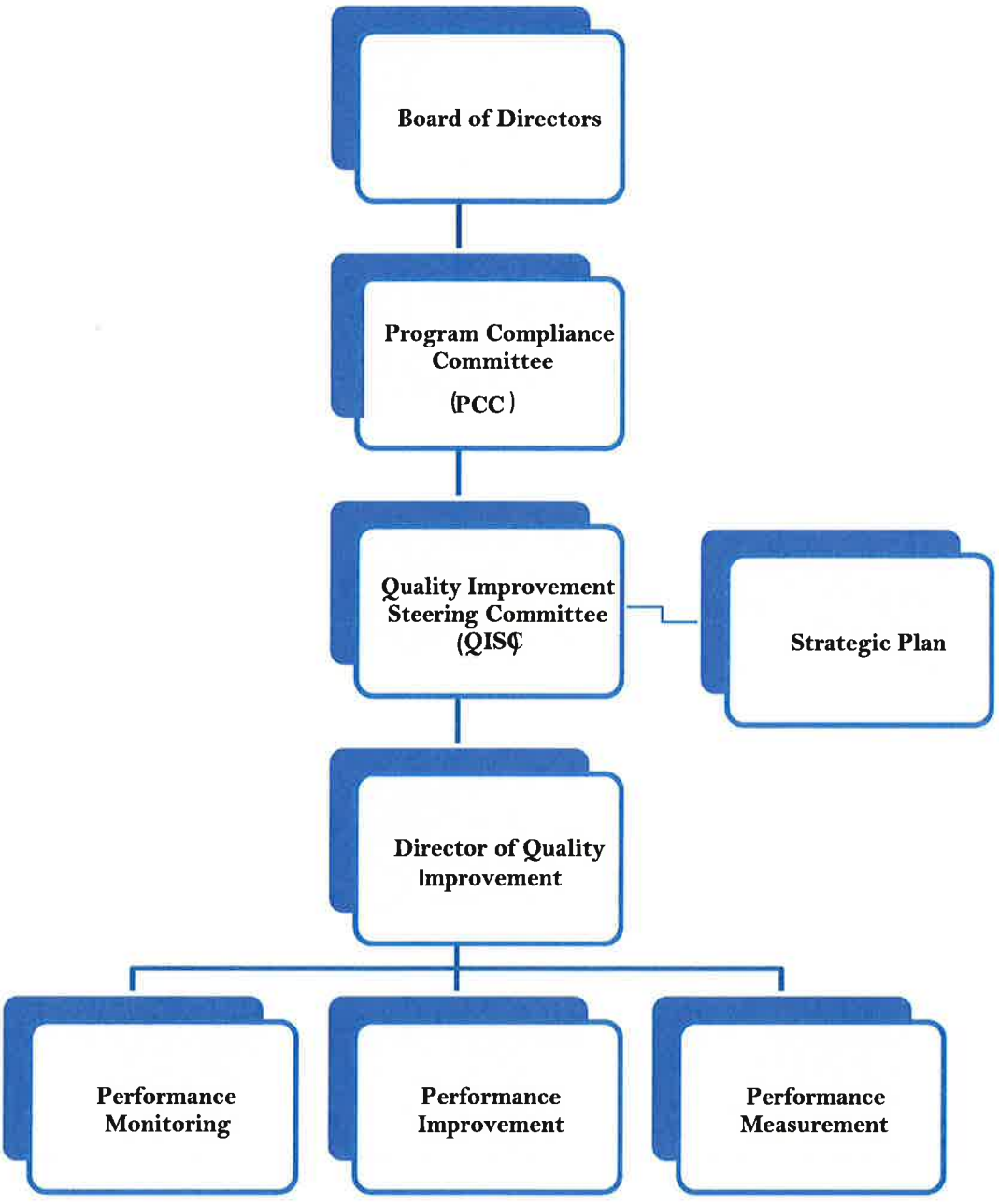
o. Identification of staff training needs and provision of in-service training, continuing education and staff development activities.

p. DWIHN process to verify whether services reimbursed by Medicaid were actually provided to enrollees by affiliates and service providers.

The Quality Improvement Unit reviews the response received regarding the effectiveness of the methods proposed or used to implement, monitor and evaluate the quality improvement processes. The results and recommendations are incorporated in the QAPIP for the next fiscal year cycle.

DWIHN quality improvement goals are integrated and communicated throughout the organization with structured work plans, goals and objectives that are owned at the department level. Our organizational monitoring activities and reports are reviewed throughout the year to identify opportunities for needed changes and improvements. These activities, in addition to ongoing improvement projects, form the basis of the organization's work plan and support all services offered by DWIHN.

Leadership. The key to the success of the Continuous Quality Improvement (CQI) process is leadership. Consistent with a total quality Improvement philosophy, the following is the structure of the organization in which the Quality Improvement Unit resides.



GOVERNING BODY

DWIHN's Program Compliance Committee (PCC) is the governing body for the QAPIP plan. PCC delegates direct oversight of all QI functions to the Quality Improvement Steering Committee (QISC), which serve as the oversight body and has responsibilities for the day to day management of the QI program. PCC annually reviews the specific goals and objectives of DWIHN, including a description of the services provided. This includes, but is not limited to, the QAPIP, Year End Evaluation, and periodic review of quality improvement progress reports. The Director of Quality Improvement provides monthly and quarterly reports on QI activities to PCC. As the governing body, PCC, with recommendations from appropriate clinical personnel, act on all major contracts and other arrangements affecting the delivery of health care services. PCC actively supports the Quality Improvement Program as demonstrated by ongoing involvement in the policy making process of the organization. The final approval of the QAPIP is retained by DWIHN's Full Board of Directors.

Director of Quality Improvement

The Director of Quality Improvement has the overall responsibility for implementation of the QAPIP. Under the Director of Quality Improvement's leadership, an integrated interdivisional approach to improving DWIHN services and systems is undertaken. The Director of Quality Improvement is also responsible for the following:

1. Assisting staff in understanding and participating in the Continuous Quality Improvement (CQI) process.
2. Establishing regular communication throughout DWIHN's network about CQI issues, problems, status and progress.
3. Assisting the PCC Committee and the Full Board of Director's understanding of the CQI process.
4. Developing and implementing a data collection system that yields real-time meaningful data for needs assessment, program planning, outcome evaluations and operationalizing quality improvement opportunities.
5. Pursuing opportunities for partnership between DWIHN and other public and private entities involved in quality improvement efforts.
6. Participating on quality improvement teams and work groups at DWIHN and state levels.
7. Assisting in the Strategic Planning process.
8. Developing a DWIHN Audit Ready philosophy.
9. Standardized protocols for ensuring appropriate use for telehealth services, appropriate billing codes and quality measures.

SECTION 3: Quality Improvement (QI) Unit

The Quality Improvement Unit is responsible for performing quality improvement functions assuring that program improvements are occurring within the Pre-Paid Inpatient Health Program (PIHP) and the Community Mental Health Services Program (CMHSP). The QI unit provides support for all departments in the organization for quality improvement projects.

The QI Unit operates in partnership with stakeholders, members, advocates, contracted providers, and DWIHN staff. The QI Unit achieves the scope of continuous quality improvement through three functions: performance monitoring, performance measurement and performance improvement.

Performance Improvement

Performance Improvement is a formal approach to the analysis of performance and systematic efforts to prevent, reduce or eliminate waste, and problems that will lead to improvement in service quality. As the steward of the system, the Performance Improvement component ensures guidance is provided to the system through the provisions of policy directives. This approach is system-wide, and addresses DWIHN and its service provider network. All service providers are required to have certain policies in place which mirror DWIHN's policies. The policies address those areas that are contractually mandated in the contract with MDHHS, and describes the process for ensuring compliance. DWIHN's policies undergo a public comment period before becoming final. This process allows for stakeholders to comment and provide feedback on proposed policies. In addition, approved policies are reviewed and disseminated to DWIHN service provider network via Quality and Provider meetings. Approved policies are located on DWIHN's website.

To meet the regulatory requirements for MDHHS and NCQA requirements, DWIHN conducts all Performance Improvement Projects (PIPs) that are approved through the Improving Practices Leadership Team (IPLT) and the Quality Improvement Steering Committee (QISC). The purpose of the PIPs is to provide and promote continuous quality improvement through on-going measurement and interventions that are clinical and/or non-clinical services with beneficial effect on health outcomes and member satisfaction. DWIHN requires its provider network to participate in the PIPs related to their respective programs and services. In addition, each of the providers in the network are expected to conduct PIPs based on their own self-assessment of need, risk, frequency and performance. In addition, DWIHN's contract with MDHHS requires a State mandated performance improvement activity as well as, activities identified by QISC.

During the waiver renewal period DWIHN has at least two affiliation-wide Performance Improvement Projects (PIPs). These are conducted to promote continuous quality improvement through on-going measurement, intervention as well as verifiable and sustained improvement in significant aspects of clinical care and/or non-clinical services. These projects are expected to have a beneficial effect on health outcomes, member safety and satisfaction.

The MDHHS Quality Improvement Council identifies the project topic on at least one of the PIPs and DWIHN identifies at least one project topic. The DWIHN PIP topic is to address performance issues that have been identified through the External Quality Review (EQR), the Medicaid Site Review, the Needs Assessment, the Performance Indicator system, the performance monitoring and measurement system.

Once the performance of *a* selected process has been measured, assessed and analyzed, the information gathered by the above performance indicator(s) is used to identify DWIHN's defined continuous quality improvement initiative to be undertaken. The decision to undertake the initiative is based upon DWIHN priorities. The purpose of an initiative is to improve the performance of existing services or to design new ones. The model utilized by DWIHN is called Focus-Plan-Do-Study-Act (PDSA).

The Substance Use Disorder Providers and the Clinical Responsible Service Providers (CRSP) are expected to participate in DWIHN's PIP related to their programs and services. They are also expected to conduct PIPs based on their own self-assessment of need, risk, frequency and performance.

Oversight of the quality improvement infrastructure is achieved through collaboration with members, advocates, providers, DWIHN's Medical Director, and other stakeholders. Planned, systematic activities are implemented so that quality requirements for community mental health services are fulfilled by DWIHN and contracted service providers.

In partnership with stakeholders Quality Improvement activities include:

- Assessment of needs, quality of services, accessibility of care, availability of care, outcomes of services provided and beneficiary experiences with services
- Evaluation of systems, programs and services
- Collect performance data utilizing effective quantitative metrics that are specific, measurable, actionable, relevant and timely for Michigan Mission Based Performance Indicator System, MDHHS and DWIHN Performance Improvement Projects, QAPIP Status/Outcomes, Satisfaction Surveys (Member and Provider), Standardized HCPCS Code Utilization, Medicaid and Other Claim Verification, MDHHS and DWIHN Needs Assessments, and Network Policies
- Identification of positive and negative process trends
- Analysis of causes of positive and negative statistical variation and outliers
- Identification of opportunities for improvement
- Determination of goals and objectives
- Decision making and planning
- Stakeholder education/information sharing
- information and technical assistance regarding the quality improvement issues, trends, techniques and proposed outcomes
- Implementation of performance improvement activities
- Measure and monitor progress toward goal achievement
- Evaluate outcomes and modify performance improvement process as needed
- Implementation of standardized performance improvement activities
- Strategic and annual planning

Some of the tools and techniques used in the continuous quality improvement process include Problem Solving Methodology, Process Mapping, Force Field Analysis, Cause and Effect Diagrams, Brainstorming, Pareto Analysis, Control Charts, Check Sheets, Bar Charts, Scatter Diagrams, Matrix Analysis, Tally Charts and Ishikawa Fishbone Diagram.

Quality Assurance and Improvement functions include informing practitioners, providers, members, and the Governing body of assessment results, and facilitates a process of evaluating the effectiveness of the assessments and outlining systematic action steps to follow-up on findings.

The Leaders support QI activities through the planned coordination and communication of the results of measurement activities related to QI initiatives and overall efforts to continually improve the quality of care provided. This sharing of QI data and information is an important leadership function. Leaders, through a planned and shared communication approach, ensure the Board of Directors, staff, members and families have knowledge of and input into ongoing QI initiatives as a means of continually improving performance.

This planned communication may take place through the following methods:

- Story boards and/or posters displayed in common areas
- Recipients participating in QI Committee reporting back to recipient groups
- Sharing of the annual QI Plan evaluation
- Newsletters and or handouts
- Dashboards
- DWIHN website

Performance Monitoring

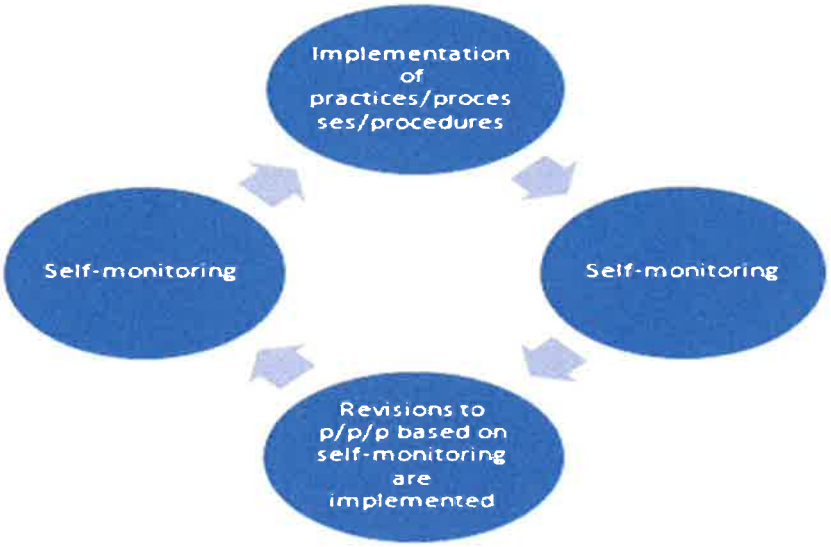
The continuous monitoring of DWIHN's service provider network includes any affiliates or subcontractors to which it has delegated managed care functions. The standards used to assess contractors are the applicable sections of the Social Security Act, the Code of Federal Regulations (CFR), the Center for Medicare and Medicaid (CMS), MDHHS Operations Manuals, Michigan's Medicaid State Plan, and the Michigan Medicaid Provider Manual.

In an ever-changing economy, quality services and supports that result in positive outcomes for persons that receive services in a cost-effective manner are crucial. DWIHN continues to move toward a system that ensures accountability and transparency relative to service quality and cost. As a result, DWIHN's QI Unit will continue to develop, train and implement a standardized system in which to measure performance and outcomes. These measurements will ensure accountability and transparency relative to the quality of services and cost. DWIHN's monitoring, which includes but is not limited to onsite, virtual and provider self-monitoring these monitoring measures are a component of the CQI process.

This process is designed to provide an organized documented process for assuring that eligible Detroit and Wayne County residents are receiving quality services for members with Serious Mental Illness, Severe Emotional Disturbance, Substance Use Disorders, Intellectual Developmental Disabilities, and Co-Occurring Disorders that are both medically necessary and appropriate standards of care while achieving the member desired outcomes.

DWIHN has adopted a performance monitoring process to support a CQI practice in an on-going effort to improve services through consistent evaluation, resulting in process/procedure/program refinements by on-going monitoring improvements as seen in Figure 1.

Figure 1.

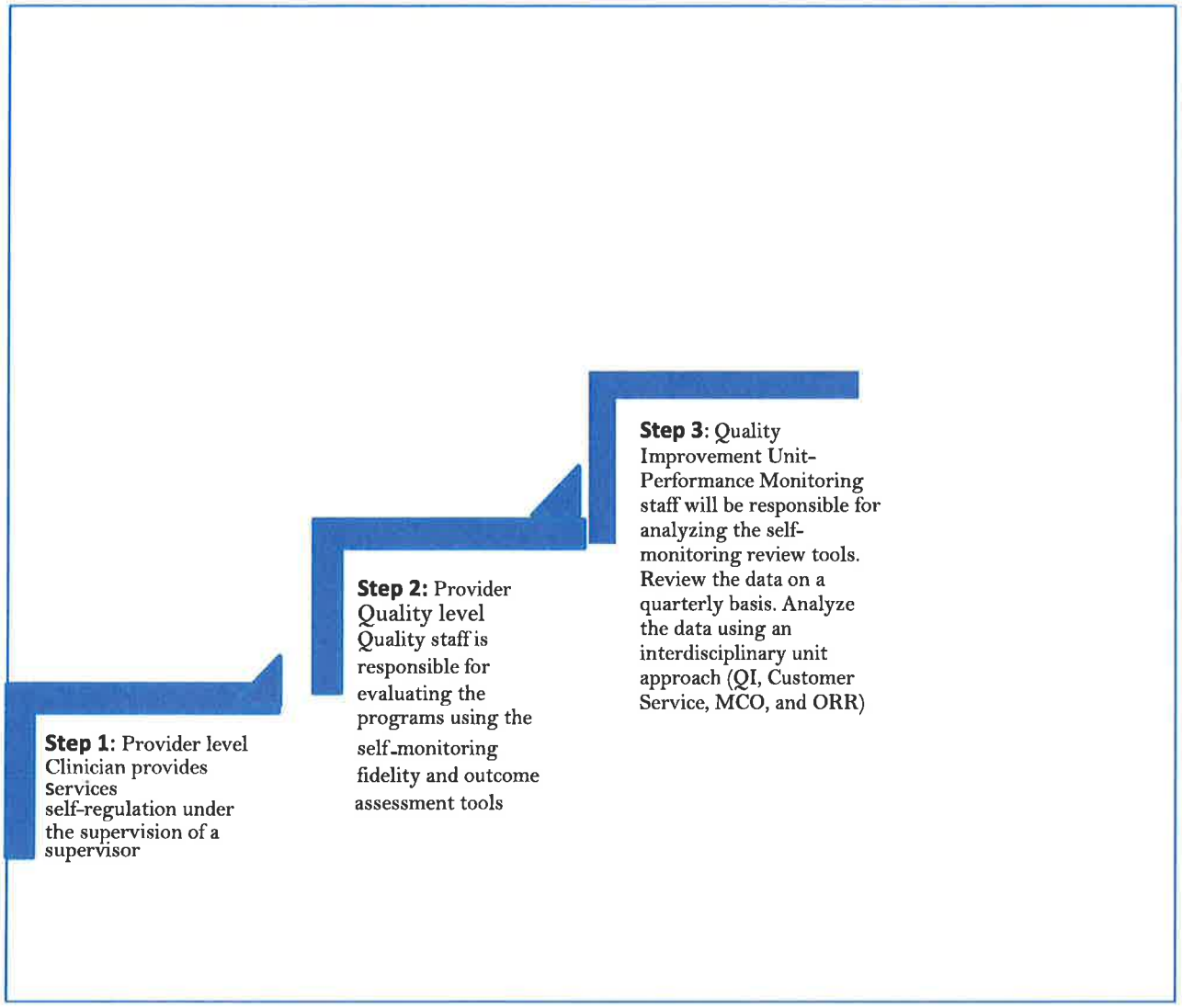


The Performance Monitoring Plan is geared to improve quality and measure our performance in the delivery of service and compliance with required standards. This plan requires the involvement, skills, expertise and input from DWIHN's Service Provider Network and internal staff. Requiring self-regulation and monitoring by all partners (DWIHN, Contracted Providers, Practitioner and Members).

As part of the monitoring process, DWIHN developed multiple levels using a standardized self-monitoring/self-regulating approach. This multilevel monitoring approach begins at the service provider level and cascades up to DWIHN's Quality Improvement Team. The "Monitoring Process" standardized tools assist in the documentation to ensure that:

- Actions and/or process requirements are not open to different interpretations
- The process is made easier to understand
- Non-value-added steps are eliminated
- Effectiveness and efficiency are increased
- The process can be benchmarked to determine if it is excellent or to set new performance goals
- DWIHN and Contracted Provider staff can collect evidence relying on process conformity to increase validity and reliability in findings.

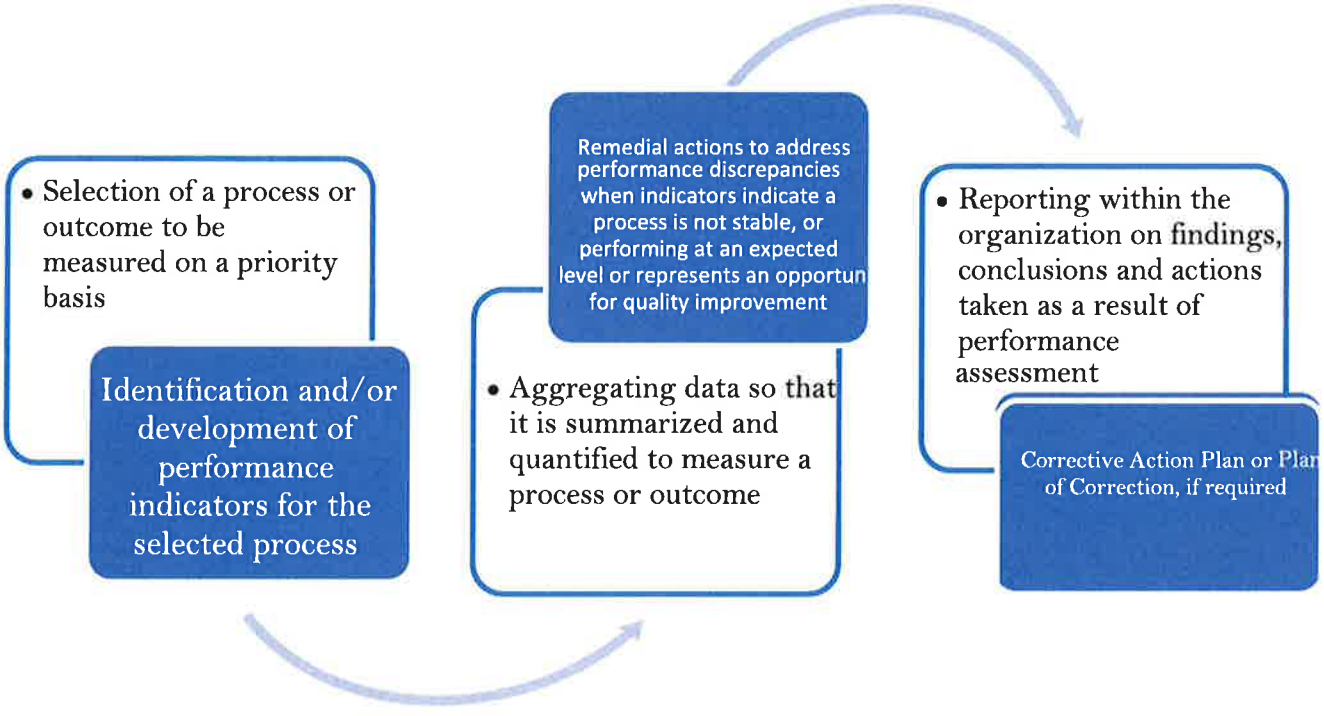
Process Steps of Performance Monitoring Pathway (defined by QI)



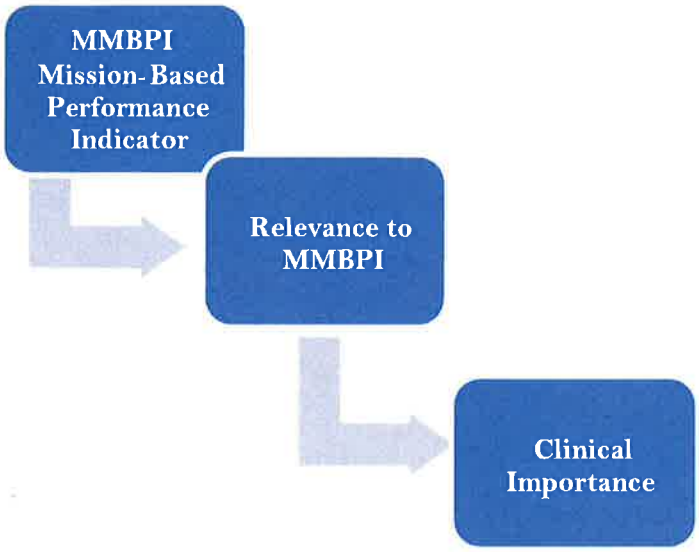
Performance Measurement

Performance measurement is a critical component of the PDSA cycle. Performance Measurement is the process of regularly assessing the data results produced by a program. The ***purpose*** of measurement and assessment is to:

Measurement and assessment ***involve***:



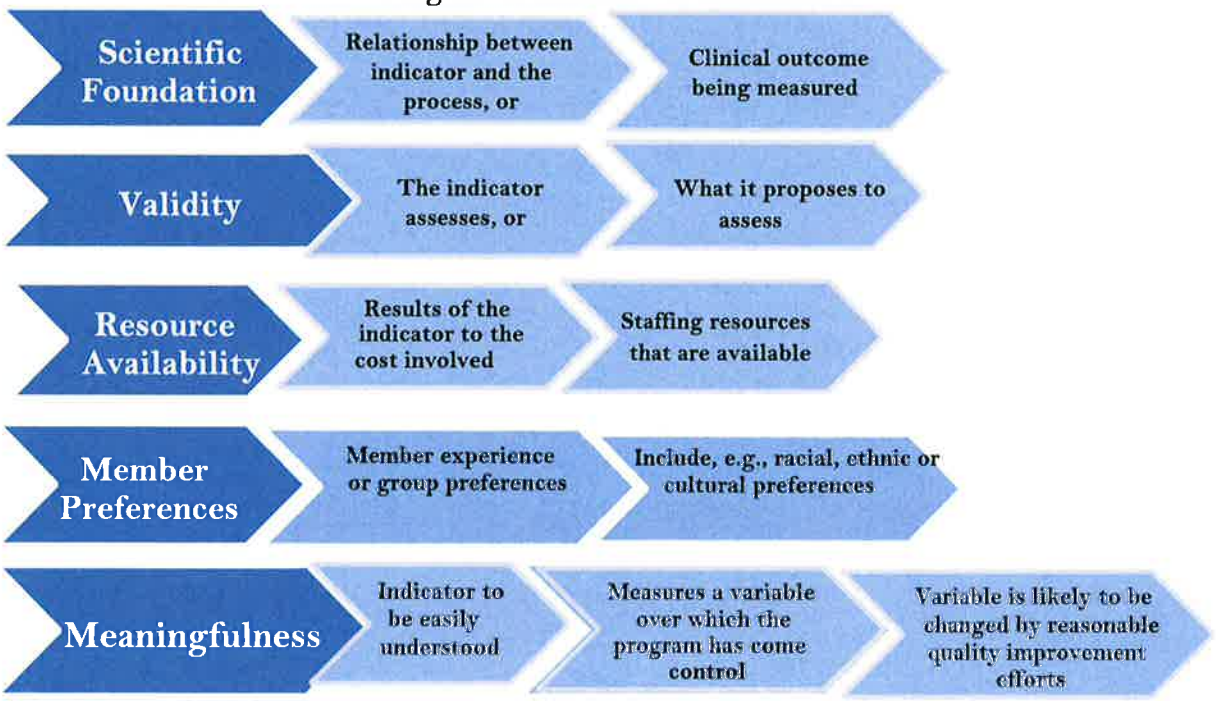
Selection of a Performance Indicator



- High Volume, or
- Problem Prone, or
- High Risk

Characteristics of a Performance Indicator

Factors to consider in determining which indicator to use include:



The Performance Indicators Selected for the DWIHN'S Quality Improvement Plan FY 21-23 from the Strategic Plan

For purposes of this plan, an indicator(s) comprises of five (5) key elements: name, definition, data to be collected, the frequency of analysis or assessment, and preliminary ideas for improvement. The following ten (10) performance indicators will be the focus using the Board approved Strategic Plan, Pillars and Focus Areas.

Measure of Service	
Name	***Michigan Mission Base Performance Indicators (MMBPI)***
Definition	*This includes the indicators found in the MDHHS Code Book.*
Data Collection	*The data is collected through MH-WIN, and the remainder is calculated by MDHHS.*
Assessment Frequency	*The Quality Improvement Committee will assess information associated with the indicator on a monthly basis and submit to MDHHS Quarterly.*
Measure of Service	
Name	***Member Grievances***
Definition	*An expression of dissatisfaction with any aspect of the operations or activities by the Service Provider or DWIHN.*
Data Collection	*Primarily collected through MHWIN.*
Assessment Frequency	*The Customer Service Committee will assess information associated with the indicator on a Quarterly basis.*
Measure of Service	
Name	***Member Satisfaction***
Definition	*Measure of how services meet or exceed member expectation.*
Data Collection	*MH-WIN, Survey, Member Questionnaire.*
Assessment Frequency	*The Customer Service Committee will assess information associated with the indicator on a Quarterly basis.*
Measure of Service	
Name	***Clinical Practice Improvement***
Definition	*Measure of Model Fidelity or Measure of outcomes of persons served within various Best Practices.*
Data Collection	*Through Provider Data, MH-WIN Data.*
Assessment Frequency	*The Quality Improvement Committee will assess information associated with the indicator on a Quarterly basis.*

Measure of Service	
Name	***Finance***
Definition	*Ensure financial solvency of DWIHN and Network Providers*
Data Collection	*Site Reviews, Audits, Financial Reports.*
Assessment Frequency	*The Quality Improvement Committee will assess information associated with the indicator on a Quarterly basis or as needed.*
Measure of Service	
Name	***Crisis Services***
Definition	*Completion of Crisis/Safety Plans as applicable for each member by Contracted Providers.*
Data Collection	*Crisis Plans in MH-WIN, Performance Monitoring.*
Assessment Frequency	*The Quality Improvement Committee will assess information associated with the indicator on a Quarterly basis.*
Measure of Service	
Name	***7 Day Follow-up***
Definition	*Ensure appointments are scheduled and attended by members.*
Data Collection	*Appointments scheduled with follow-up in MH-WIN*
Assessment Frequency	*The Quality Improvement Committee will assess information associated with the indicator on a Quarterly basis.*
Measure of Service	
Name	***30 Day Follow-up***
Definition	*Ensure appointments are scheduled with Mental Health Professionals and attended by Members.*
Data Collection	*MH-WIN, Performance Monitoring*
Assessment Frequency	*The Quality Improvement Committee will assess information associated with the indicator on a Quarterly basis.*

Measure of Service	
Name	***Critical Event/Sentinel Event/Death Reporting***
Definition	*Reporting of health and safety incidents and 911 calls by Contracted Providers.*
Data Collection	*MH-WIN*
Assessment Frequency	*The Quality Improvement, Critical Sentinel Event, Peer Review and Death Review Committees will assess information associated with the indicator on a Quarterly basis.*
Measure of Service	
Name	***Advocacy***
Definition	*Identify ways to improve community inclusion and integration.*
Data Collection	*MH-WIN, Site Review, Performance Monitoring, HCBS*
Assessment Frequency	*The Quality Improvement and Constituents Voice Committees will assess information associated with the indicator on a Quarterly basis.*

Performance Indicators Assessment

The Assessment of the Performance Indicators is accomplished by comparing actual performance on an indicator with:

- Self over time
- Pre-established standards, goals or expected levels of performance;
- Information concerning evidence-based practices;
- Other systems or similar service providers

Specific, measurable, actionable, relevant and timely data is a critical element of Quality Improvement operations. Quality Improvement unit staff is engaged in on-going processes for identification of data process deficiencies and opportunities to improve accuracy and completeness of the DWIHN's datasets in MH-WIN and in the state's data warehouse.

The Quality Improvement Unit has responsibility for oversight of the Michigan Mission Based Performance Indicator (MMBPI) System data. Standardized indicators, based on the systematic, on-going collection and analysis of valid and reliable data are utilized. Performance measures utilized have been established by MDHHS in the areas of access, efficiency and outcome. This data is reported to MDHHS according to established timelines and formats. Data is also reported quarterly to various factions of the quality Improvement infrastructure (i.e., Program Compliance Committee, Quality Improvement Steering Committee, Quality Operations Technical Assistance Workgroup, etc.).

SECTION 4: Committee Structure

To promote quality throughout DWIHN's organization, DWIHN has created committees to provide oversight and implementation of all quality improvement activities.
The quality improvement activities are achieved through a complex infrastructure which includes key stakeholders and process owners, and cross-functional units and committees. Due to the Covid-19 global pandemic, committees have been utilizing virtual meeting platforms. The structure is depicted below:

Program Compliance Committee (PCC)

The Program Compliance Committee (PCC) is a committee of the Board of Directors, and provides leadership for the Quality Improvement process through supporting and guiding implementation of quality improvement activities at DWIHN; and reviewing for changes, evaluating, need for Board Actions and approving the QAPIP Description biennial, the QAPIP Evaluation and Work Plan annually.

Membership:
DWIHN's PCC Committee consists of members of the Board of Directors. The Chief Clinical Officer is the liaison to the committee. Meeting notices are posted in public places and on DWIHN's website. Meetings are open to the public.

Function of the Committee:
The committee monitors the effectiveness of the QAPIP and make recommendations on the following:

- Annual evaluation of the effectiveness of the QAPIP and recommends approval of reports to the Board
- System-wide trends and patterns of key indicators
- Opportunities for improvement
- Studies in areas identified from data review as having the potential for affecting the outcomes of care and related quality concerns
- Policy or procedure
- System-wide attainment of goal(s) and objective(s)
- Developing and approving the QAPIP description and evaluation
- Establishing measurable objectives based upon priorities identified through the use of established criteria for improving the quality and safety of clinic services
- Developing indicators of quality on a priority basis
- Periodically assessing information based on the indicators, acting as evidenced through quality improvement initiatives to solve problems and pursue opportunities to improve quality
- Establishing and supporting specific quality improvement initiatives
- Reporting to the Full Board of Directors on quality improvement activities on a regular basis
- Review of program operations
- Recommend Board Actions to the Full Board of Directors

Quality Improvement Steering Committee (QISC)

DWIHN's Quality Improvement Steering Committee (QISC) is an advisory group with responsibility for ensuring system-wide representation in the planning, implementation, support and evaluation of DWIHN's continuous quality improvement program. The QISC provides ongoing operational leadership of continuous quality improvement activities for DWIHN. It meets at least monthly or not less than nine (9) times per year. The QISC provides leadership in practice improvement projects and serves as a vehicle to communicate and coordinate quality improvement efforts throughout the quality Improvement program structure.

Membership:

Membership includes the Medical Director, directors of DWIHN's units or designee, chairperson of the committees within the Quality Improvement structure or designee, members, advocates and Contracted Providers of services to members with Serious Mental Illness, Severe Emotional Disturbance, Substance Use Disorders, Intellectual Developmental Disabilities, and Co-Occurring Disorders.

Function of the Committee:

- Establish and annually review committee operational guidelines, such as confidentiality, meeting frequency, management of information requests, number of members required for a quorum, membership, etc.
- Establish committee goals and timelines for progress and achievement
- Participate in the development and review of quarterly/annual reports to the Program Compliance Committee and the Full Board of Directors regarding the Quality Improvement System
- Annually review and evaluate the effectiveness of the Quality Assessment Performance Improvement Program
- Oversee a circular communication process in order to ensure that all involved constituencies, including the Board of Directors, DWIHN staff, and members, providers and other stakeholders are a part of the Quality Improvement Process
- Provide recommendations and feedback on process improvement, program implementation, program results and program continuation or termination
- Examine quantitative and qualitative aggregate data at predetermined and critical decision-making points and recommend courses of action
- Review reports from regulatory DWIHN reviews
- Review of DWIHN improvement plans and make recommendations based on these reviews
- Monitor progress and completion of plans of correction in response to recommended remedial actions identified for the DWIHN or by regulatory organizations
- Review quality Improvement operating procedures and propose changes in procedures as needed
- Oversee a process for establishing, continuing or terminating subcommittees, standing committees, improvement teams, task groups and work groups

- Identify training needs and opportunities for staff development in the quality Improvement process
- Identify future trends and make recommendations for next steps
- Develop standardized forms required for the work of the Steering Committee
- Initiate and participate in recognition and acknowledgement of successes in quality Improvement for the DWIHN and the community mental health system
- Leadership in practice improvement projects

Improving Practices Leadership Team (IPLT)

DWIHN endeavors include implementation and support of Best and Evidence-Based Practices (EBP). The purpose of the Improving Practices Leadership Team (IPLT) is to oversee and monitor these practices. IPLT is charged with developing work plans, coordinating the regional training and technical assistance plan, working to integrate data collection, developing financing strategies and mechanisms, assuring program fidelity, evaluating the impact of the practices, and monitoring clinical outcomes.

Membership:

The IPLT committee is chaired by the Clinical Officer and includes Improving Practice Leadership Specialists in the following areas:

- Individuals with Serious Mental Illness (SMI)
- Children with Serious Emotional Disturbance (SED)
- Individuals with Intellectual and/or Developmental Disabilities (I/DD)
- Individuals with Substance Use Disorders (SUD)
- Quality Improvement
- Finance
- Data Evaluation
- Member employed by the system
- Family Member of a child receiving PIHP services Peer support specialist
- An identified program leader for each practice being implemented
- Identified program leader for peer-directed or peer-operated services

Function of the Committee:

Develop and communicate a strategy that is tailored to the context and the roles, capabilities, and interests of the stakeholder groups involved in the public mental health system:

- Identify and mobilize program leaders or change agents within the organization to implement the activities required to achieve the desired outcomes
- Develop an on-going process to maximize opportunities and overcome obstacles
- Monitor outcomes and adjust processes based on learning from experience
- Align relevant persons, organizations, and systems to participate in the transformation process
- Support Membership of a Member/Certified Peer Support to represent the PIHP/CMHSP on the Recovery Council of Michigan
- Assess parties' experience with change
- Establish effective communication systems
- Ensure effective leadership capabilities

- Enable structures and process capabilities
- Improve cultural capacity
- Demonstrate their progress in system transformation by implementing evidence based, promising and new and emerging practices

Standing Committees

DWIHN's quality Improvement system consists of standing committees that oversee on-going monitoring, peer evaluation, and improvement functions, including receipt and review of data related to their identified areas of responsibility. This structure is designed to improve quality of care to members, improve operations of providers and promote efficient and effective internal operations. Standing Committees may be assigned quality indicators to use in monitoring aspects of care and service or may establish indicators for which data will be collected and monitored.

The standing committees consist of qualified representatives of DWIHN units, providers and in some cases, stakeholders and members. The committees define aspects of services and supports to be monitored for opportunities to improve, based on priorities established in the MDHHS contract and on the needs of high-risk members and high volume/problem-prone programs. Results from DWIHN's Performance Indicators System, which is an extension of the MDHHS data collection program, are a key source for identification of aspects to be monitored. The committees develop plans by which data for their scope of responsibility will be reviewed and opportunities for improvement identified. QI staff work with the committees and assure that the principles of data based continuous quality improvement are followed. The standing committees monitor improvements that are implemented for effectiveness and improved outcomes.

Standing committees identify and recommend needs for quality improvement teams, as appropriate, and may bring in outside resources, if needed, to facilitate the work of teams and to facilitate involvement of internal staff, providers, members, stakeholders and various outside groups, as needed. The standing committees are:

Critical/Sentinel Events Committee (CSEC)

The Critical/Sentinel Event process involves the reporting of all unexpected incidents involving the health and safety of the members within DWIHN's service delivery area. Incidents include, at a minimum, member deaths, medication errors, behavioral episodes, arrests, convictions, physical illness and injuries. The CSEC retains the right to make the final decision whether an incident is a Critical/ Sentinel Event. As applicable, when necessary to respond to questions/concerns of the CSEC others will be requested to attend.

Membership includes but not limited to:

- Medical Director
- Utilization Management
- Managed Care Operations
- Quality Improvement
- Substance Use Disorders Initiatives
- Office of Recipient Rights

Function of the Committee:
The mission and goal of the CSEC is to ensure the Contracted Providers and/or Clinically Responsible Service Providers (CRSP) conduct a thorough review of incidents with an action plan to ensure the incident does not reoccur or the risk of the incident reoccurring is minimized.

The CSEC uses a four-tiered system of peer review activity. In the first tier, the Critical Events are reviewed by QI Critical/Sentinel Event Liaison for data collection, reviewed for quality of care issues, request for additional documents, completeness of the information and notification of high-risk critical incidents to DWIHN's QI Director and the DWIHN's Administration.

In the second tier, the Critical/Sentinel Events are reviewed by the Medical Director, Chief Clinical Officer and the QI Critical/Sentinel Event Liaison for clinical issues, standards of care and potential Sentinel Events.

In the third tier, the Critical/Sentinel Events are reviewed by DWIHN's Peer Review Committee, if needed, as a peer review activity. Findings can include requests for corrective action plans, if needed. Repeated deficits or failures to correct identified deficits may result in recommendations for performance sanctions as defined by DWIHN policy, procedures and contracts.

In the fourth tier, the data collection is reviewed by DWIHN's Critical/Sentinel Event Committee for policy review and implementation, patterns, trends, compliance, education and improvement and presentation to DWIHN PCC.

Death Review Committee (DRC)
All unexpected* deaths of Member who at the time of their deaths were receiving specialty supports and services must be reviewed and must include:

- Screens of individual deaths with standard information (e.g., coroner's report, death certificate)
- Involvement of medical personnel in the mortality reviews
- Documentation of the mortality review process, findings, and recommendations
- Use of mortality information to address quality of care
- Aggregation of mortality data over time to identify possible trends.

* Unexpected deaths include those that resulted from suicide, homicide, an undiagnosed condition, accidental, or suspicious for possible abuse or neglect. As applicable, when necessary to respond to questions/concerns of the DRC other persons will be requested to attend.

Membership includes but not limited to:

- Medical Director
- Clinical Practice Improvement
- Managed Care Operations

- Quality Improvement
- Office of Recipient Rights
- Integrated Health Care
- Substance Use Disorders

Function of the Committee:
The mission and goal of the DRC is to ensure that a thorough review of the Member's death has been conducted by the Member's respective Service Provider, CRSP, Recipient Rights and Clinical Practice Improvement Units. All reviews are conducted in accordance with DWIHN's Death Reporting Policy and procedures, state and federal laws and regulations that govern death review activities.

Peer Review Committee (PRC)

The PRC Committee is a peer review activity responsible for the clinical peer review of critical incidents involving, at a minimum, Member deaths, Critical/ Sentinel Events, incidents involving the media or special requests from DWIHN's Medical Director or Administration. All peer review activities are privileged, confidential and are in accordance with the state and federal laws and regulations that govern peer review activities. As applicable, when necessary to respond to questions/concerns of the PRC Committee other persons will be requested to attend.

Membership:
- Medical Director
- Clinical Practice Improvement
- Managed Care Operations
- Quality Improvement
- Office of Recipient Rights
- Integrated Health Care
- Substance Use Disorders

Function of the Committee:
The mission and goal of the PRC Committee is to ensure the Service Providers and CRSP conduct a thorough review of incidents and provide an action plan that will ensure similar incidents do not reoccur and that the risk of reoccurring is minimized. The goal of the PRC Committee is to review the processes at the Service Provider and CRSP when conducting a thorough clinical review of the incident in accordance with DWIHN's Peer Review Policy and Procedures. All Peer Review activities are privileged, confidential and are in accordance with state and federal laws and regulations that govern Peer Review activities.

Behavioral Treatment Advisory Committee (BTAC)

DWIHN's Behavioral Treatment Advisory Committee is charged with the oversight of nine (9) Behavioral Treatment Plan Review Committees (BTPRC) in the network. The committee takes the lead for implementing a systematic approach to monitor service providers and compliance with the MDHHS standards for BTPRC. The committee reviews system-wide BTPRC trends and patterns compared to key indicators such as psychiatric hospitalization, behavior stabilization, reductions or increases in the use of interventions, crisis plans, and behavior treatment plans. The representatives from the network providers are invited for the case validation review process at the BTAC as part of continuous quality improvement

at the PIHP level. The committee submits quarterly BTPRC data analysis reports to MDHHS.

Membership:
The committee consists of DWIHN's Medical Director, licensed psychologist, Member, DWIHN staff, provider representatives and Office of Recipient Rights (ORR). The representative of DWIHN's ORR is required to attend each Behavior Treatment Review Committee (BTRC) on Behavior Treatment Plan Requirements for the service provider network.

Each of the providers BTRC consists of a licensed psychologist, a licensed physician/psychiatrist and DWIHN's ORR who assigns a representative. Each committee sends representative(s) to the monthly DWIHN's Behavior Treatment Advisory Committee.

Function of the Committee:
DWIHN's committee provides oversight and monitoring of Behavioral Treatment Plan Review Committees (BTPRC) to ensure compliance with MDHHS Technical requirements and collects data and information on implementation issues including:

- Percent of provider Behavior Management committees with active Recipient Rights representation
- Types of challenging behaviors resulting in intrusive and/or restrictive interventions
- Percent of Member exhibiting challenging behaviors per the client record with behavior treatment plans
- Types of interventions used
- Frequency and duration of interventions used
- Frequency of review of behavior management plans
- Percent of interventions matching behavior management plans
- Percent of charts labeled appropriately
- Number of Critical/Sentinel Events involving challenging behaviors
- Percent of care staff at all levels trained in behavior management (i.e., positive behavior management, the culture of gentle teaching, management of challenging behaviors, etc.)
- Percent of care staff at all levels who demonstrate the required behavior management competencies
- Number of behavior management related Office of Recipient Rights complaints.

Credentialing Committee

The purpose of the committee is to delineate and describe the functions and oversight of DWIHN's Credentialing Verification Organization (CVO) and the responsibilities of the Service Providers, and to implement credentialing/re-credentialing functions.

In compliance with MDHHS' Credentialing and Re-credentialing processes, DWIHN has established written policy and procedures for ensuring appropriate credentialing and re-credentialing of the provider network. Quality Improvement monitors the provider network qualification of staff to ensure compliance with federal, state, and local regulations. Performance monitoring is completed no less than annually through an established process to ensure providers of care or support are qualified to perform their jobs.

Membership:

- Medical Director
- Network Providers
- DWIHN Staff

Risk Management

The purpose of the committee is to review incidents involving Member and the provider system under the protection of protected information. The Risk Management Committee is an ad-hoc committee and meets as required.

Membership:

- Chief Financial Officer
- Medical Director
- Corporate Compliance Officer
- Deputy CEO/COO
- Others as needed

Function of the Committee:

- Continuously improve member safety and minimize and/or prevent the occurrence of errors, events, and system breakdowns leading to harm to patients, staff, volunteers, visitors, and others through proactive risk management and patient safety activities.
- Minimize adverse effects of errors, events, and system breakdowns when they do occur.
- Minimize losses to the organization overall by proactively identifying, analyzing, preventing, and controlling potential clinical, business, and operational risks.

Cost Utilization Steering Committee

The utilization, standards, access etc. to clinical services, Cost Utilization looks at where our spending is occurring, analyzes the trends, and makes recommendations for the system based on Strategic Initiatives, Market Forecasts, and our historical data.

Membership:

- Chief Financial Officer
- Deputy Chief Financial Officer
- Chief Information Officer
- Deputy CEO/COO
- Medical Director

Function of the committee:

- To receive data from the Cost Integrity Group (CIG), Procedure Code Work Group, along with the contractual expectations
- Review the needs for improved clinical outcomes (UM/QM/CPI data or input), state mandates (such as EBPs...)
- Finds ways fund necessary functions or services. It contemplates state funding (revenue) and network funding (costs) and fund source management along with cost and utilization data integrity and even system processes.
- As a steering committee it would set the priorities for managing our funding to achieve our operating expectations.

Compliance Committee

The Compliance Committee shall meet, at a minimum, on a bi-annual basis during the fiscal year. However, the Compliance Officer can schedule additional meetings as deemed necessary. A majority of the Committee constitutes a quorum for the transaction of business. The Committee shall act by the affirmative vote of a majority of the Committee Member present at a duly held meeting.

Membership:

- Corporate Compliance Officer
- Deputy CEO/COO
- Chief Financial Officer
- Medical Director

Function of the Committee:

- Assist the Compliance Officer with risk assessment and the need for and design of compliance reviews within the organization;
- Advise the Compliance Officer on compliance training needs within the organization and assist in arranging for and conducting such compliance training;
- Assist the Compliance Officer with developing organizational policies supporting the Compliance Plan;
- Assist the Compliance Officer with implementation of the Compliance Plan;
- Assist the Compliance Officer with evaluation of the effectiveness of the Compliance Plan; and
- Refer all matters to the Program Compliance Committee (PCC) and the Board for review that relate to the following:
  - Violations that require notification to federal, state, and/or local agencies;
  - (ii)Violations that have an economic impact (i.e. budgetary) on the Network and/or require funds to be returned to federal or state agencies; or
  - (iii) Any other information that the Compliance Committee deems appropriate for Board notification

Customer Service Committee

The purpose of the committee is to provide procedural and operational guidance on Customer Service functions to DWIHN, the Access Center, Crisis services vendor, and Service Providers. The Customer Service Committee meets on a quarterly basis.

Membership:

- Customer Service Director
- Grievance Coordinator
- Appeals Coordinator
- Provider Customer Services, Grievance, and Appeal staff
- Others as needed

Function of the Committee:

The quarterly meetings are facilitated by DWIHN's Customer Service Department to coordinate with the Customer Service, Grievance and Appeals management at the Service Provider levels that addresses Customer Service, Grievance and Appeals related updates and issues. It also provides for a venue to network and share programs, processes and upcoming events that are occurring in their respective networks.

Recipient Rights Advisory Council (RRAC)

The RRAC is mandated by the Michigan Mental Health Code (MCL 330.1757). The RRAC meets bi-monthly, on the first Monday of every odd-numbered month, from 1:00 – 3:00. The meetings are governed by the Open Meetings Act and the public is welcome to attend.

Membership:

Is broadly based so as to best represent the varied perspectives of the CMHSP's geographical area. At least 1/3 of the Membership shall be primary Member or family Member, and of that 1/3, at least ½ shall be primary Member.

Function of the committee:

- Protect the Office of Recipient Rights (ORR) from pressures that could interfere with the impartial, even-handed, and thorough performance of its functions
- Serve in an advisory capacity to the executive director and the director of ORR Other specific functions include:
- Review the process for funding ORR
- Recommend candidates for the Director of ORR to the Executive Director
- Consult with the Executive Director regarding any proposed dismissal of the Director of ORR
- Receive education and training in ORR policies and procedures
- Review the Semi-Annual report submitted to the State
- Review the Annual report submitted to the State
- Provide "Goals for ORR" and "Recommendations for ORR" for the Annual Report
- For DWIHN, the RRAC also serves as the Recipient Rights Appeals Committee

Research Advisory Committee (RAC)

The purpose of the committee is to implement a research proposal review process, recommend research and evaluation aligned with DWIHN's strategic priorities, and to oversee the protection of any human subjects/members and staff involved in research initiatives. The RAC shall meet at least quarterly or as often as necessary to carry out its charge.

Membership

- Chief Financial Officer
- Medical Director
- Quality Improvement
- Clinical Practices Improvement
- Utilization Management
- Service Providers

Function of the committee:

- Act as a collaborative body to encourage the development of research and evaluation proposals within the framework of a research agenda informed by DWIHN's strategic priorities
- Provide recommendations regarding research and evaluation projects
- Encourage and promote the utilization of research-based practice

Constituent's Voice

The Constituents' Voice (also known as the "CV") is a DWIHN Member advisory group. The body is charged with advising the Network, and specific to driving policies and agendas that facilitate community inclusion.

Membership:

The diverse group of Member, advocates and providers meets monthly. Generally, meetings are held at DWIHN on the fourth Friday of each month from 10:00am -12:00pm.

Function of the Constituent's Voice:

The CV provides oversight for hosting an annual conference that focuses on trending community inclusion issues. The education of stakeholders about community inclusion, i.e. personally, valued participation and interactions with others. The solicitation of funds and sponsorships for the mini-grant project – The George Gaines & Roberta Sanders Fund for Community Inclusion, which was established in 2015. The body also sponsors various advocacy and community efforts to advance inclusion. Events include the annual Michigan Walk-A-Mile in My Shoes event and voter registration drives.

Quality Improvement Teams, Ad Hoc Committees and Workgroups

DWIHN may identify opportunities for improvement that do not fit into the existing standing committee structure. Ad hoc teams, workgroups and quality circles are appointed for a limited period of time for a specific task by the Quality Improvement Steering Committee, Quality Improvement or a Standing Committee based on organizational need. Reports from the various Committee(s), Ad hoc team(s), DWIHN Unit(s) and workgroup(s) will include outcome measures and are forwarded to the Quality Improvement Steering Committee (QISC).

Utilization Management Committee (UM) – see UM Program Description for further information.


President/CEO
Full
Board of Directors
PCC
QISC
Medical Director
SUD Policy Board
Program Compliance Committee
Quality Improvement Steering Committee
IPLT
Standing Committee
Critical Sentinel Event Committee
Death Review Committee
Peer Review Committee
Behavioral Treatment Advisory Committee
Credentialing Committee
Risk Management
Cost Utilization Steering Committee
Compliance Committee
Customer Service Committee
Recipient Rights Advisory Committee
Research Advisory Committee
Constituent's Voice
Quality Improvement Teams, Ad-hoc Committees and Workgroups
Utilization Management Committee

SECTION 5: Quality Improvement Evaluation

The Quality Improvement evaluation is completed at the end of each fiscal year. The annual evaluation is conducted by DWIHN and submitted to MDHHS and kept on file at DWIHN, along with the QAPIP description. These documents will be reviewed by Health Services Advisory Group (HSAG) and MDHHS as part of the certification process. The evaluation summarizes the goals and objectives of DWIHN's Quality Improvement Work Plan. The Quality Improvement Work Plan specifies quality improvement activities DWIHN will undertake in the upcoming year. The plan includes goals and objectives based on the strengths and weaknesses identified in the previous year's evaluation and issues identified in the analysis of quality metrics. The Work Plan is the mechanism for tracking quality improvement activities and is updated as needed to assess the progress of initiatives. The foundation of the Work Plan addresses the following NCQA focus areas:

- Quality and safety of clinical care
- Quality of service
- Member Experience
- Yearly goals and objectives
- Planned Activities
- Monitoring of previously identified issues
- Evaluation/outcomes
- Time frame for each activity's completion
- The staff member responsible for each activity
- Evaluation of the QI program

The Quality Improvement Work Plan is reviewed and approved by the Program Compliance Committee (PCC) and the Full Board of Directors annually.

Plan Actions for 2021

In FY 2021, the QAPIP work plan will be reviewing these areas to achieve continuous quality improvement in the quality and safety of clinical care, quality of service and member experience.

- Maintain NCQA accreditation.
- Telehealth services have emerged as essential technology for providing services to our members during Covid-19. It is imperative to ensure adequate and efficient services are being provided to the people we serve and that proper monitoring of this service delivery is accomplished.
- Establish an effective Crisis Response System and Call Center
- Continuously improve the quality, appropriateness, availability, accessibility, coordination and continuity of health care services to members across the continuum of care.
- Improve member and provider satisfaction.
- Conduct reviews through virtual monitoring to ensure that telehealth services are compliant in accordance with regulatory standards.

- Ensure a high-quality network through credentialing, peer review and contracting processes.
- Continue to collaborate with providers to share ideas and implement strategies to improve care coordination and quality of service.
- Improve and manage member outcomes, satisfaction and safety.
- Maintain excellent compliance with state and federal regulatory requirements, and accreditation standards.
- Ensure DWIHN's organizational initiatives related to cultural competency and diversity for members and providers meet the needs of DWIHN members.
- Demonstrate and communicate DWIHN's commitment to improving progress toward influencing network-wide safe clinical practices.

DETROIT WAYNE MENTAL HEALTH AUTHORITY UTLIZATION MANAGEMENT PROGRAM DESCRIPTION FY 2019-2021

Approved by
(Detroit Wayne Mental Health Authority Board of Directors 3/20/2019)
(Reviewed and Approved with no Changes at UMC 12/15/2020)

Table of Contents:

Attachments:

1. UM Functions for MI Health Link Program
2. Waiver and State Plan Amendments
3. DWMHA Prior Authorized Service UM Chart Review Tool
4. DWMHA Eligibility of Service Review Tool
5. DWMHA's Quality Department Clinical Record Review Tool (or its Successor)
6. Crisis Service Vendors' UM Annual Evaluation Template
7. Access Center's UM Annual Evaluation Template
8. Access Center and Crisis Service Vendors' UM Plan Outline
9. Access Center and Crisis Service Vendors' UM Plan Audit Tool

References:

1. DWMHA Affirmative Statement Policy
2. DWMHA Appropriate Professionals for Making UM Decision Policy
3. DWMHA Behavioral Health Utilization Management Review Policy
4. DWMHA Behavioral Health Medical Necessity Policy
5. DWMHA Benefit Policy and Benefit Grid
6. DWMHA Denial of Service Policy
7. DWMHA HIPPA Privacy Manual and Policy
8. DWMHA HIPAA Security Policy
9. DWMHA Individual Plan of Service Policy
10. DWMHA Inter Rater Reliability Policy
11. DWMHA Local and Alternative Dispute Resolution Policy
12. DWMHA UM/Provider Appeal Policy
13. MDHHS Person Centered Planning Policy Practice Guidelines (3/15/11)
14. Michigan Medicaid Provider Manual

I. INTRODUCTION:

Utilization Management (UM) functions are driven by the Detroit Wayne Mental Health Authority (DWMHA) Board's commitment to the provision of effective, consistent and quality care for behavioral health services that produces financial outcomes. 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 DWMHA Chief Medical Officer has substantial involvement in the development, implementation, supervision and evaluation of the UM program. The Board of Directors (BOD) has the ultimate responsibility for ensuring overall quality of supports and services delivered to Wayne County residents and oversight of UM functions.

II. MISSION:

DWMHA is a safety net organization that provides access to a full array of services and supports to empower persons within the Detroit Wayne County behavioral health system.

III. VISION:

To be recognized as a national leader that improves the behavioral and overall health status of the people in our community.

IV. VALUES:

- We are a person centered, family and community focused organization.
- We are an outcome, data drive and evidenced based organization.
- We respect the dignity and diversity of individuals, providers, staff and communities.
- We are culturally sensitive and competent.
- We are fiscally responsible and accountable with the highest standards of integrity.
- We achieve our mission and vision through partnerships and collaboration.

V. PURPOSE:

The purpose of the UM Program Description is to define and describe processes that will align the Utilization Management program with DWMHA's Strategic Plan as identified by the Board of Directors.

The UM program description will:

- Guard against conflict of interest and protects the integrity of clinical decision making through the use of written evidence based and professional consensus criteria;
- Promotes DWMHA accountability for any delegated functions and responsibilities;
- Confirm that individuals have a significant role in the design of the systems that support them;
- Promise UM decisions are made in a fair, impartial and consistent manner that is in the best interest of the person;
- Assure UM decisions are timely, efficient and consistent with standardized guidelines to increase the likelihood that services for vulnerable persons are equal in amount, duration and scope;
- Ensure compliance with state and federal law as well as regulatory and accreditation standards. Ensures use of Level of Care Criteria, Clinical Practice Protocols and best practices to improve process and reduce inappropriate variations in practice;
- Assure that people get individualized, appropriate behavioral health services and supports that are sufficient in scope, frequency and duration to achieve effective outcomes;
- Encourage equitable access to behavioral health services across the network; and

- Promote the availability of cost effective behavioral health services within available resources for a greater number of people;
- Respond in a timely manner to member and practitioner/provider complaints/appeals regarding UM issues after coordinating a comprehensive and timely investigation.

VI. SCOPE:

The Behavioral Health UM Program consists of activities that promote appropriate allocation of behavioral health and substance use resources for individuals managed by staff in the DWMHA office, Access Center and Crisis Service Vendors. Processes used within the context of UM include: pre-service, concurrent and post-service review; denials and appeals; discharge planning and other care management activities.

DWMHA's UM department maintains standardized policies and procedures that are created by the UM Director or their designee and reviewed by the Chief Medical Officer and Directors of all DWMHA departments through Policy Stat (DWMHA's software policy and procedure management system) and are ultimately reviewed and approved by the Chief Operating Officer. The policies are reviewed on an annual basis. In addition, procedures are reviewed annually and updated on an as needed basis. The policies and procedures provide documentation of the framework of authority in which the UM program operates. The UM staff are authorized to make decisions that operate within the framework described within these policies and procedures. The Access Center and Crisis Service Vendors' policies and procedures must align with DWMHA policies.

Depending on the level of care, certain behavioral health and substance use services require prior authorization. For example, acute inpatient hospitalization, state hospitalization, partial hospitalization, crisis residential services and withdrawal maintenance/sub-acute detox are some of the services that need prior authorization. Along with monitoring the appropriate level and allocation of care, DWMHA assesses Ambulatory Follow-Up (AFU) rates. Ambulatory Follow-Up activities serve to ensure that enrollee/members are provided with a timely out-patient appointment after they are discharged from the hospital. Care Coordinators and Support Care Coordinators provide support to enrollee/members following discharge to ensure appointment compliance within seven (7) days following discharge and assist with rescheduling of appointments on an as needed basis.

DWMHA staff, contractors and subcontractors are bound by all applicable local, state and federal laws, rules, regulations, and policies, all federal requirements, state and county contractual requirements, polices and administrative directives in effect and as amended.

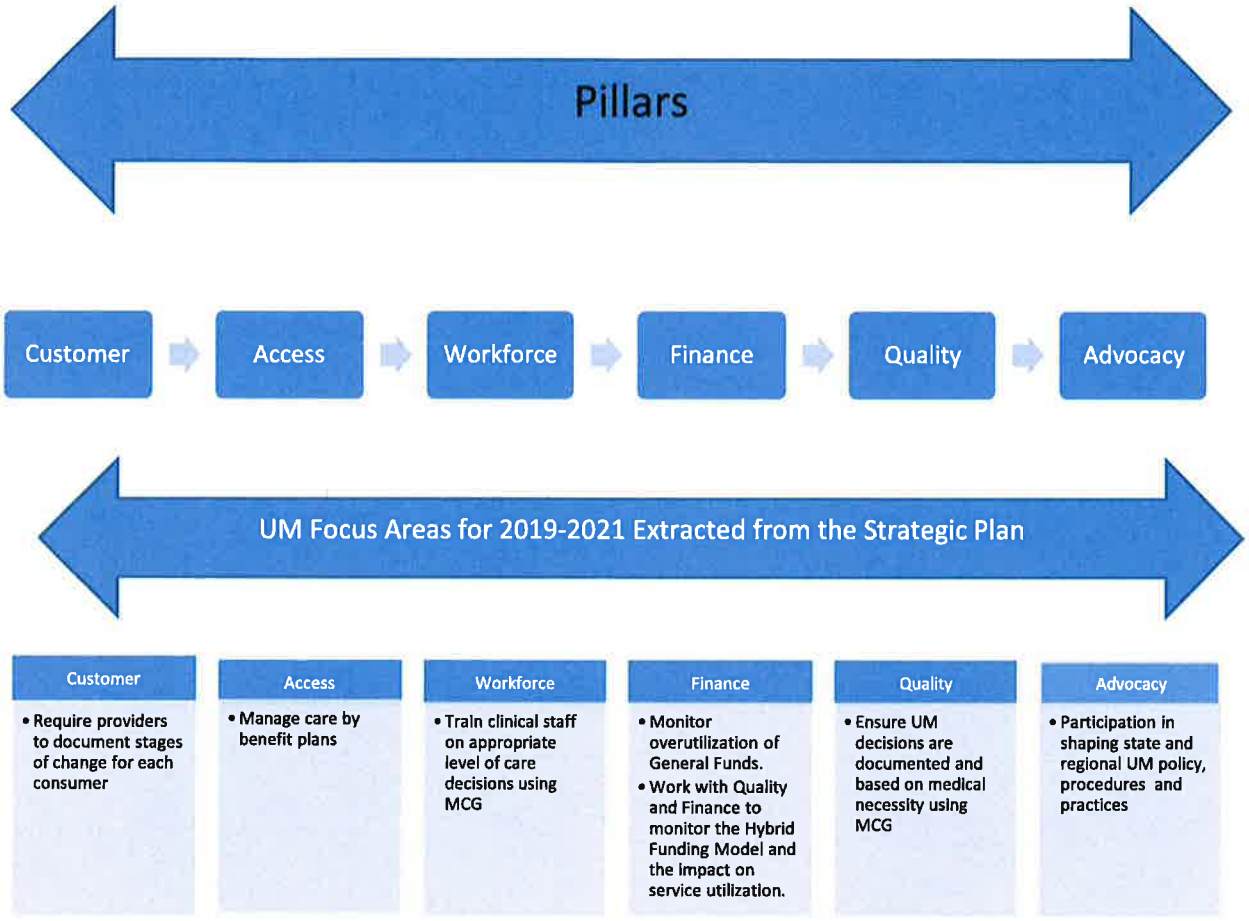
VII. DWMHA'S STRATEGIC PLAN AND THE UTILIZATON MANAGEMENT PROGRAM:

The DWMHA Board Strategic Plan is an overarching framework that strives towards common goals, establishes agreement around intended outcomes/results, and assesses and adjusts the organization's direction in response to a changing environment. The UM Program is one of the mechanisms to accomplish this. It is a systematic approach to providing independent, unbiased determinations of medical necessity using evidence based treatment criteria and guidelines to enhanced the quality and effectiveness of care. The DWMHA's approach to utilization management is based on the following six (6) pillars with support from six (6) focus areas under each pillar in the DWMHA's Board approved Strategic Plan.

Strategic Plan Pillars by Definition:

- Customer: Services should be designed to meet the needs and expectations of consumers. An important measure of quality is the extent to which customer needs and expectations are met.
- Access: Provide affordability of the services provided to the customer. To ensure availability and accessibility of the services.
- Workforce: Provide staff development activities while empowering staff in the competitive and market-driven workforce.
- Finance: Ensure the Administrative Cost as a portion of the Total Cost is low and reasonable.

- Quality: Deliver a robust decision support system as DWMHA will be recognized as the Behavioral Health Subject Matter expert through the use of standardized treatment protocols and guidelines.
- Advocacy: Establish leadership in shaping public policy for behavioral health in Michigan that fosters regional cooperation and informs and engages local and state resources as well as stakeholders.



VIII. DWMHA SYSTEM TRANSFORMATION:

DWMHA has begun transforming its role in the behavioral health system from "funder of care' to "manager of care". This system transformation will ensure more efficient and effective, person centered services by removing administrative layers that have existed for more than 12 years. In addition, the new approach allows for more comprehensive care that positively impacts the members we serve. DWMHA's goal is to provide quality holistic care to the whole person, behavioral, emotional, physical, social and spiritual.

For many years, DWMHA has contracted with several Managed Care Provider Networks (MCPNs) that were responsible for coordinated the system's direct care providers. These MCPNs included Integrated Care Alliance (ICA), Community Living Services (CLS), CareLink and ConsumerLink. Each MCPN managed specific services for the behavioral health community for individuals diagnosed with an intellectual-developmental disability, Serious Emotional Disturbance (SED), Severe Mental Illness and a Substance Use Disorder (SUD). The System Transformation eliminates the MCPN layer, allowing a direct link to Providers and a closer connection with people receiving services in Detroit and Wayne County.

Many individuals and families served by the DWMHA system of care have co-occurring disorders. These persons present with co-occurring psychiatric, substance use disorders and/or intellectual developmental disabilities, which are recognized as often resulting in poorer outcomes and higher costs in multiple clinical domains. DWMHA's efforts will focus on ensuring that consumers have access to appropriate treatment by promoting resiliency, recovery and the right to control one's life. Together with our stakeholders, including enrollees/members, family, advocates, peer support specialists, peer mentors, recovery coaches, youth

advocates, parent partners, contractors and subcontractors, DWMHA has committed to engaging in systems transformation process aimed at achieving this vision.

In June 2018, during a Special Full Board Meeting, the DWMHA Board of Directors passed a resolution in regards to the future of DWMHA and its System of Care. With input from the Board of Directors' System Transformation Committee, healthcare delivery experts, MDHHS, executive leadership and current President & CEO, Willie Brooks, the Board agree with the recommendation to the eliminate the current MCPN structure. As of October 1, 2018, DWMHA assumed full management of all services and supports taking over the responsibility for functions previously delegated to the MCPNs.

As DWMHA engaged in efforts to transform the service delivery system, DWMHA Board Directors and President/CEO charged staff with ensuring that the following requirements and standards are met and maintained:

- Seamless transition to the consumers
- Seamless transition to the providers
- Keeping transition cost within or under current administrative costs
- Complete and accurate data migration
- Smooth and complete transition of all applicable funds and assets

Within the framework of efficient utilization and effective outcomes DWMHA collects data, reviews utilization trends for over and under-utilization as well as ensuring the following:

- Individuals and families found to have co-occurring psychiatric, substance use disorders, developmental disabilities, physical health, cultural or linguistic challenges and/or age-specific special needs are served.
- Individuals and their families with higher utilization of supports and services associated with a higher cost of care and resources will be served and not limited to a few specialized programs.
- Individuals and their families will be engaged in a welcoming manner with a "no wrong door" policy that promotes greater treatment accessibility to treatment supports and services.
- Successful outcomes will involve the formation of empathetic, hopeful and integrated relationships among all parts of the DWMHA.

IX. PROGRAM STRUCTURE:

DWMHA's UM staff are highly skilled, experienced professionals who are required to have ongoing training and participate in regularly scheduled case consultations with the DWMHA Chief Medical Officer. DWMHA is committed to increasing competency and the quality of services through continuous staff development activities.

UM Staff Members' Assigned Activities and Professional Qualifications:

1. Board of Directors (BOD):
    - The BOD primary responsibility is to provide leadership, governance and oversight of the region. The Board is a policy setting body, the fiduciary of the Medicaid funds.

2. Chief Medical Officer (CMO):
    - Must have a valid Michigan License to practice as a physician, and Michigan controlled substance license. Additionally, the must has a valid and current Drug Enforcement Authority Registration. Board certification by the American Board of Psychiatry and Neurology as an adult psychiatrist is required;
    - Five (5) years of experience working in a state or community psychiatric hospital or outpatient setting, as a direct provider of mental health services;
    - At least five (5) years of administrative experience as CMO in a Mental Health Program with experience in: policy writing; accreditation activities, staff development; peer review management of direct report staff (i.e. nurses, social workers, etc.);

- Responsible for setting UM behavioral healthcare policies;

- Develop policies, procedures and protocols for the delivery of psychiatric and medical services;
- Guides, leads and assesses the overall clinical knowledge of the UM staff;
- Provides on going oversight of the UM Program;
- Reviews and updates the behavioral health medical necessity criteria;
- Reviews UM behavioral healthcare cases including appeal cases;
- Maintain accurate records of all communications and interventions in clinical software system, Mental Health Wellness Information Network (MHWIN);
- Chair of the UM committee;
- Active Participation in the Peer Review Committee Activities;
- Active Participation in the Sentinel Events Committee Activities;
- Active Participation in the Review of Death Committee;
- Active Participation in the Executive Leadership Team;
- Participates on various internal and external committees;
- Serves as a liaison to the medical community on all issues designed to improve the quality of behavioral health services to enrollee/members;
- Develops continuing education and in-service training opportunities for Board staff, Board of Directors, and Community Mental Health (CMH) network;
- Functions as a liaison with local, state, and national psychiatric and medical organizations for the purpose of information gathering, networking to keep the Board of Directors and staff aware of trends in psychiatric and medical practice, research, training, and issues;
- Develops advisory committees of CMOs of Access Center, Crisis Screening Entities and Providers to meet on a regular basis and provide input into psychiatric and medical standards, policies, procedures, and protocols;
- Provides oversight of DWMHA contracted behavioral health psychiatrists;
- Presents to the Board of Directors and Board subcommittee meetings;
- Collaborates with Director of UM to set UM department yearly goals;
- Assists with the development of quality improvement processes and ensure accreditation and regulatory requirements are met;
- Conducts analysis of internal and external reports to evaluate UM outcomes and performance;
- Collaborates with Director of UM to develop annual UM program description and work plan and revise based on UMC recommendations; and
- Reviews and provides oversight to the annual UM Program evaluation.

3. DWMHA Psychiatrist:
   - Must have a valid Michigan License to practice as a physician, and Michigan controlled substance license. Additionally, they must have a valid and current Drug Enforcement Authority Registration. Board certification by the American Board of Psychiatry and Neurology as an adult psychiatrist is preferred but not require;
   - Must have completed a Psychiatric Residency approved by Accreditation Council for Graduate Medical Education (ACGME);
   - Five (5) years of experience working in a state or community psychiatric hospital or outpatient setting, as a direct provider of mental health services;
   - At least five (5) years of administrative experience as Medical Director in a Mental Health Program with experience in: policy writing; accreditation activities, staff development; peer review management of direct report staff (i.e. nurses, social workers, etc.);
   - Reviews UM behavioral healthcare cases including appeal cases;
   - Maintains accurate records of all communications and interventions in clinical software system (MHWIN);

- Participates on the UM committee;
- Participates on various internal and external committees;
- Administration of clinical aspect of Medicaid Fair Hearings;
- Administration of the Death Review Program;
- Assists in Behavioral Health Policy development and review;
- Provides Staff Training and Development;
- Participates in Peer Reviews;
- Provides leadership within committee structures, i.e. Utilization Management, Sentinel Events, Quality Management, Child Death Review Team etc.; and
- Provides clinical consultation to Recipient Rights.

4. Access Center and Crisis Service Vendors Medical Director:
   - Must have a valid Michigan License to practice as a physician, and Michigan controlled substance license. Additionally, they must have a valid and current Drug Enforcement Authority Registration. Board certification by the American Board of Psychiatry and Neurology as an adult psychiatrist is preferred but not require;
   - Must have completed a Psychiatric Residency approved by Accreditation Council for Graduate Medical Education (ACGME);
   - Five (5) years of experience working in a state or community psychiatric hospital or outpatient setting, as a direct provider of mental health services;
   - At least one (1) year of administrative experience as Medical Director in a mental health program with experience in policy writing, accreditation activities, staff development, peer review management of direct report staff (i.e. nurses, social workers, etc.);
   - Reviews UM behavioral healthcare cases including first level appeal cases; and
   - Assist in DWMHA Behavioral Health Policy development and review.

5. Director of Utilization Management:
   - Minimum Master's Degree in Mental Health Field with a valid Michigan licensure/certification as a Psychologist (LLP, FLP), Social Worker (CSW, ACSW), Counselor (LPC), Marriage and Family Therapist (LMFT), or Nurse (RN)
   - Ten (10) years' supervised experience with adults who are seriously mentally ill, or persons with a developmental disability, or with children who have serious emotional disturbances or elderly persons with serious mental illness. Knowledge and experience with co morbid conditions. Cultural competence training required.
   - Minimum eight (8) years' management & supervisory experience in managed care clinical setting.
   - Eight (8) years post Master's degree, administrative utilization management experience at least six (6) years of which must have been in a hospital, school or community mental health agency that provides care to mentally ill and emotionally disturbed adults children and adolescents.
   - Responsible for the development and continual updating of all UM processes, policies and procedures within department;
   - Co-chair of UM committee;
   - Provides supervision and implements development plans for all UM staff;
   - Makes recommendations regarding staffing, hiring, training and allocation of resources;
   - Oversees the on-going utilization review activities to monitor usage of services across all covered populations;
   - Assists with the development of quality improvement processes and ensure accreditation and regulatory requirements are met;
   - Leads multidisciplinary case reviews, to recommend/develop alternative treatment plans for complicated consumer cases;

- Conducts analysis of internal and external reports to ensure compliance with contract, accreditation and regulatory requirements;
- Performs analysis of internal and external reports to evaluate UM outcomes;
- Collaborates with other departments and agencies;
- Sets yearly UM goals for department;
- Represents DWMHA as assigned, in collaborative meetings or presentations with DCH, Board Association, and contracted entities;
- Responsible for all UM reporting requirements;
- Prepares annual UM program evaluation;
- Provides oversight of staff audits and evaluations; and
- Provides oversight of outcomes of delegated entities.

6. UM Clinical Specialist:
   - Minimum of five (5) years' experience working in mental health services;
   - UM Experience strongly preferred;
   - At a minimum a Bachelor's degree in social work or psychology;
   - For Bachelor degree social work or sociology, valid Michigan license required;
   - Knowledge and skills in community based behavioral health care and case management preferred;
   - Assists UM Director in developing policies and procedures for daily operations of the UM staff;
   - Assists UM Director and CMO in writing the UM program description, work plan and annual UM evaluation;
   - Works collaboratively to implement UM model with affiliated providers;
   - Works with behavioral health provider organizations to develop and update the UM program;
   - Works collaboratively with other DWMHA departments to implement and improve the utilization management program at DWMHA;
   - Assists UM Director in providing oversight of the UM program processes;
   - Works collaboratively with the Integrated Care Organizations in relation to UM program for MI Health Link enrollee/members;
   - Participates in meetings, committees, and collaboration internally and externally;
   - Offers training and education to DWMHA staff, providers, stakeholders and the community at a large specific to medical necessity criteria and DWMHA's UM program;
   - Participates in audit activities as required;
   - Develops written and timely reports as requested; and
   - Provides timely reporting of pertinent observations and system challenges which may directly impact the achievement of expected outcomes.

7. Utilization Review Substance Use Disorder (SUD) Clinical Specialist:
   - Master's degree in nursing or social work preferred. Bachelor's degree in psychology, social work, or related human services required. Certification as an addiction drug counselor (CADC) or certification as advanced addiction drug counselor (CAADC) or an approved development plan by the Michigan Certification Board for addiction professional (MCBAP) required;
   - Promotes and facilitates specific communication and coordination of care with providers and behavioral health practitioner(s);
   - Supports discharge planning activities that include aftercare referrals and referrals to community resources;
   - Facilitates complex care management services through treatment plan review and provider consultation;
   - Conducts ongoing assessment of clinical status and functioning;
   - Monitors enrollee/member progress and outcomes;

- Facilitates communication with medical and behavioral health providers regarding the enrollee/member's treatment plan;
- Ensures the enrollee/member receives appropriate and medically necessary services thru out the continuum of care as well as coordination of care;
- Reviews targeted case management needs, vocational and/or housing assistance and interacts with providers as needed;
- Maintains accurate records of all communications regarding the authorization process in the clinical software system (MHWIN); and
- Provides education and motivation to enrollee/members.

8. UM Reviewer:
   - Master's degree in nursing or social work preferred. Bachelor's degree in nursing, psychology, social work required;
   - For Bachelor degree nursing or social work, valid Michigan license required;
   - Qualified Mental Health Professional certification preferred;
   - Eight (8) years' experience in mental health field and five (5) years' experience in managed care;
   - Reviews pre-service behavioral health requests for benefits and/or medical necessity;
   - Refers cases as appropriate to physician for review;
   - Reviews clinical information for BH concurrent reviews, extending the length of stay for inpatient admissions as appropriate;
   - Participates in discharge planning activities post inpatient behavioral health admission;
   - Provides appropriate consultant information to case management staff;
   - Assists in the identification of appropriate resources for each individual case to fully utilize all available resources;
   - Maintains accurate records of all communications and interventions in clinical software system (MH-WIN); and
   - Prepares denial letters.

9. DWMHA UM Integrated Care Review Specialist:
   - Master's degree in nursing or social work preferred. Bachelor's degree in nursing, psychology, social work, or sociology required;
   - For Bachelor degree social work or sociology, valid Michigan license required;
   - Qualified Mental Health Professional certification preferred;
   - Eight (8) years' experience post-degree in mental health field and five (5) years' experience in managed care;
   - Reviews pre-service behavioral health requests for benefits and/or medical necessity for dual eligible MI Health Link enrollee/members;
   - Refers cases as appropriate to physician for review;
   - Reviews clinical information for behavioral health concurrent reviews, extending the length of stay for inpatient admissions as appropriate for dual eligible MI Health Link enrollee/members;
   - Participates in discharge planning activities post inpatient behavioral health admission;
   - Provides appropriate consult information to case management staff.
   - Assists in the Identification of appropriate resources for each individual case to fully utilize all available resources;
   - Maintains accurate records of all communications and interventions in clinical software system (MH-WIN) in compliance with regulatory and accreditation standards; and
   - Prepare denial letters for all dual eligible MI Health Link enrollee/members.
   -

10. DWMHA UM Appeals Coordinator:
    - At a minimum has a Bachelor's degree in social work, counseling or psychology and a combined three (3) years of direct clinical, managed care and/or community service;
    - For Bachelor degree social work or counseling, valid Michigan license required;

- Conducts first level review of concurrent and post-service appeals;
- Reviews clinical documentation to determine completeness of information submitted;
- Requests additional information as needed to assist with review of appeals;
- Coordinates case review with DWMHA physician consultants on clinical cases that are not meeting the medical necessity criteria;
- Prepares appeals for independent medical review and other state and federal government reviews;
- Responds to inquiries regarding status, process and outcome of UM appeals;
- Communicates either verbally or in writing regarding outcome of UM appeals
- Interfaces with other DWMHA departments to resolve UM appeals issues;
- Completes appropriate documentation in clinical systems (MHWIN) in compliance with regulatory and accreditation standards;
- Participates on committees or special projects as needed; and
- Manages the data gathering and analysis of reports regarding UM appeal activity as well as preparation for appeal audits.

11. DWMHA Hospital Liaison:
    - At a minimum has a bachelor's degree in nursing, social work or psychology;
    - For Bachelor degree nursing or social work, valid Michigan license required;
    - Communicates with the enrollee/member, family and treatment team on enrollee/members admitted to hospital/facility for behavioral health condition(s);
    - Attends team meetings;
    - Works with enrollee/member, family and treatment team and/or providers to ensure safe and appropriate and timely transitions after an inpatient behavioral health admission;
    - Enters authorizations for post admission services as needed;
    - Completes appropriate documentation in clinical systems in compliance with regulatory and accreditation standards; and
    - Participates on committees or special projects as needed.

NOTE: Staff performing UM reviews and/or UM functions such as initial, concurrent and post-service reviews, denials and appeals must be credentialed and re-credentialed. The credentialing process defined by DWMHA supports our commitment to ensure that each provider, directly or indirectly or contractually engaged, meets at least MDHHS licensing, training and scope of practice, CMS, contractual and Medicaid Provider Manual requirements. Only highly qualified clinicians (MD, DO, PhD, LPC, LMSW, LLP, MSN, NP and BSN) who have demonstrated experience in the specialty areas in which they are making decisions may initiate and carry out UM reviews and duties. Clinicians authorizing SUD services must have certification as a Certified Addiction Drug Counselor (CADC) or a Certified Advanced Addiction Drug Counselor (CAADC) or have an approved development plan by the Michigan Certification for Addiction Professionals (MCBAP), or be certified as a Qualified Mental Health Professional (QMHP). A clinician must be credentialed and re-credentialed as Qualified Mental Health Professional (QMHP), Qualified Intellectual Disability Professional (QIDP) and/or a Child Mental Health Professional (CMHP), if authorizing those populations in order to be certified to complete the pre-admission review (PAR) or Utilization Management (UM) staff functions. Due to a conflict of interest, these practitioners may not provide direct services, including crisis intervention, for the enrollee/member they are screening for pre-admission review. See DWMHA Appropriate Professionals for Utilization Management Decision Making Policy for more details.

X. COMMITTEE STRUCTURE:

A. Utilization Management Committee (UMC):

DWMHA's UM Department supports a Utilization Management Committee. The CMO is the chairperson and the UM Director is the co-chair. The UMC is a standing committee reporting up to The Quality Improvement Steering Committee (QISC), which makes reports to both the Program Compliance Committee (PPC) of the Board of Directors (BOD) and the President/CEO, who both report up to the

Board of Directors (BOD). The DWMHA BOD has granted the UMC the authority to develop, monitor and annually evaluate the UM Program.

Membership includes:

- Chief Medical Officer-Chair
- Utilization Management Director-Co-Chair
- DWMHA Psychiatrist
- UM Clinical Specialist
- UM Hospital Liaison
- Children's Initiatives Representative
- Customer Service Representative
- IT Representative
- Finance Representative
- Total Quality Management Representative
- Network Administrators and Contract Manager Representative
- Substance Use Disorder Director or designee
- Peer Specialist

Others may be invited for specific projects and/or issues to serve on an as needed basis and providers will be invited to participate quarterly.

The purpose of the committee is:

- Provide on-going review and oversight of the UM program;
- Evaluate the utilization of services with the goal of ensuring that each enrollee/member receives the right services, in the right amount and in the most appropriate time frames to achieve the best outcomes. To accomplish this, the committee reviews specified aggregate data in order to identify over or under utilization of services. With improved reporting capabilities in the Mental Health Wellness Information Network (MH-WIN) computer system, including Pivot Tables, Cube Analytics and newly developed dashboards, the committee coordinates and recommends quality improvement efforts that may impact structure, process and outcomes. Opportunities for improvement are prioritized based on risk factors, performance history, and effect on overall DWMHA system performance;
- Review of standing UM reports on inpatient admissions, length of stay, denials and appeals, timeliness of decisions and notifications and readmissions;
- Review monthly reports on Autism, Waivers, Hospital Liaison Activity, Access Center and Crisis Service Vendor functions, County of Financial Responsibility (COFR), Substance Abuse Disorders (SUD) and Integrated Care;
- Monitor, document and submit for review any potential quality of care concerns, for both inpatient and outpatient care;
- Monitor utilization practice patterns of contracted providers to identify variations;
- Ensure that UM inter-rater reliability audits are conducted; and
- Review, evaluate, revise and approve the UM Program Description, UM work plan and UM Program evaluation annually.

The UMC meets monthly. Minutes are maintained and distributed to all committee members. The minutes are also reviewed and approved at the next meeting. The UMC has ground rules for meeting operations and membership including the decision making process, attendance, goals, participation, preparation, and discussion and reporting formats.

B. Quality Improvement Steering Committee (QISC):

The QISC is an advisory group with responsibility for ensuring system-wide representation in the planning, implementation, support and evaluation of the DWMHA's continuous quality improvement

program. The QISC provides ongoing operational leadership of continuous quality improvement activities for the DWMHA.

Membership includes:

- Chief Medical Officer
- Directors or designee from UM, Customer Service, Quality Management, Recipient Rights, Risk Management, Compliance, SUD, Managed Care Operations, Integrated Care
- Enrollee/members
- Advocates
- MCPN's
- Direct contracted providers of service to enrollee/members with SMI, SED, SUD, I/DD.

The purpose of committee:

- Participate in the development and review of quarterly/annual reports to the Total Quality Management Program Compliance Committee and the BOD regarding Quality Management System;
- Annually review and evaluate the effectiveness of the Quality Assessment Performance Improvement Program;
- Provide recommendations and feedback on process improvement, program implementation, program results and program continuation or termination;
- Examine quantitative and qualitative aggregate data at predetermined and critical decision making points and recommend courses of action;
- Review reports from regulatory DWMHA reviews;
- Review of DWMHA improvement plans and make recommendations based on these reviews;
- Monitor progress and completion of plans of correction in response to recommended remedial actions identified for the DWMHA or by regulatory organizations;
- Oversee a process for establishing, continuing or terminating subcommittees, standing committees, improvement teams, task and work groups
- Identify training needs and opportunities for staff development in the quality management process;
- Identify future trends and make recommendations for next steps; and
- Leadership in practice improvement projects.

The QISC meets at least ten (10) times a year. The committee establishes and annually reviews committee operational guidelines, meeting frequency, management of information requests, membership, the number of members required for a quorum. It annually establishes committee goals and timelines for progress and achievement. The UM Program Description and evaluation are also reported by the UM Director or designee to the QISC annually for approval prior to review and approval by the Program Compliance Committee and the Board of Directors.

C. Program Compliance Committee (PCC):

The PCC consists of members from the BOD and provides leadership for the Quality Improvement process through supporting and guiding implementation of quality improvement activities DWMHA and reviewing changes, evaluating the need for board actions and approving the Quality Improvement Plan annually.

The purpose of the committee:

- Annual evaluation of the effectiveness of the Quality Assurance Performance Improvement Program (QAPIP) and recommends approval of reports and standing committee and department evaluations to the BOD;
- Monitor the system-wide trends and patterns of key indicators and attainment of goals and objectives;
- Identify opportunities for improvement;
- Establish and support specific quality improvement initiatives;

- Recommend studies in areas identified from data review as having the potential for affecting the outcomes of care and related quality concerns;
- Assist in the development and approval of the Quality Improvement Plan; and
- Recommend board actions to the full Board of Directors.

The PCC meets monthly. The committee establishes and annually reviews committee operational guidelines, meeting frequency, management of information requests, membership, the number of members required for a quorum. It annually establishes committee goals and timelines for progress and achievement. The UM and Quality Program Descriptions and evaluations are reported to the PCC annually for approval prior to review and approval by the Board of Directors.

D. Board of Directors (BOD):
The DWMHA's BOD's primary responsibility is to provide leadership, governance and oversight of the region. The Board is a policy setting body, the fiduciary of the Medicaid funds. The membership is comprised of professionals in the behavioral health field and community leaders all with varied backgrounds and experience which helps sustain diversity throughout the organization. There are twelve (12) board members including the Chairman, Vice-Chairman and Secretary. The UM and Quality Program Descriptions and evaluations are reported to the BOD annually for approval.

The BOD meets monthly. The committee establishes and annually reviews committee operational guidelines, meeting frequency, management of information requests, membership, the number of members required for a quorum. It annually establishes committee goals and timelines for progress and achievement.

E. Reporting Flow of Committees:

XI. PROGRAM GOALS:

DWMHA's Board Strategic Plan is an overarching framework that strives towards common goals, establishes agreement around intended outcomes/results and assesses and adjusts the organization's direction in response to a changing environment. The following UM related goals shall be incorporated in DWMHA's 2019-2021 Fiscal year Quality Assessment and Performance Improvement Plan (QAPIP). The goals and objectives shall be completed by DWMHA and when applicable, the Access Center, Crisis Service Vendors and/or Service Providers and can be modified to move DWMHA toward desired outcomes.

Customer Service Pillar

A. Utilize Provider and Practitioner Satisfaction Surveys related to service access and Utilization Management, make recommendations for improvement regarding service provision, treatment experiences and outcomes.

Access Pillar

B. Advance the implementation of DWMHA's standardized UM Program Description to assure effective and efficient utilization of behavioral health services through on-going development and oversight of the following:
   - The Benefit Plans/UM Authorization Guidelines; and
   - Setting standards and monitoring adherence to the delegated entities UM Plans.

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

Finance Pillar

D. Set the standards for service authorization system wide by identifying patterns of behavioral health service utilization by funding source and by monitoring over and under-utilization of services using dashboards.

Workforce/Quality Pillar

E. Assure fair and consistent UM/review decisions based on MCG, Local Coverage Determination (LCD), National Coverage Determination (NCD) and/or American Society of Addition 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.

Quality Pillar

F. 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 DWMHA, State, Federal regulations and National Committee for Quality Assurance (NCQA) standards.

G. Provide oversight of delegated UM functions through use of policies that reflect current practices, standardized/inter-rater reliable 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.

Advocacy Pillar

H. Provide collaboration in shaping state and regional policies, procedures and practices relative to utilization management e development and implementation of processes that promote clinical review procedures, practices.

XII. BEHAVIORAL HEALTH MEDICAL NECESSITY CRITERIA AND BENEFITS:

A. Development and Description of Medical Necessity Criteria:

1. DWMHA has adopted nationally developed and published Behavioral Health guidelines from MCG which is part of the Hearst Health Network. MCG utilizes clinical editors who analyze and classify more than 100,000 peer reviewed papers and research studies each year. By applying rigorous evidence classification techniques, they select more than 25,000 unique references to formulate into medical necessity clinical guidelines. Nationally recognized quality measures from the Hospital Quality Alliance are also embedded in the guidelines. The clinical editors are supported by a team of data analysts, librarians, and medical copy editors who together have over 115 cumulative years of guideline development experience. In addition, the team coordinates peer reviews by panels that include approximately 100 additional clinicians. The MCG Behavioral Health Medical Necessity guidelines

describe best practice care for the majority of mental health and substance related disorder diagnosis, covering 15 diagnostic groups with graded evidence from published resources.

Some of the best known resources include the American Psychiatric Association, the American Association of Pediatrics, the American Society of Addiction Medicine, the National Institute on Alcohol Abuse and Alcoholism and the Local and National Coverage Determination criteria due to their acceptance as the best of evidence-based/best practice and emerging practice for mental health and substance use disorders. This criterion then serves as a decision support tool to help define the most appropriate treatment setting and help assure consistency of care for each individual. DWMHA believes its criteria should be transparent and available to everyone and be flexible enough to continuously adapt to the changes in mental health and substance use disorder treatment systems.

The MCG Behavioral Health guidelines are available through a secure website at the following URL, http://cgi.careguidelines.com/login-careweb.htm. Since the guidelines are proprietary, access is limited to the DWMHA provider network. A login and password can be obtained from the DWMHA UM Department.

DWMHA and their UM delegated entities utilize an MCG software called Indicia. DWMHA requires these entities to have at least one machine installed with the online version of the MCG Behavioral Health guidelines and to make it accessible to all their clinical practitioners during hours of operation.

2. The MCG Behavioral Health Care criteria includes:
    - Behavioral health guidelines which identify the most effective level of care for specific behavioral health conditions;
    - Level of care guidelines that assess a patient's level of care needs in situations where a diagnosis-specific guideline does not apply.
    - Five (5) levels of care covering inpatient, residential, partial hospitalization, intensive outpatient, and outpatient.
    - Therapeutic and testing procedures that provide specific criteria for determining when a procedure, treatment, or diagnostic test may be indicated.
    - Detailed discharge criteria focus on specific care elements to consider when discharging patients to a lower level of care.
    - Flexible recovery courses manage longer behavioral health episodes with recovery courses listed in care days for in-patient treatments and stages for out-patient treatments.
    - Alterative care planning help to select effective alternative therapies and levels of care based on the specifics of a patient's case.

3. For MI Health Link enrollees/member, the National Coverage Determination (NCD) criteria developed by the Centers for Medicare and Medicaid Services (CMS) is utilized. If no NCD has been issued, or an NCD requires further clarification, a Local Coverage Determination (LCD) criteria will be utilized. LCDs' are developed by the Medicare Administrative Contractor for the geographic service area and either supplement or explain when an item or service will be covered if there is no NCD. Michigan is in jurisdiction 8. In addition, the CMS Coverage Manual or other CMS-based resources such as the Medicare Program Integrity and Medicare Benefit manuals are used to determine coverage provisions for this population. In coverage situations where there is no NCD or LCD or guidance on coverage in original Medicare manuals, DWMHA may make its' own coverage determination utilizing the MCG criteria or send out to an Independent Review entity. Communication will also be sent to the Medicare Administrative Contractor to be addressed in a future version of the LCD.

4. DWMHA has adopted nationally developed and published criteria from the American Society of Addiction Medicine (ASAM) to determine medical necessity and level of care decisions for substance use disorders (SUD). This criterion has become the most widely used and comprehensive of guidelines for placement, continued stay, and transfer/discharge of enrollee/members with addiction and co-

occurring conditions. ASAM's criteria provide separate placement criteria for adolescents and adults developed through a multidimensional assessment over five (5) broad levels of treatment that are based on the degree of direct medical management provided, the structure, safety, and security provided and the intensity of treatment services provided. It uses six (6) dimensions including Acute Intoxication and/or Withdrawal Potential, Biomedical Conditions and Complications, Emotional/ Behavioral Conditions, Treatment/Acceptance/Resistance, Relapse/Continued Use Potential and Recovery Environment to create a holistic assessment of an individual to be used for service planning and treatment across all service and levels of care. Through this strength-based multidimensional assessment, the ASAM criteria addresses the individual's needs and obstacles as well as their strengths, assets, resources and support structure. The website (https://ASAM.org.) further describes the medical necessity criteria. The ASAM Criteria, Third Edition, is copyrighted but can be purchased by contacting the American Society of Addiction Medicine located at 4601 North Park Avenue, Chevy Chase, MD, 20815, telephone (301)-656-3920, and fax (301) 656-3815.

Oversight and revision of the criteria is collaborative between ASAM leadership and the Steering Committee of the Coalition for National Clinical Criteria. The Coalition represents major stakeholders in addiction treatment and has been meeting regularly since the development of the first ASAM Patient Placement Criteria in 1991. The Coalition addresses feedback and ensures that the Criteria adequately serves and supports medical professionals, employer purchasers and providers of care in both the public and private sectors.

B. Criteria Review, Approval and Distribution:

1. The MCG Behavioral Health Medical Necessity guidelines, ASAM criteria, NCD and LCD criteria and DWMHA's procedures for application are reviewed at least annually or as new treatments, applications and technologies are adopted as generally accepted professional practice by the DWMHA CMO and is based on the most current research, relevant quality standards and evidence based/best practice, emergency practice models of care and the local delivery system (LCD/NCD).

2. The MCG, ASAM, NCD and LCD criteria are then reviewed by the committees below and approved with applicable clinicians at the Improving Practices Leadership team meetings and the UM committee.
    - Practice collaborative such as the Intellectual/Developmental Disabilities (I/DD), Adult Mental Illness and Child Seriously Emotionally Disturbed (SED);
    - Provider partnership meetings;
    - DWMHA Improving Practices Leadership Team Meetings; and
    - The UM Committee.

3. Once approved by the DWMHA CMO and Committees above, DWMHA makes the most current version of the online version of the MCG behavioral health medical necessity guidelines available to be installed on at least one computer accessible to all DWMHA, Access Center and the Crisis Service Vendors' clinical practitioners during normal business hours of operation. DWMHA also makes the most current version of the personal computer software of the behavioral health MCG medical necessity guidelines available for download at the time of initial distribution through various means such as secured Google Drive or removable media such as a flash drive or CD thus allowing access to the criteria in the event of a mass or individual internet outrage or for contracted practitioners without internet access. Notification is emailed, mailed or faxed to all contracted providers using Indicia advising them when the criteria or updates to the criteria are available.

4. Enrollee/members and both network and out of network practitioners/providers can request a copy of the medical necessity criteria in relation to a specific requested service by contacting DWMHA's UM Department, and this will be provided free of charge.

5. In accordance with the American with Disabilities Act, the criteria is available in other formats such as Braille or larger font if needed.

6. DWMHA has an established process for recognizing and evaluating new technologies and new applications of existing technologies to ensure individuals have access to safe and effective care. Proven Behavioral health clinical technology (PT) includes practice standards as well as technology that have undergone extensive practical evaluation as well as research via external mechanisms and are mandated covered services through DWMHA contracts. PT's that are not included in a benefit plan are uncovered services meaning they are not reimbursable for that benefit plan. There are a variety of mechanisms by which they may progress to covered services.
    - Providers may propose a pilot utilizing a PT for a specific population to the Research Advisory Committee.
    - Improving Practices Leadership Team (IPLT) may determine that there is a gap in service delivery across the network which current covered services are not addressing.
    - PT's may be covered by General Funds, Local Funds, or other appropriate resources when not covered by the member's benefit plan.

    Technology/Clinical practices that have been demonstrated through controlled trials, meta-analysis of the literature to be ineffective, or whose safety profile results in a negative risk-benefit from a negative risk-benefit ratio, will not be supported nor covered by DWMHA. Technology/Clinical practices that are not sufficiently researched and/or published so as to qualify as PT's may be presented to the Research Advisory Committee for consideration as a trial. DWMHA's medical staff participate in regional and state level medical directors' meetings which include reviews of medical procedures, pharmaceuticals, health practices and devices, regulatory changes and scientific data.

C. MCG Behavioral Health Guidelines:

1. The published professional literature (the National Library of Medicine database via the PubMed search engine) is systematically queried at least annually using specially developed, customized, tested, proprietary search strings. Search strategies are developed to allow efficient yet comprehensive analysis of relevant publications for a given topic and to maximize retrieval of articles with certain desired characteristics pertinent to a guideline.

2. All retrieved publications are individually reviewed by an MCG clinical editor and assessed in terms of quality, utility and relevance. Preference is given to publications that:
    - Are designed with rigorous scientific methodology.
    - Are published in higher-quality journals (i.e. journals that are read and cited most often within their field).
    - Address an aspect of specific importance to the guideline in question (i.e. admission criteria, length of stay).
    - Represent an update or contain new data or information not reflected in the current guideline.

3. Annually undergoes external review by clinically active experts (i.e. board-certified specialist physician without stated financial conflicts of interest) to confirm the clinical appropriateness, accuracy, validity and applicability of each guideline and then a supervising clinical editor evaluates all comments from these external reviewers and makes necessary changes to the guideline.

4. Oversight and revision of the criteria is collaborative between ASAM leadership and the Steering Committee of the Coalition for National Clinical Criteria. The coalition represents major stakeholders in addiction treatment and has been meeting regularly since the development of the first ASAM Patient Placement Criteria in 1991. The coalition addresses feedback and ensures that the criteria adequately serves and supports medical professionals, employer purchasers and providers of care in both the public and private sectors.

D. Benefit determinations are based on the following sources:

To assist the Access Center and UM staff in determining services that are available based on clinical findings and available resources, DWMHA has developed a Benefit Management grid that outlines the

services available by funding stream, patient population, and level of functioning. The primary funding sources currently include Medicaid, MI-Child, Healthy Michigan Plan, Medicare/Medicaid, and General Fund. Each of the Waiver programs (Serious Emotional Disturbance (SED), Habilitation and Supports Wavier (HAB), Children's Waiver Program (CWP) and the Autism Spectrum Disorder (ASD) Benefit provide an array of services based on consumers meeting admission and eligibility criteria and subsequently receiving services that are medically necessary and clinically appropriate.

In the area of Substance Use Disorders, a varied array of services is available based on the funding sources of block grant, Public Act 2 monies, Medicaid and Healthy Michigan. The Benefit Management Grid and the SUD UM Guidelines provide the foundation for UM initial and continued stay service authorizations that must be supported by documentation that supports medically necessary services. As funding changes, the benefit grid is adjusted.

Parity, as it relates to mental health and substance abuse, prohibits insurers or health care service plans from discriminating between coverage offered for mental illness, serious mental illness, substance abuse, and other physical disorders and diseases. In short, parity requires insurers to provide the same level of benefits for mental illness, serious mental illness or substance abuse as for other physical disorders and diseases. These benefits include visit limits, deductibles, copayments, lifetime and annual limits.

With the enactment of the federal Mental Health Parity Act (MHPA) in 1996 and the Mental Health Parity and Addition Equity Act (MHPAEA) in 2008, insurers are now required to make formulation of benefits, utilization management, and out-of-pocket payments equivalent between behavioral health services and other medical services.

The regulations delineate the following classifications of benefits:

1. Inpatient in-network
2. Inpatient out-of-network
3. Outpatient in-network
4. Outpatient out-of-network
5. Emergency care
6. Prescription drugs

If a plan covers mental health or substance use services, in any of the above classifications, the plan must provide coverage for all classifications, as long as it also provides medical/surgical benefits in the classifications.

Under MHPA (1996):

- Lifetime & annual dollar limits for mental health services had to be equivalent to other health services.
- Parity applied only to commercial plans offering mental health benefits.

Under MHPAEA (2008) and the interim final rule (2010):

- Parity was extended to substance use services.
- Financial requirements and quantitative treatment limitations for mental health & substance use services had to be equivalent to other health services.
- Utilization management techniques had to be formulated in a manner similar to that for mental health & substance use and other services.
- Application of benefits design for mental health & substance use and medical/surgical services had to be equivalent by classification and network.

Pre-existing conditions are medical conditions or other health issues that existed before a person's enrollment in a health plan. Examples include chronic conditions such as asthma, heart disease and schizophrenia. Under the Affordable Care Act, health insurance companies including Medicaid cannot

refuse to cover an individual and refuse to pay for essential health benefits for a condition he/she had prior to the onset of coverage. See DWMHA Benefit Policy for more details.

Pharmaceuticals are covered by the Medicaid health plans or Part D plans with the exception of medications that are carved out by the state and covered by the state.

E. Inter Rater Reliability:

Review of consistency of Behavioral Health UM decision making Inter-rater reliability testing is administered annually for UM reviewers and psychiatrists involved in UM reviews. DWMHA utilizes the MCG web-based Inter-Rater Reliability module which tests the proper use of MCG guidelines with clinician-developed case studies. It evaluates an individual's ability to find and apply the appropriate guideline based on a specific scenario. DWMHA has a benchmark standard of scoring 90% or greater.

Any UM reviewer or physician reviewer with an inter-rater reliability score less than 90% will be placed on a corrective action plan (CAP) with the expectation that he/she pass a re-test administered within thirty (30) days. CAPS can involve such activities as face to face supervision and coaching and/or education and re-training. During the time period of the CAP, random samples of the person's current cases may be audited. If upon re-testing, he/she does not achieve 90% or greater, the person will be subject to a transfer to a role outside the UM Department or termination. Note that annual education and training on the criteria is provided for all staff performing UM activities that involve application of the medical necessity criteria. MCG does have web-based on-demand training modules available 24/7. The results of inter-rater reliability case reviews will be used to identify areas of variation among decision makers and/or types of decisions and will help to identify opportunities for improvement as well as future training needs. See DWMHA Inter Rater- Reliability Policy for more details.

F. Clinical Documentation:

Audits of UM Reviews are also conducted on a quarterly basis to ensure appropriate documentation and appropriate level of care decisions. DWMHA has a benchmark standard of scoring at least 85% on each documentation audit. Any UM Reviewer with a documentation audit score less than 85% will be placed on a corrective action plan (CAP) with the expectation that the person passes at the next review. CAP's can involve such activities as face-to-face supervision and coaching and/or education and re-training. If upon the next review, the staff person does not achieve 85% or greater, he/she may be subject to a transfer to a role outside the UM Department or termination.

XIII. DELEGATION OF UM FUNCTIONS AND DWMHA OVERSIGHT:

Delegation occurs when DWMHA gives to another organization the decision-making authority to perform UM functions on their behalf. It is a formal process, contractual and consistent with accreditation, state and federal regulations.

DWMHA has delegated several UM functions to the Access Center and the Crisis Service Vendors. As a result, these entities must develop and implement a UM Plan that meets regulatory and contractual requirements and mirrors DWMHA's UM Plan. The regulatory and contractual requirements are articulated in the following documents:

- The Center for Medicare and Medicaid services, 42 CFR 438.210
- The External Quality Review Health Services Advisory Group Corrective Action Plan, Standard 5, Utilization Management
- The MDHHS-PIHP Contract, Section 6.8, Service and Utilization Management
- The MDHHS-PIHP Contract, Attachment P.6.7.1.1
- Substance Abuse & Mental Health Service Administration Guidelines
- MDHHS Provider Manual
- Application for Renewal and Recommitment (ARR)
- NCQA UM 1

The federal law and MDHHS contracts are clear that where any DWMHA UM functions are delegated, DWMHA UM staff must evaluate the entity's ability to perform the delegated activities prior to delegation. DWMHA must actively oversee delegated functions using clear criteria and performance expectations, including potential contract termination. If DWMHA identifies any deficiencies or areas for improvement, the appropriate entity must take corrective action to address and provide DWMHA with documentation of completed action(s).

DWMHA will provide training to the Access Center and the Crisis Service Vendors to assure consistent understanding and application of the MCG Medical Necessity Criteria Clinical Protocols and Evidence Based and Promising Practices. Credentialed staff must be available with expertise in each population group served by DWMHA. Cultural competency is practices and staff is also trained in specific competencies related to key ethnic groups and trans-gender groups within the community annually. Each staff person shall have credentials and licensure necessary to provide direct service to the population or group for whom he/she reviews care.

The Access Center and the Crisis Service Vendors must:

1. Have mechanisms to identify and correct under- utilization and over utilization;
2. Follow pre-service, concurrent and post-service (retrospective) policies and procedures established by DWMHA;
3. Have qualified medical professionals to supervise review decisions;
4. Ensure decisions to approve, deny or reduce services are made in a fair, impartial and consistent application of review criteria that best serve the enrollee/member;
5. Ensure decisions to approve, deny or reduce services are made by physicians who have the clinical expertise to treat the conditions;
6. Ensure efforts are made to obtain all necessary information including pertinent clinical information and consult with the treating provider/physician as appropriate.
7. Have the reasons for decisions clearly documented and appeal rights are available to the enrollee/member;
8. Have well-publicized and readily available appeal mechanisms for both providers and enrollees/members;
9. Have written notification of the denial sent to the provider and the enrollee/member;
10. Have written notification of a denial including a description of how to file an appeal.
11. Ensure decisions and appeals are made timely as required by exigencies of the situation;
12. Ensure there are mechanisms to evaluate the program using data on recipient satisfaction, provider satisfaction, or other appropriate measures and data is presented to DWMHA for identification of opportunities for improvement;
13. Ensure when the organization delegates responsibility for any aspect of utilization management, it has mechanisms to ensure that the delegate meets these standards;
14. Ensure the Access Center and the Crisis Service Vendors oversee and are accountable for any functions it delegates to any subcontractor;
15. Ensure that before any delegation, the Access Center and the Crisis Service Vendors must evaluate the subcontractor's ability to perform the delegated activity;
16. Ensure the Access Center and the Crisis Service Vendors have a written agreement that specifies the activities and responsibilities designated to any subcontractor;
17. Ensure the written agreement provides for revoking delegation or imposing other sanctions;
18. Ensure the Access Center and the Crisis Service Vendors shall monitor their subcontractor's performance on an ongoing basis and subjects their performance to a formal review according to a periodic schedule established by the State, consistent with applicable federal laws, Medicaid Statutes, MDHHS Regulations and Industry Standards; and
19. Ensure if deficiencies or areas for improvement are identified, the Access Center and the Crisis Service Vendors will place their subcontractors on a corrective action plan and notify DWMHA.

Below is a chart of the Utilization Management Monitoring Activities of the Delegates:

Monitoring Activity	Frequency	Compliance Goal
DWMHA & the Crisis Service Vendors must conduct & submit a sampling of case reviews for all staff making UM decisions utilizing the DWMHA Prior Authorized Service UM Chart Review tool to the DWMHA UM Department.	Quarterly Results will be reported to the Utilization Management Committee (UMC)	85% or greater*
The Crisis Service Vendors must conduct and submit 100% of denials utilizing the DWMHA Prior Authorization UM Chart Review tool to the DWMHA UM Department.	Monthly Results will be reported to the UMC	90% or greater*
The Crisis Service Vendors must submit denial tracking logs & 100% of case files of any denied case to be audited by the DWMHA UM Appeal Coordinator utilizing Denial & Appeal Audit tools.	Monthly Results will be reported to the UMC	90% or greater*
DWMHA must maintain a tracking log of all appeals and conduct 100% of case files of all appeals to be audited utilizing the Denial & Appeal Audit tools.	Monthly Results will be reported to the UMC	90% or greater*
The Access Center must conduct & submit reviews of sampling of eligibility denials & a sampling of eligibility approvals using DWMHA's Access Center Service Eligibility Review tool to the DWMHA UM Department.	Quarterly Results will be reported to the UMC	90% or greater*
The Crisis Service Vendors must submit timely decision & timely notification reports to the DWMHA UM Appeal Coordinator.	Quarterly Results will be reported to UMC	90% or greater for each type of decision & notification*
Access Center and Crisis Service Vendors must submit UM Program Plans for review by DWMHA UM Director or his/her designee utilizing the UM Plan Audit tool.	Annually Results of audit will be included in annual DWMHA UM evaluation & reported to UMC	100%*
The Crisis Service Vendors must submit results of the inter-rater(s) on all staff performing UM functions utilizing the medical necessity criteria.	Annually Results will be reported to UMC	90% or greater*
Affirmative Statement will be sent annually to all staff performing UM functions.	Annually	100%*

*Delegated entities not meeting compliance goals will be reported to the DWMHA's Quality Improvement Department for follow up and to the DWMHA Quality Improvement Steering Committee (QISC) as needed.

XIV. UM METHODS AND ORGANIZATIONAL PROCESS FOR MAKING DETERMINATIONS OF MEDICAL NECESSITY AND BENEFIT COVERAGE FOR INPATIENT AND OUTPATIENT SERVICES:

DWMHA safeguards confidential recipient information and makes disclosures only within the limits of informed consent of the parties involved and in accordance with HIPAA, state and federal law, as well as industry standards and professional ethics. Therefore, all proceedings, records, writings, data, reports, information, and any other material labeled as "utilization management" are held in strictest confidence and protected from disclosure. Clinical review and information used in activities and functions of the UM program are appropriately safeguarded by DWMHA, Access Center, Crisis Service Vendors and Service Providers. Confidentiality safeguards apply to all UM/QI committee recipients, reports, and any employee of DWMHA whose duties require knowledge of, and access to UM information and committee activities. The UM Department collects only the information necessary to certify the admission, procedure, treatment, length of stay, frequency and/or duration of behavioral health and substance use services. See DWMHA HIPAA Privacy Manual and Policies and DWMHA HIPAA Security Policies and Procedures for more details.

The purpose of the UM review is to determine enrollee/member eligibility, benefit coverage, and/or establish the presence or absence of medical necessity so that a decision can be made regarding the request for services. Services may include requests for all levels of behavioral health care and substance use and requests for services from enrollees/members and behavioral health providers. The UM process provides a clear and timely response to enrollees/members and providers regarding requests for authorization of services.

DWMHA establishes UM Authorization Guidelines and Benefit Plans based on funding sources, various standard functional assessment tools and clinical presentation. It is the expectation of DWMHA that delegated entities manage adherence to the DWMHA UM Authorization and Benefit Plans. The Guidelines do not replace clinical judgement, and as such, all delegated entities must implement a clinical review process for cases that fall outside the Authorization Guidelines.

The UM review staff uses all available information along with clinical judgment, department policies and procedures, needs of the enrollee/member and characteristics of the local delivery system, including the availability of the proposed services within the network service area, to make a decision. The UM review staff will request additional information if needed. The UM reviewer has the authority to approve services based on medical necessity criteria and the benefit grid. If the UM reviewer is unable to approve the request for service, the case is referred to the physician for determination.

Requests for coverage of out-of-network services that are only covered when medically necessary or in clinically appropriate situations require medical necessity review. Such requests must indicate that the enrollee/member has a specific clinical need that the provider believes cannot be met in-network (i.e. a service or sooner than able to be provided or allowed by DWMHA's access or availability standards) as long as covered by the enrollee/member's benefit plan. If the request does not indicate the enrollee/member has a specific clinical need for which out-of-network coverage may be warranted, the UM reviewer will contact the requestor for more information.

Emergent and Urgent Service:
Emergency services are defined as those health care items and services furnished or required to evaluate or stabilize a sudden and unforeseen situation or occurrence or a sudden onset of a medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the failure to provide immediate medical attention could reasonably be expected by a prudent layperson, possessing average knowledge of health and medicine, to result in:

- Placing the person's health (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; *or*
- Serious impairment of bodily functions; *or*
- Serious dysfunction of any bodily organ or part; *or*
- Serious harm to an enrollee/member or others due to an alcohol or substance use emergency; *or*
- Injury to self or bodily harm to others; *or*
- With respect to a pregnant woman who is having contractions:

    1. That there is inadequate time to effect a safe transfer to another hospital before delivery; *or*
    2. That transfer may pose a threat to the health or safety of the woman or the unborn.

Urgently-needed services are covered services that:

- Are medically necessary and immediately required as a result of an unforeseen illness, injury, or condition and where application of the time frame for making routine or non-life threatening care determinations could seriously jeopardize the life, health or safety of the individual or others, due to the person's psychological state or in the opinion of a practitioner with knowledge of the Individual's medical or behavioral health condition, would subject the person to adverse health consequences without the care or treatment that is the subject of the request.

- Are provided when the individual is temporarily absent from the plan's service (or, if applicable, continuation) area, or under unusual and extraordinary circumstances, when the member is in the service or continuation area, and the network is temporarily unavailable or inaccessible; *and*
- It was not reasonable given the circumstances to wait to obtain the services through the plan network.

Urgent service request designations should only be used if the treatment is required to prevent serious deterioration in the person's health or could jeopardize his/her ability to regain maximum function. Requests outside of this definition will be handled as non-urgent.

XV. ACCESS, TRIAGE AND REFERRAL PROCESS FOR BEHAVIORAL HEALTH AND SUBSTANCE USE SERVICES:

Serving as the central front door and screening agent for DWMHA, the Access Center is operated twenty-four (24) hours a day, seven (7) days a week. The Access Center runs with a "no-wrong door" philosophy regardless of where the person contacts the public mental health system including those with co-occurring mental health and substance use disorders. The DWMHA Access Center's purpose is to link individuals with DWMHA's provider network by ensuring eligible persons are appropriately linked with a Service Provider for a face-to-face comprehensive intake assessment.

The Access Center provides most of the core functions of DWMHA's access system and works with the local Service Providers to ensure an overall integrated and effective access system for persons with severe mental illness (SMI), severe emotional disturbance (SED), intellectual developmental disabilities (I/DD), substance use disorders (SUD) and persons with co-occurring conditions (COD).

The Access Center is responsible for the following:

- Coverage and Eligibility Determination
- Clinical Screening
- Referral and linkage to a Service Provider for enrollees/members admitted into the public health system
- Referral, linkage and follow up to enrollees/members deemed not eligible for the public mental health system
- Substance Use Disorder Authorizations for services not requiring medical necessity review.

The Access Center makes triage and referral decisions according to protocols that define the level of urgency and appropriate level of care. They adopt triage and referral protocols that are based on sound clinical evidence and are currently accepted practice within the industry. The protocols are reviewed and revised, as needed, annually. Triage and referral staff are supervised by a licensed behavioral healthcare practitioner with a minimum of a master's degree and five (5) years of post-master's clinical experience. A licensed psychiatrist oversees triage and referral decisions.

Enrollee/members are instructed by the health plan to contact DWMHA through the twenty-four (24) hour Access Center toll free number 1-800-241-4949 or the TYY number 1-866-870-2599 for the hearing impaired. All calls are answered by a live trained Access Center Customer Service Technician (CST) who identifies themselves by name, title and organization. The CSTs are required to have at least a bachelor of arts degree in the human services field (LBSW preferred but not required) and must have at least three (3) years of experience working in human services or one (1) year of experience working in human services with an LBSW. The CST initially ascertains if it is a "crisis call" based on safety concerns and immediacy challenges as well as protocols that define the level of urgency and appropriate level of care, and if yes, collects the required demographic information and immediately warm transfers the caller to DWMHA's Behavioral Health Emergency Response Call Center. This organization is an integral part of the overall DWMHA's crisis safety net, both for active enrollees/members of DWMHA services as well as for the community at large. The organization holds the highest accreditations with the American Association of

Sociology (AAS) and the Commission of the Accreditation of Rehabilitation Facilities (CARF). Using licensed Master level (or above) clinicians, the organization provides telephonic crisis intervention and stabilization services, twenty-four (24) hours a day, seven (7) days a week. All of their clinicians are professionally credentialed experts in crisis work or Suicidology. The organization integrates and coordinates with other established components of the existing DWMHA's safety net, including but not limited to the Mobile Crisis Team, 24/7 clinical services teams (ACT and Home-based) and contracted hospital providers.

For more information on triage tools used by the Access Center see the UM Program Description Policy attachments regarding clinical assessment tools and flow.

DWMHA also contracts with another vendor to provide mobile crisis stabilization services and in-home/community based crisis stabilization services to enrollees/members. Mobile Crisis is a behavioral health service which serves the community by providing urgent response and emergency evaluations. The program operates twenty-four (24) hours a day, seven (7) days a week. Calls for mobile crisis services, including inpatient services are directed through the Access Center which will contact the Crisis Service Vendor. However, calls may also come directly to the Crisis Service Vendor at 1-800-844-296-2673 (TYY 248-424-4800 for hearing impaired) from 8am-5pm Monday-Friday and 248-995-5055 after normal business hours when the enrollee/member is reported to be in crisis. A team comprised of a master degree clinician and a peer support staff person travel together in the community and are backed up with telephonic assistance by a nurse and psychiatrist as needed.

The team is expected to respond to the enrollee/member's location, including but not limited to Hospital Emergency Rooms, Specialized AFC Homes, law enforcement settings, homeless shelters, public locations (like restaurants), private residence, or other appropriate location. The team provides mobile outreach crisis services, including screening and assessment, counseling/therapy, and therapeutic support services. The team attempts to defuse a crisis situation, enacting a person's crisis plan when available and appropriate; resolve presenting problems; procure needed services and resources; and arrange extended support. Extended support may include daily on-site visits, or it could mean that a team member-most likely a trained paraprofessional – remains with the client for a number of hours as needed, to provide supervision, monitoring, support and assistance.

If determined that more intensive services are needed, the team then performs an inpatient assessment in collaboration with other team members, care givers, or other contributors, and authorize the appropriate, indicated level and type of services. The team also assists with transportation, transitional housing or referral support on an as-needed basis. The team's face-to-face assessment may occur at a Hospital Emergency Room or when an enrollee/member has walked into the Crisis Service Vendor Center.

For individuals calling the Access Center who do not require crisis response services and are requesting entry into the public health system, the CST collects the demographic information and screens the enrollee/member for initial eligibility by verifying he/she is a resident of Wayne County. The CST uses the DWMHA electronic system, MHWIN, to verify Medicaid, Medicare, MI-Child and Healthy Michigan insurance and current enrollment. Other insurance information is obtained verbally from the caller. If the caller does not require a clinical screening to determine eligibility for community mental health service and is seeking information and community resource referrals, the CST completes a warm transfer to a community resource and provides the telephone number of at least one more community resource.

For enrollees/members who require a clinical screening, the CST warm transfers the caller to an Access Center Clinician in either the mental health, intellectual developmental disability screening unit or the substance use screening unit.

All Access Center Clinicians are licensed/certified, credentialed and trained practitioners capable of rendering clinical triage and screening services to ensure appropriate level of services determination and eligibility coverage. All of the Clinicians are supervised by a fully licensed master level practitioner with at

least 5 years post master clinical experience. There is also a fully licensed psychiatrist who oversees all triage and referral decisions.

XVI. EMERGENCY CARE RESULTING IN ADMISSIONS:

DWMHA provides coverage to enrollees/members if they require emergency or urgently needed services. Prior authorization is not needed for emergency room services or any emergent services needed to stabilize the emergent or urgent condition. Emergent and/or urgent care should be rendered as needed with notification of any admission to the Crisis Service Vendor within forty-eight (48) hours of the admission. A Crisis Service Vendor UM staff will review emergent and/or urgent admissions within one (1) calendar day of request for services and make a determination

XVII. PRE-SERVICE AND CONCURRENT REVIEWS:

DWMHA makes efforts to assure the enrollee/member receives individualized, appropriate and efficient services and supports that are sufficient in scope, frequency and duration to achieve effective outcomes.

DWMHA uses a prior authorization review process designed to promote the appropriate utilization of medically necessary services, to prevent unanticipated denials of coverage and to ensure that all services are provided at the appropriate level of care for the enrollee/member's needs in a timely manner. The purpose is to determine enrollee/member eligibility, benefit coverage and or establish the presence or absence of medical necessity so that a decision can be made regarding the request for services.

Medical Necessity review is a process to consider whether services that are covered only when medically necessary meet criteria for medical necessity and clinical appropriateness. A medical necessity review requires consideration of the enrollee/member's circumstances, relative to appropriate clinical criteria and DWMHA's policies.

All acute inpatient treatment, partial hospitalization, crisis residential services, substance use disorder services, state hospitalization, psychological and neuropsychological testing and electroconvulsive therapy and all out of network services require authorization prior to service being rendered from the DWMHA and/or the Crisis Service Vendors.

All authorizations shall be in compliance with the Medicaid Code of Federal Regulations 42 USC § 1396u-2(b) (8) provisions related to manage care and 42 C.F.R. § 438.210 provisions related to coverage and authorization of services.

Pre-service (initial) reviews are conducted telephonically. The information for the UM activity comes from the Access Center, the requesting facility or practitioner/provider and/or enrollee/member. The request for authorization may come from the psychiatrist, physician, treatment team, enrollee/member, family or advocate or facility representative. If the caller is someone other than the enrollee/member, they should be familiar with the case as a result of a face-to-face meeting with the enrollee/member or as a result of an informed review of the clinical record.

Initial reviews will include, but are not limited to, the following relevant information:

- Presenting problem including current symptoms
- History of presenting problem(s)
- Precipitant(s) to services
- Results of clinical examination
- Diagnosis
- Current level of functioning and baseline level of functioning
- Prior psychosocial, psychiatric, and substance abuse history and prior treatment
- Mental status

- Current and Past Medications (dosage and side effects)
- Results of diagnostic testing
- Results of the Urine Drug Screen
- Blood Alcohol Level
- Medical complications and significant medical history
- Information on consultations with the treating practitioner
- Evaluations from other health care practitioners and providers
- Support Systems
- Specific Severity of Illness/Intensity of Service Criteria
- Treatment plan and progress notes
- Discharge Plan
- Information gained through peer to peer conversations with treating providers

Providers are given an opportunity to discuss any behavioral health or SUD decision with a DWMHA, Access Center or Crisis Service Vendor physician (MD or DO) upon request during any review. Certified addiction medicine physicians are available to review substance use medical necessity cases if needed. The DWMHA Chief Medical Officer is also available twenty-four (24) hours a day, seven (7) days a week as well.

With medical oversight, continuing (concurrent) care reviews are completed at an interval dictated by the clinical severity of the case. Concurrent reviews are conducted prior to the end of the authorized period. Concurrent reviews will consistently include, but are not limited to, the following relevant information:

- Progress toward treatment goals and any changes in treatment goals
- Current and any changes in medications (dosage and side effects)
- Current level of functioning
- Information on consultations with the treating practitioner
- Evaluations from other health care practitioners and providers
- Intensity of Service Criteria
- Status of discharge plan
- Information obtained through peer to peer conversations with treating providers

DWMHA and the Crisis Service Vendors must adhere to the following:

Type of Review	Decision Timeframe	Exception to Decision Timeframe	Provider Notification Timeframe
Non Urgent Pre-Service Review	Within 14 calendar days of receipt of request.	N/A	Written Notification within 14 calendar days of receipt of provider's request. Verbal Notification within 3 hours of decision.
Non Urgent Concurrent Service Review	Within 14 calendar days of receipt of request.	N/A	Written Notification within 14 calendar days of receipt of provider's request. Verbal Notification within 3 hours of decision.
Urgent Pre-Service Review	Within 24 hours of receipt of request if all information is received.	Timeframe extends to 72 hours if additional information is requested & the request for the information is within 24 hours of receipt of the provider's request.	Written Notification within 72 hours of the decision. Verbal Notification within 3 hours of decision.

Urgent Concurrent Service Review	Within 24 hours of receipt of request if all information is received & request is made 24 hours prior to expiration of current authorization period.	Timeframe extends to 72 hours if additional information is requested & the request for the information is within 24 hours of receipt of the provider's request or if the provider's request for service is not made prior to the 24 hours before the expiration of the current authorization period.	Written Notification within 72 hours of the decision. Verbal Notification within 3 hours of decision.

DWMHA only allows physicians (MD or DO) to render behavioral healthcare and SUD non-authorizations. DWMHA ensures that practitioners/physicians have the opportunity to discuss any UM decision with a physician.

For non-authorization determinations, the physician reviewers must provide written documentation to justify the clinical non-authorization, and the documentation must include a description of due process rights and appeal procedures. They must also have their complete written name, signature and credentials on the written notification document.

DWMHA ensures that annually an affirmative statement about incentives to all employees of DWMHA, the Access Center and the Crisis Service Vendors who make UM decisions is distributed. UM decisions are based only on the appropriateness of care and services, as well as the existence of coverage or service or reducing the provision of care which is deemed medically necessary. See DWMHA's Behavioral Health Utilization Management Review Policy, DWMHA Denial of Service Policy and DWMHA's UM Affirmative Statement Policy for more details.

XVIII. POST-SERVICE REVIEWS:

A post-service review involves a review of the medical record *after* the services have been provided. The review may be conducted for all or part of the treatment service/or encounter. A determination is made within thirty (30) calendar days of receipt of the request. A *post*- service review resulting in an authorization determination or a non-authorization is communicated in writing to the enrollee/member and provider within thirty (30) calendar days of receipt of the request as well.

Post-service reviews will include, but are not limited to, the following relevant information:

- Presenting problem including current symptoms
- History of presenting problem(s)
- Precipitant(s) to services
- Results of clinical examination
- Diagnosis
- Current level of functioning and baseline level of functioning
- Prior psychosocial, psychiatric, and substance abuse history and prior treatment
- Mental status
- Current and Past Medications (dosage and side effects)
- Results of diagnostic testing
- Results of the Urine Drug Screen
- Blood Alcohol Level
- Medical complications and significant medical history
- Information on consultations with the treating practitioner
- Evaluations from other health care practitioners and providers
- Support Systems
- Specific Severity of Illness/Intensity of Service Criteria
- Treatment plan and progress notes

- Discharge Plan
- Information gained through peer to peer conversations with treating providers

DWMHA only allows physicians (MD or DO) to render behavioral healthcare and SUD non-authorizations. DWMHA ensures that practitioners/physicians have the opportunity to discuss any UM decision with a physician.

For non-authorization determinations, the physician reviewers must provide written documentation to justify the clinical non-authorization, and the documentation must include a description of due process rights and appeal procedures. They must also have their complete written name, signature and credentials on the written notification document.

See DWMHA's Behavioral Health Utilization Management Review Policy, DWMHA Denial of Service Policy and DWMHA's UM Affirmative Statement Policy for more details.

XIX. DISCHARGE PLANNING:

Discharge planning supports continuity of care and efficient use of resources, and incorporates the involvement and decision-making process with the enrollee/member. DWMHA's UM reviewers collaborate with hospital discharge planners and case managers to support the facility's discharge planning arrangements.

XX. UTILIZATION MANGEMENT/PROVIDER APPEALS AND ALTERATIVE DISPUTE RESOLUTION:

The types of UM/Provider appeal and alternative dispute resolution reviews are as follows:

Administrative- an appeal or dispute review involving utilization management issues such as denials resulting from not obtaining a prior authorization and/or continued authorization for some or all types of services and/or for all dates of services.

Benefit- an appeal or dispute review involving a request that is not a benefit or where the benefit limit has been exceeded.

Medical Necessity- an appeal or dispute review involving a decision that a service does not meet MCG, ASAM, NCD, or LCD medical necessity criteria or is considered to be experimental or investigational. The medical necessity appeal is reviewed by a DWMHA, Crisis Service Vendor or MCPN physician with the same or similar credentials as would usually treat the condition which is being appealed. The physician reviewing the appeal has no involvement in the initial denial.

Expedited/Urgent-a request to review a decision concerning eligibility, screening, admission, continued/concurrent stay, or other behavioral healthcare services for an enrollee/member who has received urgent services but has not been discharged from a facility, or when a delay in decision-making might seriously jeopardize an enrollee/member's life, health, or ability to attain, maintain, or regain maximum function.

Standard-a request to review a decision concerning eligibility, screening, admission, continued/concurrent stay, or other behavioral healthcare services for an enrollee/member who has received services or is currently receiving services but a delay in decision-making does not jeopardize an enrollee/member's life, health, or ability to attain, maintain, or regain maximum function.

In the event an enrollee/member, enrollee/member's representative, or practitioner/provider disagrees with a non-authorization, an appeal process is available for redetermination of the request for services or payment for services. Enrollee/members and providers are notified of how to initiate the appeal process

and the steps in the appeal process at the time of the non-certification notification. The following is a summary of the steps in the appeal process.

In the event an enrollee/member, enrollee/member's representative, or practitioner/provider disagrees with a non-authorization, an appeal process is available for redetermination of the request for services or payment for services. Enrollee/members and providers are notified of how to initiate the appeal process and the steps in the appeal process at the time of the non-certification notification. The following is a summary of the steps in the appeal process.

A. UM/Provider Appeals for **Medicaid** Covered Services

Pre-Service or Post-Service Medicaid Medical Necessity or Benefit (Redetermination) Appeal:

a. If an enrollee/member, enrollee/member's representative or practitioner/provider chooses to appeal an initial non-authorization of benefit coverage, screening, admission, continued/concurrent stay or other behavioral healthcare service, they must notify DWMHA of an internal appeal request within sixty (60) calendar days from receipt of the standardized Advance or Adequate Notice of Adverse Determination form or the standardized Notice of Denial of Medical Coverage form for Medicaid Covered Services. If the enrollee/member is enrolled in a Managed Care Health Plan, MI Health Link, CMHSP/PIHP or MI Choice Waiver program, he/she must also have exhausted the internal appeal process before he/she can request an external Medicaid State Fair Hearing. A Medicaid State Fair Hearing is an impartial state level review of a Medicaid enrollee/members appeal of an action presided over by a MDHHS Administrative Law Judge.

   However, if the enrollee/member does not receive the standardized Notice of Appeal Approval form or the standardized Notice of Appeal Denial form for the Medicaid SMI, IDD or SUD population or the Notice of Appeal Decision form for the MI Health Link population within the mandated time frame, he/she may request a Medicaid State Fair Hearing as well.

b. There is only one (1) internal level appeal process for all pre-service, concurrent and/or post-service provider/practitioner medical necessity or benefit denials.
c. The request for a pre-service Medicaid (redetermination) medical necessity or benefit internal appeal can be verbal or in writing to DWMHA. However, the request for a post-service Medicaid (redetermination) medical necessity or benefit internal appeal must be in writing.
d. All requests must include at a minimum the following:
   - An explanation of what is being appealed and the name, address and telephone number of the person responsible for filing the appeal; *and*
   - Any additional supporting documentation such as additional clinical information that had not been previously submitted;
   - The staff member preparing case for physician review will review all information in their electronic medical record system and gather any other information available such as previous denials and appeals and follow-up care that has occurred after the denial.
   - However, for **post-service requests**, the complete medical record (at a minimum the intake, psychiatric evaluation, psychiatric progress notes, social work evaluation, social work progress notes, nurse evaluation, nurse progress notes, medication administration notes and discharge summary) if not provided previously.
e. The provider and/or enrollee/member can ask for an expedited (redetermination) internal medical necessity or benefit appeal as long as the enrollee/member has not been discharged from the treatment.
f. After receiving an internal medical necessity or benefit appeal request, DWMHA must complete and send the standardized Notice of Receipt of Appeal form within twenty-four (24) hours of receipt of an expedited appeal request and within five (5) calendar days of receipt of a standard appeal request.
g. Upon receipt of the medical necessity or benefit appeal request, DWMHA is required to review the case including all documentation submitted and to fully investigate all aspects of the clinical care

provided without deference to the initial determination and make a decision within the following timeframes:

- For a pre-service expedited 1st level request, within seventy-two (72) hours of receipt of the request;
- For a pre-service standard request, within thirty (30) calendar days of receipt of the request; *and*
- For a post-service, which are all standard, within thirty (30) calendar days of receipt of the request.

h. The enrollee/member and/or DWMHA may need to ask for an extension to obtain more information that will assist in the processing of the appeal. All extensions can request the necessary information as long as the request is within fourteen (14) calendar days of the initial request.

i. The physician with the same or similar specialty will review the appeal and will not be a subordinate of the physician who rendered the initial denial.

j. The physician when reviewing a medical necessity appeal, in conjunction with independent professional medical judgment, will use nationally recognized guidelines which include but are not limited to third party guidelines, CMS guidelines, and State guidelines, recommendations from professional societies and advice from authoritative review articles and text books.

k. The physician who made the original denial determination may review the case and overturn the initial denial.

l. If the decision results in upholding part or all of the initial denial, verbal communication is given to the provider within three (3) hours of the decision. Written Notification using the standardized Notice of Appeal Denial form for the Medicaid SMI, IDD and SUD population or the standardized Notice of Appeal Decision form for the MI Health Link population and the standardized Physician Letter are sent to both the provider and enrollee/member within twenty-four (24) hours of the decision. The only exception is when the decision for a pre-service expedited appeal is made on the last/3rd calendar day, when the decision for a pre-service standard appeal is made on the last/30th day or when the decision for a post-service appeal is made on the last/30th day. In these cases, the Notice and Physician Letter must be mailed on the same day as the determination.

m. The Notice of Appeal Denial form for the Medicaid SMI, IDD and SUD population and the Notice of Appeal Decision form for the MI Health Link population must include a statement that this is the only internal level of appeal.

n. The Notice of Appeal Denial form and the Notice of Appeal Decision form must also include a statement that the enrollee/member has a right to an external State Fair Hearing after he/she has exhausted the internal appeal process and an explanation of the process to file a State Fair Hearing which is at no cost to the enrollee/member.

o. If the decision results in overturning part or all of the initial denial, verbal communication is given to the provider within three (3) hours of the decision. For a complete overturned determination, written notification using the standardized Notice of Appeal Approval form for the Medicaid SMI, IDD, SUD population or the standardized Notice of Appeal Decision form for the MI Health Link population and the standardized Physician Letter are sent to the provider and enrollee/member within twenty-four (24) hours of the determination. For a partially overturned determination, written notification using the standardized Notice of Appeal Denial form for the Medicaid SMI, IDD, SUD population or the standardized Notice of Appeal Decision form for the MI Health Link population and the standardized Physician Letter are sent to both the provider and enrollee/member within twenty-four (24) hours of the decision. The only exceptions are when the decision for a pre-service expedited appeal is made on the last/3rd calendar day or when the decision for a pre-service standard appeal is made on the last/30th day. In these cases, the Notice and Physician Letter must be mailed on the same day as the determination.

p. A DWMHA physician is available to discuss a pre-service or post-service Medicaid (redetermination) denial.

q. When DWMHA fails to make a timely decision for a MI Health Link enrollee/member, the enrollee/member and provider will be sent the standardized Notice of Our Failure to Make a Coverage Determination form.

Post-Service Medicaid Administrative (Redetermination) Appeal:

a. The provider and/or enrollee/member has up to sixty (60) calendar days from the receipt of the standardized Adequate Notice of Adverse Benefit Determination form or the Advance Notice of Adverse Benefit Determination form for the Medicaid SMI, IDD or SUD population or the standardized Notice of Denial of Medical Coverage form for the MI Health Link population to request an internal administrative appeal for a post-service Medicaid covered service.
b. DWMHA and the Crisis Service Vendor has a one (1) level appeal process for post-service provider administrative denials. Examples of administrative denials are failure to authorize services according to required, contracted time frames.
c. The provider's request for a post-service Medicaid (redetermination) administrative internal appeal must be in writing to DWMHA or the Crisis Service Vendor.
d. Once the service or procedure has occurred or the enrollee/member has been discharged from the facility, the provider must utilize the described post-service process in order to appeal.
e. All requests must include at a minimum the following:
    - An explanation of what is being appealed and the name, address and telephone number of the person responsible for filing the appeal; *and*
    - Documentation including the request, the reasons why the provider feels the services should be paid and a copy of the claim(s). In addition, documentation of the reason for notification outside of DWMHA's or the Crisis Service Vendor's notification time frames must be provided.
f. DWMHA's Customer Service Department handles all enrollee/member administrative appeals for Medicaid covered services. Enrollees/members are held financially harmless for any provider/practitioner administrative denial for Medicaid covered services.
g. After receiving an administrative appeal request from a provider, DWMHA or the Crisis Service Vendor must complete and send the standardized Notice of Receipt of Appeal form within five (5) calendar days of receipt of the standard appeal request to the provider and enrollee/member.
h. Upon receipt of the administrative appeal request, DWMHA or the Crisis Service Vendor Professional staff is required to review the case including all documentation submitted and to fully investigate all aspects of the case without deference to the initial determination and make a decision within the following timeframe:
    - For a post-service request, which are all standard, within thirty (30) calendar days of receipt of the request.
i. If the decision results in upholding part or all of the initial denial, verbal communication is given to the provider within three (3) hours of the decision. Written Notification using the standardized Administrative Appeal Determination form is sent to both the provider and enrollee/member within twenty-four (24) hours of the decision. The only exception is when the decision for a post-service administrative appeal is made on the last/30th day. In this case, the Notice must be mailed on the same day as the determination.
j. The Administrative Appeal Determination Form must state that this is the final level of appeal and that the enrollee/member is to be held financially harmless for any provider/practitioner administrative denial for Medicare covered services.
k. A DWMHA and/or Crisis Service Vendor professional staff is available to discuss a post-service Medicaid (redetermination) administrative denial.

B. UM/Provider Appeals for **Medicare** Covered Services:

Pre-Service or Post-Service Medicare Medical Necessity or Benefit First Level (Redetermination) Appeal:

a. If an enrollee/member, enrollee/member's representative or provider chooses to appeal an initial non-authorization of eligibility, benefit coverage, screening, admission, continued/concurrent stay or other behavioral healthcare service, they must notify DWMHA an appeal request within sixty (60) days from the standardized Notice of Denial of Medical Coverage form for Medicare Covered Services.
b. The request for a pre-service Medicare 1st level (redetermination) medical necessity or benefit internal appeal can be verbal or in writing to DWMHA. However, the request for a post-service Medicare 1st level (redetermination) medical necessity or benefit internal appeal must be in writing.

c. All requests must include at a minimum the following:
    - An explanation of what is being appealed and the name, address and telephone number of the person responsible for filing the appeal;
    - Any additional supporting documentation not submitted previously; *and*
    - The staff member preparing the case for physician review will review all information in their electronic medical record system and gather any other information available such as previous denials and appeals and follow-up care that has occurred after the denial.
    - However, for **post-service requests**, the complete medical record (at a minimum the intake, psychiatric evaluation, psychiatric progress notes, social work evaluation, social work progress notes, nurse evaluation, nurse progress notes, medication administration notes and discharge summary) if not provided previously.

d. The provider and/or enrollee/member can ask for an expedited (redetermination) internal medical necessity or benefit appeal as long as the enrollee/member has not been discharged from the treatment.
e. After receiving an internal medical necessity or benefit appeal request, DWMHA must complete and send the standardized Notice of Receipt of Appeal form within twenty-four (24) hours of receipt of an expedited appeal request and within five (5) calendar days of receipt of a standard appeal request.
f. Upon receipt of the 1st level medical necessity or benefit appeal request, DWMHA is required to review the case including all documentation submitted and to fully investigate all aspects of the clinical care provided without deference to the initial determination and make a decision within the following timeframes:
    - For a pre-service expedited 1st level request, within seventy-two (72) hours of receipt of the request;
    - For a pre-service standard 1st level request, within thirty (30) calendar days of receipt of the request; *and*
    - For a post-service 1st level request, which are all standard, within thirty (30) calendar days of receipt of the request.
g. The enrollee/member and/or DWMHA may need to ask for an extension to obtain more information that will assist in the processing of the appeal. All extensions can request the necessary information as long as the request is within fourteen (14) calendar days of the initial request.
h. The physician with the same or similar specialty will review the 1st level appeal and will not be subordinate of the physician who rendered the initial denial.
i. The physician when reviewing a medical necessity 1st level appeal, in conjunction with independent professional medical judgment, will use nationally recognized guidelines which include but are not limited to third party guidelines, CMS guidelines, and State guidelines, guidelines from professional societies and advice from authoritative review articles and text books.
j. The physician who made the original denial determination may review the case and overturn the initial denial.
k. If the decision results in upholding part or all of the initial denial, verbal communication is given to the provider within three (3) hours of the decision. Written Notification using the standardized Notice of Appeal Decision form and the standardized Physician Letter are sent to both the provider and enrollee/member within twenty-four (24) hours of the decision. The only exception is when the decision for a pre-service expedited appeal is made on the last/3rd calendar day, when the decision for a pre-service standard appeal is made on the last/30th day or when the decision for a post-service appeal is made on the last/30th day. In these cases, the Notice and Physician Letter must be mailed on the same day as the determination.
l. The Notice must include an explanation that the case is automatically forwarded to the Qualified Independent Contractor, MAXIMUS Federal Services for a pre-service Medicare 2nd level (reconsideration) appeal if the determination is to uphold all or part of the non-authorization of eligibility, screening admission, continued/concurrent stay or other behavioral healthcare services.
m. A DWMHA is available to discuss a pre-service or post-service Medicare (redetermination) denial.

n. When DWMHA fails to make a timely decision, the enrollee/member and provider will be sent the standardized Notice of Our Failure to Make a Coverage Decision form.

Pre-Service or Post-Service Medicare Second Level Medical Necessity or Benefit (Reconsideration) Appeal:

a. DWMHA automatically forwards the case to MAXIMUS for a pre-service Medicare 2nd level (reconsideration) appeal.
b. MAXIMUS attempts to review a case, make a decision and notify DWMHA, the provider and enrollee/member of the decision within thirty (30) calendar days of receipt of the request.
c. If MAXIMUS upholds part or all of the 1st level redetermination decision, they provide written notification of the decision to DWMHA, the provider and the enrollee/member. The Notice also includes an explanation of the next (3rd) level appeal process. However, if they overturn the 1st level redetermination decision and approve some or all of the services/days, DWMHA has thirty (30) calendar days to effectuate (pay claim) and provide MAXIMUS with the check number, check date, amount paid and explanation of benefits no later than thirty (30) calendar days from the MAXIMUS decision.

Pre-Service or Post-Service Medicare Third Level Medical Necessity or Benefit Appeal:

a. The 3rd level appeal is the Administrative Law Judge (ALJ) Hearing. This hearing allows the provider to present the appeal to a new person who will review the facts independently and listen to testimony before making a new and impartial decision. An ALJ hearing is usually held by phone or video-teleconference, or in some cases, in person. To secure an ALJ hearing, the minimum amount of the case must be $150. All requests for an ALJ hearing must be written and forwarded to the Office of Medicare Hearing and Appeals (OMHA). The address is documented in the MAXIMUS decision notice. In most cases, the ALJ sends a written decision within ninety (90) days of receipt of the request.
b. If the ALJ upholds part or all of the 2nd level decision by MAXIMUS, they provide written notification of the decision to DWMHA, the provider and the enrollee/member. The Notice also includes an explanation of the next (4th) level appeal process.

Pre-Service or Post-Service Medicare Fourth Level Medical Necessity or Benefit Appeal:

a. A 4th appeal level can be sought if the provider is dissatisfied with the decision made in the hearing. The request for a Medicare Appeals Council (MAC) review must be submitted in writing within sixty (60) calendar days of the ALJ decision and must specify the issues and findings that are being contested. (Refer to the ALJ decision for details regarding the procedures to follow when filing a request for Appeals Council review.) In general, the MAC will issue a decision within ninety (90) days of receipt of a request for review. However, that timeframe may be extended for various reasons, including but not limited to, the case being escalated from an ALJ hearing. If the Appeals Council does not issue a decision within the applicable timeframe, you may ask the Medicare Appeals Council to escalate the case to the next (5th) level, the Judicial Review.
b. If the MAC upholds part or all of the 3rd level decision by the ALJ, they provide written notification of the decision to DWMHA, the provider and the enrollee/member. The Notice also includes an explanation of the next (5th) level appeal process.

Pre-Service or Post-Service Medicare Fifth Level Medical Necessity or Benefit Appeal:

a. If at least $1,460 or more is still in controversy following the MAC decision, the provider on behalf of the enrollee/member may request judicial review before a U.S. District Court judge; this is the fifth and final level of appeal. The provider must file the request for review within sixty (60) days of receipt of the MAC's decision, which contains information about the procedures for requesting judicial review. There is no statutory timeframe for the Federal Court decision.
b. If the US District Court Judge upholds part or all of the 4th level decision by MAC, they provide written notification of the decision to DWMHA, the provider and the enrollee/member. The Notice also includes an explanation that this is the final appeal level.

Post-service (Retrospective) Medicare Administrative First Level (Redetermination) Appeal:

a. The provider and/or enrollee/member has up to sixty (60) calendar days from the receipt of the standardized Notice of Denial of Medical Coverage form to request an internal administrative appeal for a post-service Medicare covered service.
b. DWMHA and the Crisis Service Vendor have a one (1) level appeal process for post-service provider administrative denials. Examples of administrative denials are failure to authorize services according to required, contracted time frames.
c. The provider's request for a post-service Medicare 1st (redetermination) administrative internal appeal must be in writing to DWMHA or the Crisis Service Vendor.
d. Once the service or procedure has occurred or the enrollee/member has been discharged from the facility, the provider must utilize the described post-service process in order to appeal.
e. All requests must include at a minimum the following:
    - An explanation of what is being appealed and the name, address and telephone number of the person responsible for filing the appeal; *and*
    - Documentation including the request, the reasons why the provider feels the services should be paid and a copy of the claim(s). In addition, the reason for the notification outside of DWMHA's or the Crisis Service Vendor's notification time frames must be documented.
g. DWMHA's Customer Service Department handles all enrollee/member administrative appeals for Medicaid covered services. Enrollees/members are held financially harmless for any provider/practitioner administrative denial for Medicaid covered services.
h. After receiving a 1st level administrative appeal request from a provider, DWMHA or the Crisis Service Vendor must complete and send the standardized Notice of Receipt of Appeal form within five (5) calendar days of the standard appeal request to the provider and enrollee/member.
i. Upon receipt of the 1st level administrative appeal request, DWMHA or the Crisis Service Vendor Professional Staff is required to review the case including all documentation submitted and to fully investigate all aspects of the case without deference to the initial determination and make a decision within the following timeframe:
    - For a post-service 1st level request, which are all standard, within thirty (30) calendar days of receipt of the request.
j. If the decision results in upholding part or all of the initial denial, verbal communication is given to the provider within three (3) hours of the decision. Written Notification using the standardized Administrative Appeal Determination form is sent to both the provider and enrollee/member within twenty-four (24) hours of the decision. The only exception is when the decision for a post-service administrative appeal is made on the last/30th day. In this case, the Notice must be mailed on the same day as the determination.
k. The Administrative Appeal Determination Form must state that this is the final level of appeal and that the enrollee/member is to be held financially harmless for any provider/practitioner administrative denial for Medicare covered services.
l. A DWMHA or the Crisis Service Vendor professional staff are available to discuss a post-service Medicare (redetermination) administrative denial.

When a non-contracted provider files an appeal for a MI Health Link enrollee/member, he/she must forward a complete and signed Waiver of Liability (WOL) form with the 1st level (redetermination) appeal request. Section 60.1.1 of Chapter 13 of the Medicare Managed Care Manual states: "A non-contract provider, on his or her own behalf, is permitted to file a standard or expedited appeal for a denied claim only if the non-contract provider completes a waiver of liability statement, which provides that the non-contract provider will not bill the enrollee regardless of the outcome of the appeal." DWMHA cannot proceed in reviewing a non-contracted provider's request for a 1st level appeal if there is no complete and signed.

WOL form. DWMHA will make three (3) attempts via telephone or in writing to secure all needed documents including the WOL. If no WOL is forwarded to DWMHA's UM Department within sixty (60)

calendar days from the denial notice date, DWMHA must send the case to a MAXIMUS requesting a dismissal. DWMHA will also forward a written notification of the dismissal to the non-contracted provider within five (5) calendar days of the request for the dismissal.

C. UM/Provider Local and Alternative Dispute Resolution for the **Uninsured or Under Insured using General Fund** to cover services:

Pre-Service or Post-Service Medical Necessity or Benefit (Redetermination) Local Dispute Resolution Review:

a. If an uninsured or under Insured enrollee/member, uninsured or underinsured enrollee/member's representative or practitioner/provider chooses to request an internal local dispute resolution review of an initial non-authorization of benefit coverage, screening, admission, continued/concurrent stay or other behavioral healthcare service, they must notify DWMHA to request a local dispute resolution review request within thirty (30) calendar days from the receipt of the standardized Advance or Adequate Adverse Determination form for the uninsured or under Insured. The uninsured or underinsured enrollee/member can request an external Alternative Dispute Resolution with the Michigan Department of Health and Human Services (MDHHS) **after** the local dispute resolution review process.

b. There is only one (1) internal local dispute resolution review level for all pre-service, concurrent and/or post-service provider/practitioner medical necessity or benefit denials.

c. The request for a pre-service (redetermination) medical necessity or benefit internal local dispute resolution review can be verbal or in writing to DWMHA. However, the request for a post-service (redetermination) medical necessity or benefit internal local dispute resolution review must be in writing.

d. All requests must include at a minimum the following:
    - An explanation of what is being dispute and the name, address and telephone number of the person responsible for filing the local dispute resolution request; *and*
    - Any additional supporting documentation such as additional clinical information that had not been previously submitted;
    - The staff preparing the case for physician review will review all information in their electronic medical record system and gather any other information available such as previous local dispute review denials and follow-up care that has occurred.
    - However, for **post-service requests**, the complete medical record (at a minimum the intake, psychiatric evaluation, psychiatric progress notes, social work evaluation, social work progress notes, nurse evaluation, nurse progress notes, medication administration notes and discharge summary) if not provided previously.

e. The provider and/or uninsured or under insured enrollee/member can ask for an expedited (redetermination) medical necessity or benefit local dispute resolution review request as long as the enrollee/member has not been discharged from the treatment. DWMHA will assess the request for an expedited local dispute resolution review and determine if there is clinical rationale that shows the decision or delay in making the decision may have an adverse impact on the enrollee/member's health or well-being. If the request does not meet the expedited criteria, the local dispute resolution review is re-directed through the standard review process.

f. After receiving a medical necessity or benefit local dispute resolution review request, DWMHA must complete and send the standardized Notice of Receipt of Local Dispute Resolution Request form for the uninsured or underinsured form within twenty-four (24) hours of receipt of an expedited review request and within five (5) calendar days of receipt of a standard review request.

g. The Uninsured or Under Insured enrollee/member and/or DWMHA may need to ask for an extension to obtain more information that will assist in the processing of the local dispute resolution review.

All extensions can request the necessary information as long as the request is within fourteen (14) calendar days of the initial request.

h. Upon receipt of the medical necessity or benefit local dispute resolution review request, DWMHA is required to review the case including all documentation submitted and to fully investigate all aspects of the clinical care provided without deference to the initial determination and make a decision within the following timeframes:

- For a pre-service expedited local dispute resolution review request, within seventy-two (72) hours of receipt of the request;
- For a pre-service standard local dispute resolution review request, within thirty (30) calendar days of receipt of the request; *and*
- For a post-service local dispute resolution review request, which are all standard, within thirty (30) calendar days of receipt of the request.

i. The physician with the same or similar specialty will review the local dispute resolution review and will not be a subordinate of the physician who rendered the initial denial.

j. The physician when reviewing a medical necessity local dispute resolution review, in conjunction with the independent professional medical judgment, will use nationally recognized professional societies and advice from authoritative review articles and text books.

k. The physician who made the original denial determination may review the case and overturn the initial denial.

l. If the decision results in upholding part or all of the initial denial, verbal communication is given to the provider within three (3) hours of the decision. Written Notification using the standardized Notice of Appeal Denial form for the uninsured or under insured and the standardized Physician Letter are sent to both the provider and enrollee/member within twenty-four (24) hours of the decision. The only exception is when the decision for a pre-service expedited appeal is made on the last/3rd calendar day, when the decision for a pre-service standard appeal is made on the last/30th day or when the decision for a post-service appeal is made on the last/30th day. In these cases, the Notice and Physician Letter must be mailed on the same day as the determination.

m. The Notice of Appeal Denial form for the uninsured or under insured must include a statement that this is the only internal level of appeal.

n. If the decision results in overturning part or all of the initial denial, verbal communication is given to the provider within three (3) hours of the decision. For a complete overturned determination, written notification using the standardized Notice of Appeal Approval form for the uninsured or under insured and the standardized Physician Letter are sent within twenty-four (24) hours of the decision. For a partially overturned determination, written notification using the standardized Notice of Appeal Denial form for the uninsured or under insured and the standardized Physician Letter are sent to both the provider and enrollee/member within twenty-four (24) hours of the decision. The only exceptions are when the decision for a pre-service expedited appeal is made on the last/3rd calendar day or when the decision for a pre-service standard appeal is made on the last/30th day. In these cases, the Notice and Physician Letter must be mailed on the same day as the determination.

o. A DWMHA physician is available to discuss a pre-service or post-service local dispute resolution review (redetermination) denial.

Post-service Administrative (Redetermination) Local Dispute Resolution Review:

a. The provider and/or uninsured or under insured enrollee/member has up to thirty (30) calendar days from the receipt of the standardized Adequate Notice of Adverse Benefit Determination form or the Advance Notice of Adverse Benefit Determination for the uninsured or under insured to request an internal (redetermination) administrative local dispute resolution review.

b. DWMHA and the Crisis Service Vendor have one (1) level for a local dispute resolution review for post-service provider administrative denials. Examples of administrative denials are failure to authorize services according to required, contracted time frames.

c. The provider's request for a post-service 1st level (redetermination) administrative internal local dispute resolution review request must be in writing to DWMHA or the Crisis Service Vendor.
d. Once the service or procedure has occurred or the enrollee/member has been discharged from the facility, the provider must utilize the described post-service process in order to appeal.

e. All requests must include at a minimum the following:
    - An explanation of what is being disputed and the name, address and telephone number of the person responsible for filing the appeal; *and*
    - Documentation including the request, the reasons why the provider feels the services should be paid and a copy of the claim(s). It must also include the reason for notification outside of DWMHA's and/or the Crisis Service Vendor's notification time frames.
f. DWMHA's Customer Service Department handles all enrollee/member administrative local dispute resolution reviews. Enrollee/members are held harmless financially for any provider/practitioner administrative denial.
g. After receiving am administrative local dispute resolution review request from a provider, DWMHA or the Crisis Service Vendor must complete and send the standardized Notice of Receipt of Local Dispute Resolution Review Request form for the uninsured or under insured within five (5) calendar days of receipt of a standard review request to the provider and enrollee/member.
h. Upon receipt of the administrative local dispute resolution review request, DWMHA or the Crisis Service Vendor Professional Staff is required to review the case including all documentation submitted and to fully investigate all aspects of the case without deference to the initial determination and make a decision within the following timeframes:
    - For a post-service local dispute resolution review request, which are all standard, within thirty (30) calendar days of receipt of the request.
i. If the decision results in upholding part or all of the initial denial, verbal communication is given to the provider within three (3) hours of the decision. Written Notification using the standardized Administrative Appeal Determination form is sent to both the provider and enrollee/member within twenty-four (24) hours of the decision. The only exception is when the decision for a post-service administrative appeal is made on the last/30th day. In this case, the Notice must be mailed on the same day as the determination.
j. The Administrative Appeal Determination Form must state that this is the final level of appeal and that the enrollee/member is to be held financially harmless for any provider/practitioner administrative denial for Medicare covered services.
k. A DWMHA and/or Crisis Service Vendor professional staff is available to discuss a post-service administrative denial.

See DWMHA Denial of Service Policy, DWMHA Utilization Management/Provider Appeals Policy, DWMHA Utilization Management/Provider Local and Alternative Dispute Resolution Policy for more details.

XXI. CONTINUOUS COVERAGE AND SERVICE REQUIREMENTS:

DWMHA and the Crisis Service Vendors must have continual capacity 365 days a year (24x7x365) to perform any needed inpatient stay review and/or appeals for inpatient psychiatric hospital services or any other service requiring prior authorization. Authorization by DWMHA or the Crisis Service Vendor must be based on MCG criteria. The Crisis Service Vendors are responsible for notifying DWMHA of their twenty-four (24) hour access numbers for prior authorization and any changes in access to the services or procedures for requesting prior authorization.

DWMHA UM Reviewers are accessible seven (7) days a week, twenty-four (24) hours a day via a published designated toll-free number to handle urgent requests. Non-urgent pre-service requests and/or communications received by telephone, fax or email are handled on the next business day. TYY services as

well as calls through the Michigan Relay system are available for hearing impaired or speech impaired enrollee/members. Language assistance/interpretation is also available for enrollee/members to discuss UM issues.

XXII. INDIVIDUAL PLAN OF SERVICE/MASTER TREATMENT PLAN:

The Individual Plan of Service (IPOS) is a written comprehensive plan of services and supports developed through a person-centered planning process, in partnership with the enrollee/member or their authorized representative and their family/caregiver (if enrollee/member agreeable) and one or more qualified professionals (e.g. mental health professional (MHP) child mental health professional (CMHP) or qualified intellectual disability professional (QIDP)) to address the identified desires and needs and to establish meaningful and measurable goals that are prioritized by the enrollee/member. The IPOS is the fundamental document in the individual's record and must be authenticated by the dated legible signatures of the recipients/authorized representative and the person chosen by the recipient and named in the plan to be responsible for its implementation.

Currently, the Master Treatment Plan (MTP) is the guiding SUD treatment document produced by a collaborative planning effort of an interdisciplinary group of professionals (therapist/counselor and supervisor) who meet with the enrollee/member utilizing the Person Centered Planning process. If required, the doctor must approve the Master Treatment Plan. However, no pre-planning meeting is required prior to the Master Treatment Plan. It must be completed within forty-eight (48) hours and prior to service delivery.

An IPOS/MTP must specify the following:

- Scope of Services
- Amount of Services
- Duration of Services
- Frequency of Services
- Service Provider
- Service Delivery Method
- Service Delivery Location
- Service delivery start and end dates

Depending on the funding stream and responsibility for payment of services, DWMHA and/or Service Providers approve the supports and services outlined in the IPOS/MTP system wide. The IPOS/MTP then serves as the authorization for the supports and services. However, the IPOS/MTP is a working document that is not meant to be a once and done document. As interventions are completed, objectives are accomplished and goals are achieved, the plan should be updated to reflect current focuses and needs of the enrollee/member. See DWMHA's Individual Plan of Service Policy for more details.

XXIII. UTILIZATION MANAGEMENT'S ROLE IN THE QUALITY IMPROVEMENT (QI) PROGRAM:

The UM program provides the Quality Improvement (QI) program with data related to monitoring and improving care and services rendered. The UM Department and the QI Department work together to monitor the care and services provided to individuals. Through this partnership, DWMHA staff is able to identify opportunities for improvement, intervene to improve care and services and conduct re-measurement activities to determine whether objectives are achieved.

The DWMHA's quality management system consists of standing committees that oversee ongoing monitoring, peer evaluation, and improvement function including receipt and review of data related to their identified areas of responsibility. This structure is designed to improve quality of care to enrollee/members, improve operations of providers and promote efficient and effective internal operations. Standing committees may be assigned quality indicators to use in monitoring aspects of care and service or may establish indicators for which data will be collected and monitored. The committees define aspects of services and supports to be monitored for opportunities to improve, based on priorities

established in the MDHHS contract and on the needs of high-risk enrollee/members and high volume/problem-prone programs. Results from the DWMHA's Performance Indicators System, which is an extension of the MDHHS data collection program, are a key source for identification of aspects to be monitored. The committee develops plans by which data for their scope of responsibility will be reviewed and opportunities for improvement identified. Quality Management staff work with the committees and assure that the principles of data based continuous quality improvements are followed.

The standing committees monitor improvements that are implemented for effectiveness and improved outcomes. Standing committees identify and recommend needs for quality improvement teams, as appropriate, and may bring outside resources, if needed to facilitate the work of teams and to facilitate involvement of all team members. The Utilization Management Committee (UMC) is a standing committee of the Quality Improvement Steering Committee (QISC) who reports up to the Program Compliance Committee (PCC).

Annually, the DWMHA's UM program is reviewed and evaluated for overall program effectiveness and its impact is documented within the annual QI program evaluation. Results of the Behavioral Health UM program are used to identify quality of care concerns among providers. Key quality indicators are established in the Quality Improvement program to monitor Behavioral Health UM processes. These results provide a basis for prioritizing quality improvement initiatives.

The DWMHA's UM Annual Program Evaluation and DWMHA's UM Program Description are approved on an annual basis by the Board of Directors, following a recommendation from the Program Compliance Committee.

Under or over utilization of services may indicate poor quality care to enrollee/members. To ensure that enrollee/members receive the appropriate level of services, DWMHA implements a program to monitor service sites and improve the level of services received by enrollees/members. The variation in use of services is monitored by the QISC. At a minimum, the following UM measures will be reviewed to determine over and/or under-utilization and reported to QISC.

Sources for UM data may include, but are not limited to:

- ✓ Care Management Technology (CMT)
- ✓ Care Connect 360
- ✓ My Care Connect
- ✓ DWMHA's electronic system, MHWIN
- ✓ Access Center and/or the Crisis Service Vendors electronic systems

Service Event Volume including:

- Number of enrollee/members receiving services by disability designation of IDD, SED, MI, ED, SMI, age, gender, race/ethnicity, Medicaid vs. non Medicaid, residency
- Selected service encounter mix for populations designated as SED, IDD, SMI
- Number of enrollees/members with co-occurring Mental Illness/Substance Use Disorders (MI/SUD)

Hospitalization and Recidivism Reports:

- Number of inpatient admissions per hospital type (community hospital, state facility, other)
- Average length of stay per hospital type
- Number of enrollees/members re-hospitalized within 30 days after discharge from hospital

Substance Use Disorder Monitoring and Reports:

- Number of Admissions by Level of Care
- Number of Unique Individuals Served
- Recidivism Reporting by Level of Care
- Length of Stay by Level of Care
- Monitoring and Evaluation of Service Utilization trends
- UM involvement with the SUD Advisory Board

Continuity of Care Reports:

- Percent seen within seven days' post inpatient (MI/SA) hospitalization by hospital type
- Average number of days from inpatient discharge to face to face with physician

Co-Occurring Management:

- Utilization of services for selected procedure codes

When potential under and/or over utilization is identified, the following steps may be taken to determine if there are, in fact, instances of actual under and over treatment:

- The number and type of enrollee/member complaints related to high volume facilities or outpatient providers associated with under/over utilization of care will be reviewed.
- If indicated based on average length of treatment, a sample review of medical records for facilities or outpatient providers will be conducted to identify any instances of under or over treatment.
- DWMHA will review the results of medical record reviews, utilization and/or readmission patterns, and any complaints received related to care delivery to determine if potential under or over utilization can be validated. If validated, the providers responsible will be targeted for educational outreach with primary intervention(s) to correct under or over service utilization.

The CMO is a member of multiple Quality Improvement Steering Review standing committees such as

- Critical/Sentinel Events Committee
- Peer Review Committee
- Death Review Committee

DWMHA, the Access Center and the Crisis Service Vendors are expected to review a statistically sound sample of consumer records, conduct sufficient billing reviews and satisfaction surveys to assure a level of confidence in the utilization management process.

The DWMHA UM Appeal Coordinator is expected to audit all denials and all appeals rendered by DWMHA, the Access Center and the Crisis Service Vendors monthly using the standardized audit tools, collate the results of the audits and provide a monthly report to the DWMHA UM Director. Denial and/or appeal cases not scoring 90% or greater will be reviewed with the DWMHA, Access Center or the Crisis Service Vendors UM Reviewer for the purposes of coaching and training. Any UM Reviewer that scores below 90% on the audit tool three (3) times or more will be placed on a Corrective Action Plan.

XXIV. SATISFACTION WITH THE UM PROCESS

Practitioner, provider and enrollee/member surveys are conducted annually to assess UM satisfaction. Through the satisfaction surveys as well as enrollee/member and provider complaint and appeal process, DWMHA continually evaluates the UM program to ensure that difficulties are not encountered when enrollee/members are seeking care and when providers are requesting care. The UMC reviews data at least annually to identify opportunities and develop interventions for improvement.

XXV. UTILIZATION MANAGEMENT PROGRAM EVALUATION:

A. Frequency of the DWMHA UM Program Evaluation:
A formal evaluation of the UM program occurs annually. This annual evaluation includes but is not limited to the program structure and scope, UM processes, benefit coverage and medically necessity as well as the involvement of the Chief Medical Officer as well as member and provider experience. The evaluation is reported to the UMC and then reported to the QISC annually and to the PCC and then to the BOD for formal approval every two years and as needed. The UM Program evaluation is part of the QI evaluation that is reported to the PCC and to the Board annually. Results of the evaluation are used to guide the development and refinement of the Behavioral Health UM Program Description and Work Plan.

B. Responsibility for the DWMHA UM Program Evaluation:
The UM Program Evaluation is compiled by DWMHA UM Clinical Specialists and the DWMHA UM Director. It is then reviewed by the CMO prior to presentation to the UMC.

The UM Program Evaluation is organized around the DWMHA Strategic Plan and includes but is not limited to:

- Monitoring trends and patterns of key utilization management indicators for under and over utilization and appropriateness of care;
- Enrollee/member and Provider satisfaction with the UM process;
- Compliance with UM decision-making timeframes;
- Compliance with certification, non-certification and appeal resolution timeframes;
- Consistency of the selection and application of medical necessity criteria by UM decision-makers using standardized criteria and inter-rater reliability measures;
- Benefit Management;
- Quality improvement activities;
- Denial and Appeal category analysis; and
- New Technology Recommendations.

ATTACHMENT #1

Utilization Management Functions for the MI Health Link Program:

MI Health Link is a new health care option for Michigan adults, ages 21 and over, who are enrolled in both Medicare and Medicaid and live in Wayne County or one of the other participating regions.

The goal of MI Health Link is to provide seamless access to high quality care that reduces costs for those who are eligible. 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 the individual needs of the enrollee.

The following integrated care organizations provide services to MI Health Link enrollees/members in Wayne County: Aetna, AmeriHealth, Fidelis, HAP Midwest and Molina.

The benefits of being enrolled in the MI Health Link program include:

- Having one plan for all your Medicare and Medicaid benefits including medications
- Not having to pay any co-payments or deductibles for in network services including medications (nursing home patient pay amounts still apply)
- Having an individual Care Coordinator to:
  - ✓ Work with the individual to create a person care plan based on personal goals
  - ✓ Answer questions and make sure the person's health care issues get the attention they deserve
  - ✓ Connect the individual to supports and services needed to be healthy and live where he/she wants.

Access to Behavioral Health and Substance Use Services:
The maximum time between a request for an appointment and the date offered is:

- Emergent / Life Threatening: 3 hours
- Emergent / Non-Life Threatening: 6 hours
- Urgent Care: 24 hours
- Routine Care: 7 business days
- If a provider's schedule cannot accommodate the person requesting any appointment within these time intervals, an appointment will be offered with an alternative provider at the same location, or if none available, at another location. The member may choose to decline alternatives and accept a delayed appointment.

Individual Integrated Care and Supports Plan (IICSP):
The Person Centered Planning process assists in the design of the Individual Integrated Care and Supports Plan (IICSP). This is the driving document for all supports and services for persons in the dual eligible project. However, for behavioral health services, the Individual Plan of Service (IPOS) is also developed and implemented; it is the

document that the amount, scope and duration of behavioral health services to be provided to the member. The IPOS is incorporated into the Individual Integrated Care and Supports Plan (IICSP).

Emergency Care Resulting in Admissions:
DWMHA provides coverage to members if they require emergency or urgently needed services. Emergent and/or urgent care should be rendered as needed, with notification of any admission to the DWMHA UM Prior Authorization Department within forty-eight (48) hours of the admission. A DWMHA UM staff will review emergent and/or urgent admissions within one business day of receipt of clinical information.

Prior Authorized Services and Procedures:
All acute inpatient treatment, partial hospitalization, crisis residential services and withdraw maintenance (sub-acute detox), state hospitalization, psychological and neuropsychological testing and electroconvulsive therapy require authorization prior to service being rendered. Prior authorization is designed to promote the appropriate utilization of medically necessary services, to prevent unanticipated denials of coverage and to ensure that all services are provided at the appropriate level of care for the enrollee/member's needs in a timely manner. The purpose is to determine enrollee/member eligibility, benefit coverage and or establish the presence or absence of medical necessity so that a decision can be made regarding the request for services. Pre-certification is deemed necessary for all elective, non-emergent and urgent inpatient admissions and procedures rendered by a hospital/facility providing behavioral health services when consistent with current medical necessity requirements and current policies and procedures. Behavioral health care rendered by providers not participating in DWMHA network also require pre-approval for these services.

Authorizations are based on MCG criteria which is updated every year by the DWMHA CMO and is based upon the most current research, relevant quality standards and evidence-based models of care. DWMHA also has behavioral health clinical protocols. Providers are encouraged to review and use them, but they should not replace clinical judgment. A copy of the level of care criteria used in clinical decision making and/or the clinical protocols is available via email at pihpauthorizations@dwmha.com. Both documents are available in various formats to meet ADA requirements.

All authorizations shall be in compliance with the Medicaid Code of Federal Regulations 42 USC § 1396u-2(b) (8) provisions related to manage care and 42 C.F.R. § 438.210 provisions related to coverage and authorization of services. DWMHA also complies with CMS requirements and timeframes for historically Medicare primary paid services.

Pre service reviews are conducted telephonically. The source of information for the UM activity comes from the requesting facility or provider and/or enrollee/member. The request for authorization may come from the psychiatrist, physician, treatment team member, enrollee/member, family or advocate. If the caller is someone other than the enrollee/member, they should be familiar with the case as a result of a face-to-face meeting with the enrollee/member or as a result of an informed review of the clinical/medical record.

Providers are given an opportunity to discuss any behavioral health or pharmacy decision with a DWMHA physician during any review. The DWMHA Chief Medical Officer is also available twenty-four (24) hours a day, seven (7) days a week for consultation.

Both inpatient and outpatient ECT must be preauthorized. If a provider is requesting inpatient ECT treatment, the member is required to meet criteria for inpatient level of care in addition to meeting medical necessity for ECT. If the member no longer meets criteria for the inpatient level of care, then outpatient ECT can and shall be considered unless medically contraindicated. All ECT services are reviewed by a DWMHA physician.

Psychological testing and neuropsychological testing requires the submission of a standardized preauthorization

request form that is faxed or emailed to DWMHA for review by the Director of UM prior to service delivery. A determination is made within three (3) calendar days of receipt of the request

If medical necessity criteria is not met for inpatient admission or other high acuity service, the request for prior-authorization is denied. However, only a physician can render behavioral healthcare and pharmaceutical denial or a Doctoral-level clinical psychologist or certified addiction-medicine specialist can make a behavioral health denial or a pharmacist to render a pharmaceutical denial. A less restrictive alternative setting may be recommended, or, if no need for CMH services is identified, the applicant is referred to resources outside of the DWMHA network.

Utilization Management/Provider Appeals:
If a request for services is reduced, suspended or denied, the requesting provider is given verbal notification within three (3) hours of the decision. Written notification is mailed to the provider and the enrollee/member using the standardized Notice of Denial of Medical Coverage form within twenty-four (24) hours of the decision. The Notice describes the reasons for the reduction, suspension or denial of services and explains the due process procedures for both Medicaid and Medicare covered services.

Out of Network (Non-Contracted) Providers and Authorizations:
Occasionally, an enrollee/member may be referred to an out-of-network provider because of special needs and the qualifications of the provider. DWMHA will make such decisions on a case-by-case basis. Consultation with a DWMHA physician may be necessary as well. However, if a network provider refers an enrollee/member to an out of network provider, DWMHA will authorize the services as long as they are medically necessary and if the non- contracted provider has a current, unrestricted, license to practice.

When approving a service from a non-contracted provider, DWMHA assigns an authorization number which refers to and documents the approval. DWMHA sends documentation of the approval to the provider within the time frames appropriate to the type of request. By requesting authorization, the provider is affirming services are medically necessary and a covered benefit under the Medicare and/or Medicaid Program(s).

As a condition of the authorization for Medicare services, the out of network provider also agrees to accept no more than 100% of an amount equivalent to the Medicare Fee-For-Service Program allowable payment rates (adjusted for place of service or geography) set forth by CMS in effect on the date(s) of service, and any portion, if any, that DWMHA or the ICO would have been responsible for paying if the member was enrolled in the Medicare Fee-For-Service Program. Servicing out of network providers also shall recognize that members are not to be balanced billed for any uncollected monies for covered services.

Non Prior Authorized Services and Procedures:
DWMHA has implemented the UM Guidelines document to serve as the basis for payment approval for all services that do not require prior authorization. The UM Guidelines detail the specific services, frequency per year and HCPCS codes available based on the enrollee/member's Level of Care Utilization Systems (LOCUS) Score or Supports Intensity Scale (SIS) Level Score. As long as the provider requests supports and services that do not exceed the UM guidelines for an enrollee/member, no authorization is required for payment; the provider simply submits the claims to DWMHA. However, if the claims for supports and services exceed the UM Guidelines, the provider receives a message that the payment is pending a review by a DWMHA UM staff. The provider then submits the clinical reasoning for use of requested supports and services to the DWMHA UM staff for review and a determination is made within 3 calendar days of the submission.

DWMHA Monthly UM Reporting Requirements for the MI Health Link Program:
Access to Services:

- Total number of emergent/life threatening requests for an appointment and the date offered is within 3 hours

- Total number of emergent/non-life threatening requests for an appointment and the date offered is within 6 hours
- Total number of urgent requests for an appointment and date is offered is within 24 hours
- Total number of routine requests for an appointment and the date offered is within 7 business days

Hospitalization and Recidivism:

- Number of admissions per service type (acute in-patient, partial hospitalization, sub-acute detox, crisis stabilization, crisis residential)
- Average length of stay per service type
- Number of persons re-hospitalized within 30 days after discharge from hospital

Continuity of Care:

- Percent seen within 7 days post-acute inpatient hospitalization by a physician
- Percent seen within 7 days post-acute inpatient hospitalization by a health care professional other than a physician
- Average number of days from inpatient discharge to face to face with a physician
- Average number of days from inpatient discharge to face to face with a health care professional other than a physician

UM Decision Reviews:

- Total number of authorization requests by routine, urgent and emergent by contracted providers and by non-contracted providers
- Total number of denials for prior authorized service
- Total number of standard 1st level redetermination requests
- Total number of decisions upheld or resulting in a split decision by DWMHA for a standard 1st level redetermination appeal request and forwarded to MAXIMUS
- Total number overturned denial decisions by DWMHA for a standard 1st level redetermination appeal request
- Total number of expedited 1st level redetermination appeal requests
- Total number of decisions upheld or resulting in a split decision by DWMHA for an expedited 1st level redetermination appeal request and forwarded to MAXIMUS
- Total number overturned decisions by DWMHA for an expedited 1st level determination appeal request
- Total number of 2nd level reconsideration appeal requests
- Total number of decisions upheld, total number overturned and total number resulting in a split decision for a 2nd level reconsideration appeal request by MAXIMUS
- Total number of decisions overturned by MAXIMUS due to case set up by DWMHA
- Total number of 3rd level ALJ hearing appeal requests
- Total number of decisions upheld, total number overturned and total number resulting in a split decision by the 3rd level ALJ hearing request
- Total number of 4th level Medicare Council appeal requests
- Total number of decisions upheld, total number overturned and total number resulting in a split decision by the 4th level Medicare Council Review
- Total number of 5th level Judicial appeal requests
- Total number of decisions upheld, total number overturned and total number resulting in a split decision by the 5th level Judicial court
- Total number of retrospective review requests
- Total number of retrospective review requests denied by DWMHA
- Total number of retrospective 1st level appeal requests
- Total number of decisions upheld or resulting in a split decision by DWMHA for a retrospective 1st level appeal and forwarded to MAXIMUS
- Total number overturned decisions by DWMHA for a retrospective 1st level appeal

- Total number of administrative provider appeal requests
- Total number of decisions upheld or resulting in a split decision by DWMHA and forwarded to MAXIMUS for an administrative provider appeal
- Total number of decisions overturned by DWMHA for an administrative provider appeal

UM Timeliness:

- Total number of expedited decisions made by DWMHA within 72 hours of receipt of the request for an expedited 1st level redetermination request
- Average turnaround time of expedited decisions made by DWMHA for an expedited 1st level determination request
- Total number of standard decisions made by DWMHA within 60 calendar days after receipt of the request for a standard 1st level redetermination request (standard medical necessity, retrospective and/or administrative)
- Average turnaround time of a standard decision made by DWMHA for a standard 1st level redetermination request
- Total number of notification letters sent for expedited, standard and post service decisions
- Total number of claims effectuated by DWMHA 30 calendar days from the date of the letter from the MAXIMUS documenting the denial decision was overturned (the 30 calendar days includes DWMHA forwarding the check number, check date, amount paid and EOB to MAXIMUS) for a 2nd level reconsideration (medical necessity, retrospective and/or administrative) appeal

Clinical, utilization management and denial and appeal data is secured using the DWMHA electronic system MHWIN as well as using Care Connect 360 and Care Management Technologies through the Population Health Management Application. Outcomes from the data is available to the Integrated Care Organizations (ICO) with customized dashboard. However, the UM Department will generate monthly reports with the above data to the ICO. For each denial, DWMHA will include a UM denial summary with the member name, the requesting provider name, request date, type of request (i.e. routine, urgent, emergency), decision date, denial reason and date member/provider was notified of the decision. DWMHA will also monitor over and under-utilization of services quarterly and will provide documentation of such monitoring and the findings to the Integrated Care Organizations on a quarterly basis.

Quality Assurance/Improvement:

Review of consistency of Behavioral Health and Substance Use UM decision making Inter-rater reliability testing is administered annually for UM reviewers and psychiatrists involved in UM reviews. DWMHA utilizes the MCG web-based Inter-Rater Reliability module, which tests the proper use of MCG guidelines with clinician-developed case studies. It evaluates an individual's ability to find and apply the appropriate guideline based on a specific scenario. DWMHA has a benchmark standard of scoring 90% or greater. Any UM reviewer or physician reviewer with an inter-rater reliability score less than 90% will be placed on a corrective action plan (CAP) with the expectation that the person pass a re-test administered within thirty (30) days. CAPS can involve such activities as face-to-face supervision and coaching and/or education and re-training. During the time period of the CAP, random samples of the staff member's current cases will be audited. If upon re-testing, the staff person does not achieve 90% or greater, he/she will be subject to a transfer to a role outside the UM Department or termination. Note that annual education and training on the criteria is provided for all staff performing UM activities that involve application of the medical necessity criteria. MCG also has web-based on-demand training modules that are available 24/7. The results of the inter rater reliability case reviews will be used to identify areas of variation among decision makers and/or types of decisions. The results will also help to identify

opportunities for improvement as well as further training needs. MCG also provides reports outlining all of the training modules completed by each UM reviewer including physicians to ensure that all required training modules are completed.

ATTACHMENT #2

Waiver and State Plan Amendments (SPA):

State Plan Amendments and Waivers enable states expand their Medicaid programs and/or offer services that better meet the needs of Medicaid enrollees. In Michigan, DWMHA as a PIHP, manages the following:

1. State Plan Amendment for Autism Spectrum Disorder (ASD)
2. Children with Serious Emotional Disturbance Waiver (SED)
3. Children's Waiver Program (CWP)
4. Habilitation and Supports Waiver (HAB)

Each program has specific eligibility criteria, authorization process including certification and rectification and selected service array. As part of Medicaid funding, DWMHA is responsible to monitor each program's access and service delivery to ensure individuals receive the high quality service, in the appropriate amount, in the most appropriate time frames, taking into consideration medical necessity, prevailing standard of care and the preferences and values of the person to achieve the best outcomes.

Autism Spectrum Disorder (ASD) Program and Benefit:

The Medicaid Autism Benefit is a benefit under the Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) for individuals which provides access to evidence-based Applied Behavior Analysis (ABA) Services to individuals covered by Medicaid ages birth to twenty-one with an Autism Spectrum Disorder (ASD) Diagnosis. The Medicaid Autism Benefit covers Comprehensive Diagnosis Evaluations, Psychological Testing, Adaptive Testing, Behavior Assessments, Behavior Plans of Care, ABA Direct Services, Technician Direction and Observation (Supervision), and Parent/Guardian Training. Individuals receiving the Medicaid Autism Benefit also have access to any other medically necessary services covered by DWMHA.

To access the Medicaid Autism Benefit, parents/guardians or individuals contact the Access Center for screening by an Access Center Clinician using the Modified Checklist for Autism in Toddler–Revised (M-CHAT-R) or Social Communication Questionnaire (SCQ). The family is offered choice and then referred to an ASD Benefit Provider for further evaluation. The Provider in receipt of the referral receives an authorization for the evaluation, cognitive, and adaptive testing from the Access Center Clinician. To determine the diagnosis of ASD and the level of Applied Behavioral Analysis (ABA) services need by the individual, the Service Provider completes the Autism Diagnostic Observation Schedule-Second Edition (ADOS-2) and the Autism Diagnosis Interview – Revised (ADIR)/Developmental Interview. For cases where it may be challenging to identify ASD Diagnosis based solely the ADOS-2 and ADIR and there is medical necessity for further evaluation, Providers are able to conduct cognitive and adaptive testing.

Families also are connected to a general Developmental Disability Intake Interview, which begins the Person-Centered Planning process to begin the pre-plan and Individualized Plan of Service (IPOS). This plan includes the ASD services along with all other medically necessary services for the individual.

After receiving a referral, completing the diagnostic testing and recommending the level of ABA services, the Service Provider forwards an application to DWMHA. The UM Reviewer then conducts a clinical review of the requested service plan and records the enrollment details including the service plan into the Waiver Supports Application (WSA) which is MDHHS's management tool for ASD services. An MDHHS Administrator then reviews the information, approves or denies the ASD benefit, uploads the decision in WSA and then forwards the decision to DWMHA. The DWMHA UM Reviewer, in turn, notifies the Service Provider. The UM Reviewer also enters re-enrollments, continued stay service plans and discharges into the WSA for MDHHS review and approval or denial.

Per the Michigan Medicaid Manual, the medical necessity and recommendations for ASD services is determined by a physician or other licensed practitioner working within their scope of practice under the state of Michigan. The child must demonstrate substantial functional impairment in social communication, patterns of behavioral and social interaction as evidenced by meeting criteria A or B (listed below); and required ASD services to address the following areas:

A. The child currently demonstrates substantial functional impairment in social communication and social interaction across multiple contexts, and is manifested by all of the following:
    1. Child is under 21 years of age.
    2. Child received a diagnosis of ASD from a qualified practitioner using valid evaluation tools.
    3. The child is able to benefit from the treatment.
    4. Treatment outcomes are expected to result in a generalization of adaptive behaviors across different settings to maintain the treatment interventions and that they can be demonstrated beyond the treatment sessions. Measurable variables may include increased social communication, increased interactive play/age-appropriate leisure skills, increased reciprocal communication, etc.
    5. Coordination with the social and/or early intervention program is critical. Collaboration between school and community providers is needed to coordinate treatment and prevent service duplication. Collaboration may take the form of phone calls, written communication logs, participation in team meetings.

B. The child currently demonstrates substantial restricted, repetitive and stereotyped patterns of behavioral, interests and activities as manifested by at least two of the following:
    1. Stereotyped or repetitive motor movements, use of objects or speech (e.g. simple motor stereotypes, lining up toys or flipping objects, echolalia, and /or idiosyncratic phrases).
    2. Insistence on sameness, inflexible adherence to routines or ritualized patterns of verbal or nonverbal behavior (e.g. extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals and/or need to take same route or eat the same food daily).
    3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g. strong attachment to or preoccupation with unusual objects and/or excessively circumscribed or perseverative interest).
    4. Hyper or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment (e.g. apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects and/or visual fascination with lights or movement).

DWMHA UM staff also tracks monthly the following data to ensure the ASD program operates within maximum capacity:

- Number of new referrals;
- Total number of children enrolled in the program;
- Total number of children actively receiving services;
- Number of children discharged from the program and the reason(s) for discharge;
- Number of service authorizations approved;

- Number of services authorizations denied;
- Number of services authorizations pending;
- Number of adjudicated (processed) claims
- Percentage of 0-5 years open cases;
- Percentage of 6-20 years open cases

Serious Emotional Disturbance (SED) Waiver:

The Children's SED waiver provides services that are enhancements or additions to Medicaid State Plan coverage for children through age 20 who have an SED. MDHHS operates the SED waiver through contracts with the Community Mental Health Service Programs (CMHSP's). The SED Waiver is a fee-for-service program administered by the CMHSP in partnership with other community agencies.

SED waiver services are intended for children with a Serious Emotional Disturbance (SED) who are at risk of hospitalization, had multiple placements or are youth/families who are in need of additional supports/services in order to maintain the young person in the home.

Eligibility:

The child must:

- Be under the age of 18 when initially approved for the waiver, but can remain in the waiver until age 21;
- Reside with birth/adoptive parents as a Temporary Court Ward (TCW), reside in foster care as a TCW/Permanent Court Ward (MCI), or have completed the adoption process through the Child Welfare system;
- Meet current MDHHS criteria for the state psychiatric hospital for children;
- Meet Medicaid eligibility criteria and become a Medicaid beneficiary;
- Be age 18 or 19 and live independently with supports.

The child must have at least one of the following:

- Severe psychiatric signs and symptoms;
- Disruptions of self-care and independent function;
- Harm of self or others;
- Drug/medication complications or co-existing general mental condition requiring care
- Special consideration: If substance abuse, psychiatric condition must be primary;
- Youth who have an Intellectual Developmental Disability (IDD) are not eligible for the SED waiver; or
- The child must demonstrate serious functional limitations that impair his/her ability to function in the community (functional criteria is identified using the Child and Adolescent Functional Assessment Scale [CAFAS] or Preschool and Early Childhood Functional Assessment Scale [PECFAS]):
  - CAFAS score of 90 or greater for children age 7 to 12; *or*
  - CAFAS score of 120 or greater for children age 13 to 18; *or*
  - For children age 3 to 7, elevated PECFAS subscale scores in at least one of these areas: self-harmful behaviors, emotions, thinking, communicating or behavior toward others; *and*
  - Youth can remain in the waiver even if their CAFAS or PECFAS score drops the 1-year commitment.

Covered SED Waiver Services:

Each child must have a comprehensive IPOS that specifies the services and supports the child and his/her family will receive. The IPOS is developed through the Wraparound planning process. Each child must have a

Wraparound Facilitator who is responsible to assist the child/family in identifying, planning and organizing the Child and Family Team, developing the IPOS, and coordinating service delivery, as well as the child's health and safety, as part of their regular contact with the child and family, with oversight from the Community Team.

Wraparound Services:
Wraparound services is a highly individualized planning process facilitated by specialized supports coordinators. Wraparound utilizes a Child and Family Team, with team members determined by the family often representing multiple agencies and informal supports. The Child and Family Team creates a highly individualized Wraparound plan with the child/youth and family that consists of mental health specialty treatment, services and supports covered by the Medicaid mental health state plan, waiver, B3 services, and other community services and supports.

Community Living Supports:
Community Living Supports are used to increase or maintain personal self-sufficiency, thus facilitating achievement of his/her goals of community inclusion and remaining in the home. Supports may be provided in the beneficiary's home or community settings (including, but not limited to, libraries, city pools, camps, etc.)

Respite:
Respite care is services provided to beneficiaries unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

Family Supports and Training:
This service is provided by a peer-parent who has completed specialized training. It is a family-focused service provided to families (birth or adoptive parents, siblings, relatives, foster family, and other unpaid caregivers) of children with SED for the purpose of assisting the family in relating to and caring for a child with SED. The services target the family members who are caring for and/or living with a child receiving waiver services. The service is to be used in cases where the child is hindered or at risk of being hindered in their ability to achieve goals of: performing activities of daily living; improving functioning across life domain areas; perceiving, controlling or communicating with the environment in which they live; or improving their inclusion and participation in the community or productive activity, or opportunities for independent living.

Therapeutic Activities:
A therapeutic activity is an alternative service used in lieu of, or in combination with, traditional professional services. The focus of therapeutic activities is to interact with the child to accomplish the goals identified in the IPOS. The IPOS ensures the child's health, safety and skill development and maintains the child in the community. Services must be directly related to an identified goal in the IPOS. Providers are identified through the wraparound planning process and participate in developing an IPOS based on strengths, needs, and preferences of the child and family. Therapeutic activities may include: child and family training, coaching and supervision, monitoring of progress related to goals and objectives, and recommending changes to the IPOS. Services provided under Therapeutic Activities include music therapy, recreation therapy, and art therapy.

Child Therapeutic Foster Care:
Child Therapeutic Foster Care (CTFC) is an evidence-based practice. It provides an intensive therapeutic living environment for a child with challenging behaviors. Important components of CTFC include:

- Intensive parental supervision
- Positive adult-youth relationships
- Reduced contact with children with challenging behaviors
- Family behavior treatment skills

Therapeutic Overnight Camp:
A group recreational and skill building service in a camp setting aimed at meeting the goal(s) detailed in the beneficiary's IPOS. A session can be one or more days and nights of camp. Room and Board costs are excluded from the SEDW payment for this service.

Transitional Services:

Transitional services are a one-time only expense to assist beneficiaries returning to their family home and community while the family is in the process of securing other benefits (e.g., SSI) or resources (e.g. governmental rental assistance and/or home ownership programs) that may be available to assume these obligations and provide needed assistance.

Home Care Training, Non-Family:
This service provides coaching, training, supervision and monitoring of Community Living Supports (CLS) staff by clinicians. Professional staff work with CLS staff to implement the consumer's POS, with focus on services designed to improve the child's/youth's social interactions and self-control by instilling positive behaviors instead of behaviors that are socially disruptive, injurious to the consumer or others, or that cause property damage.

EDW Service Providers:

Black Family Development Inc.
2995 E. Grand Blvd.
Detroit, MI 48202
313-758-0150

Development Centers
17321 Telegraph
Detroit, MI 48219
313-531-2500

The Guidance Center
13099 Allen Road
Southgate, MI 48195
734-785-7718

Southwest Counseling Solutions
5617 Michigan Avenue
Detroit, MI 48210
313-963-2266

The Children's Center
79 Alexandrine Street
Detroit, MI 48201
313-831-5535

The Children's Home and Community Based Services Waiver Program (CWP) and Benefit:
The Children's Waiver Program (CWP) is a federal entitlement program that provides Medicaid funded home and community-based services to children (under age 18) who have developmental disabilities. The CWP waiver provides services to children with complex medical and behavioral needs who meet eligibility for the level of services similar to an Intermediate Care Facility/Individual with Intellectual Disability (ICF/IID). The CWP enables children to remain in their parent's home or return to their parent's home from out-of-home placements regardless of their parent's income.

The child must meet all of the following:

- Be below age eighteen (18);
- Meets financial eligibility for Medicaid as a "family of one";
- Reside with parent(s) or guardian (relative);
- Receive at least one waiver service per month;
- Be at risk of out of home placement; and
- Have a Developmental Disability as defined in the mental health code ***AND*** meet the criteria for an ICF/IID which implies the need for an active treatment program of specialized and generic training, treatment, health and related services directed toward the acquisition of behaviors necessary to function with as much self-determination and independence as possible.

CWP provides services that are enhancements or additions to regular Medicaid coverage to children up to age eighteen (18) enrolled in the program. It allows Medicaid to fund necessary home and community based services for children with developmental disabilities who reside with their birth or legally adoptive parent(s) or with a relative named legal guardian under State law, regardless of their parent's income. The CWP is a fee-for-service program administered by the CMHSP (DWMHA). DWMHA is held financially responsible for any costs incurred on behalf of the CWP beneficiary that were authorized and exceed the Medicaid fee screens or amount, duration and scope parameters.

The program has a capacity to serve 464 children statewide. Although the program is at capacity, a weighing list is maintained using a priority rating system to add new children to the program when openings occur.

DWMHA's UM Department is responsible to:

- Monitor the CWP providers' activities of the CWP in the identification of potential waiver candidates, the completion of the pre-screening process in the WSA, the submission to the pre-screening information to MDHHS;
- Authorize the WSA roles (pre-screener, Support Coordinator and Supervisor) for each CWP provider and assuring they are current Coordination of the Child's Waiver Program;
- Provide technical assistance (TA) and disseminate CWP information to DWMHA staff, CWP service providers, families, and stakeholders;
- Manage the waiver enrollments, (by keeping track of pre-screenings, invitations to apply for the CWP, enrollments in the CWP, organize and chair the quarterly meetings;
- Conduct the LOC evaluation activities ((site visits, validation of Performance Measures (PM) reported quarterly through the self-monitoring tool);
- Assure the participants have been given freedom of choice of providers;
- Assure the participants have consented to CWP services in lieu of the ICF/IDD;
- Assure the family have been offered and explained the Choice Voucher option;
- Assure services are provided according to the Individual Plan of Service (IPOS) and within the Category of Care/Intensity of Care determination;
- Monitor the data in the WSA;
- Enter the PDN authorization for Private Duty Nursing Services into CHAMPS system.

A CWP Support Coordinator's activities include:

- Assisting the child and his family, friends, and other professional members work cooperatively to identify the child's needs and to secure the necessary services;
- Assuring all services and supports must be included in the child's IPOS;
- Assuring the IPOS is reviewed, approved and signed by the physician;
- Assuring each CWP beneficiary receives at least one children's waiver service per month in order to retain eligibility;
- Demonstrating the CWP participants meet the continued eligibility requirement;
- Submitting request to the MDHHS Clinical Review Team (CRT) for prior authorizations when required for Services, equipment and Environmental Accessibility Adaptations (EAAs). (The CWP Clinical Review Team at MDHHS is comprised of a physician, registered nurse, psychologist, and licensed master's social worker with consultation by a building specialist and an occupational therapist.)

The services covered under the CWP are:
Community Living Supports (CLS)

- Enhanced Transportation
- Respite Care
- Family Training
- Fencing
- Non-family Training
- Specialty Services
- Home Care Training, Non-Family
- Specialized Medical Equipment & Supplies
- Environmental Accessibility Adaptations
- Fiscal Intermediary

The children enrolled in the CWP also can receive other services provided under the State Plan such as PDN, ABA, etc.

Habilitation and Supports Waiver (HSW) Program and Benefit:

The HSW is a Federal Program directed to provide services and supports for beneficiaries with Developmental Disabilities (Medicaid 1915 (c) HCBS Waiver) who meet the Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID) Level of Care (LOC). The services and supports are provided under the auspices of

the PIHP (DWMHA) under contract with Michigan Department of Health and Human Services (MDHHS) and must be specified in the beneficiary plan of services developed through the Person Centered Planning (PCP) process.

DWMHA delegates the provision of services to the providers.
Participants enrolled may not be enrolled simultaneously in another of Michigan's 1915(c) waivers.
The beneficiary must also meet all of the following requirements:

- Has a developmental disability (as defined by Michigan law) no age restrictions;
- Is Medicaid eligible and enrolled;
- Resides in a community setting or will reside in a community setting;
- Would otherwise require level of services similar to an Intermediate Care Facility/Individual w/Intellectual Disability (ICF/IID);
- Chooses to participate in the HSW instead of ICF/IID services.

The services (and their codes) offered through HSW are:

- Community living supports (H2015, H2016, H0043, T2036, T2037)
- Enhanced medical equipment (T1999, T2028, T2029, S5199, E1399, T2039)
- Enhanced pharmacy (T1999)
- Environmental modifications (S5165)
- Family training (S5111)
- Goods and Services (T5999) (Only for those participating in self-determination)
- Out of home non-vocational habilitation (H2014)
- Personal Emergency Response System (PERS) (S5160, S5161)
- Prevocational services (T2015)
- Private Duty Nursing (PDN) (S9123, S9124) for those 21 y old or older
- Supported employment (H2023)
- Respite Care (T1005, H0045)
- Support Coordination (T1016)

Service selection guidelines for the beneficiaries should be used for the determination of the amount, duration, and scope of services and supports to be used.

It is important to note that in order to retain eligibility, a HSW beneficiary must receive at least, one HSW service per month; DWMHA receives monthly reports from each provider to demonstrate this continued eligibility requirement.

The role of DWMHA's UM Department is to perform the following tasks:

- Oversight, monitoring of the activities of HSW providers.
- Provision of technical assistance (TA);
- Organize and Chair the quarterly meetings;
- Perform monthly chart reviews and periodic provider site visits;
- Disseminate HSW information;
- Manage the waiver enrollments within the PIHP allocation;
- Review of HSW applications;
- Review the LOC evaluation for the authorization of HSW re-certifications;
- Assure the participants have been given freedom of choice of providers,
- Assure the participants have consented to HSW services in lieu if the ICF/IID,
- Monitor utilization management of waiver services by monthly tracking the total number of beneficiaries enrolled in the HSW program, the total number of available HSW slots, the number of HSW applications submitted to DWMHA, the number of applications reviewed, the number of applications pended for more information, the number of pended applications re-submitted, the number of applications withdrawn, the total number of application sent to MDHHS, the number of deaths, the number of annual recertification forms reviewed and signed, the number of dis-enrollments (not meeting HSW criteria).

ATTACHMENT #3

DWMHA PRIOR AUTHORIZED SERVICE UM CHART REVIEW TOOL			
Initial Review (PAR Screening)			
Enrollee/Member Name:	Name of Organization:		
MHWIN ID No.:	Medicaid Number:		
Level of Care:	Admit Date:		
Complete name and credentials of COPE UM Staff who completed the initial review (PAR Screening):			
	Documentation		
	Found	Found but Not Accurate/Complete	Not Found
1. Date and time of initial call to request the review			
2. Date and time of initiation of review (PAR)			
3. Complete name, credentials of caller completing the review (PAR)			
4. Complete name of facility/location for the caller completing the review (PAR)			
5. Phone number of caller completing the review (PAR)			
6. Level of Care being requested			
7. Living Arrangement prior to admission			
8. Education and/or Work status			
9. Guardianship			
10. Legal Problems			
11. Vital Signs			
12. Presenting Symptoms/Current Stressors			
13. Risk Assessment *(Suicide/Homicide/Other Dangerous or Self Aggressive Behavior)*			
14. Identified Support Systems			
15. Past Treatment History			
16. Compliance with past outpatient treatment			
17. Mental Status			
18. Substance Use Assessment			
19. UDS Screening Information			
20. ETOH Screening Information			
21. Physical/Medical Health History			
22. Primary Care Physician information			
23. Current Medications *(medication name, dose, frequency, complete name of prescriber)*			
24. Compliance with Medications			

25. Presence of a Crisis Plan and/or Behavioral Plan N/A ☐			
26. Diagnosis			
27. Treatment Plan/Identified Goals			
28. Discharge Plan			
29. Estimated Length of Stay (ELOS)			
30. SI/IS criteria identified and documented *(medical necessity criteria met for level of service) using MCG Criteria*			

31. Complete Clinical Summary *(in clinical note section of criteria authorization screen)*			
32. Consult with an Organization Supervisor and/or Physician N/A ☐			
33. Number of Days/Units Authorized N/A ☐			
34. Diversion Information N/A ☐			
35. Date and Time of PAR Disposition			
36. Complete name and credentials of Organization Staff UM Reviewer and Date (can be electronic Signature)			
37. Complete Name of hospital/facility to which admission/authorization was given *(in PAR Disposition)*			
38. Complete name and credentials of the admitting physician (*in PAR Disposition)*			

DWMHA PRIOR AUTHORIZED SERVICE UM CHART REVIEW TOOL			
First Continued Stay Review			
Enrollee/Member Name:	Name of Organization:		
MHWIN ID No.:	Medicaid Number:		
Level of Care:	Name of UM Staff Reviewer:		
Admit Date:	Discharge Date:		
	Documentation		
	Found	Found but Not Accurate/Complete	Not Found
1. Date and time of concurrent review was initiated			
2. Name and credentials of caller completing the review			
3. Telephone number of caller completing the review			
4. Current status of symptoms			
5. Treatment progress to date			
6. Baseline functioning			
7. Any changes to previous treatment plan/goals			
8. Goal statement			
9. Current medications, doses and frequency			
10. Any side effects from medications N/A ☐			
11. Any consultations and/or assessment results			
12. Presenting symptoms/current stressors			
13. Status of communication/Interactions with family, guardian, legal representative, CMH service provider or other identified support systems			
14. Presence of a Crisis Plan and/or Behavioral Plan N/A ☐			
15. SI/IS criteria identified and documented *(medical necessity criteria met for level of service) using MCG Criteria*			
16. After Care/Discharge Plan *(indicate level of care, provider name and date and time of initial appointment with provider)*			
17. Placement Issues/Status of *Placement (if no placement issues, indicate where and with whom member will live after discharge)*			
18. Estimated Length of Stay (ELOS)			

19. Consult with Organization Supervisor and/or Physician N/A ☐			
20. Number of days/units authorized			
21. Date and time of disposition			
22. Complete name and credentials of Organization Staff UM Reviewer and Date (can be electronic Signature)			

DWMHA PRIOR AUTHORIZED SERVICE UM CHART REVIEW TOOL				
Second Continued Stay Review				
Enrollee/Member Name:	Name of Organization:			
MHWIN ID No.:	Medicaid Number:			
Level of Care:	Name of UM Staff Reviewer:			
Admit Date:	Discharge Date:			
	Documentation			
	Found	Found but Not Accurate/Complete	Not Found	
1. Date and time of concurrent review was initiated				
2. Name and credentials of caller completing the review				
3. Telephone number of caller completing the review				
4. Current status of symptoms				
5. Treatment progress to date				
6. Baseline functioning				
7. Any changes to previous treatment plan/goals				
8. Goal statement				
9. Current medications, doses and frequency				
10. Any side effects from medications N/A ☐				
11. Any consultations and/or assessment results				
12. Presenting symptoms/current stressors				
13. Status of communication/Interactions with family, guardian, legal representative, CMH service provider or other identified support systems				
14. Presence of a Crisis Plan and/or Behavioral Plan N/A ☐				
15. SI/IS criteria identified and documented *(medical necessity criteria met for level of service) using MCG Criteria*				
16. After Care/Discharge Plan *(indicate level of care, provider name and date and time of initial appointment with provider)*				
17. Placement Issues/Status of *Placement (if no placement issues, indicate where and with whom member will live after discharge)*				
18. Estimated Length of Stay (ELOS)				

19. Consult with Organization Supervisor and/or Physician N/A ☐			
20. Number of days/units authorized			
21. Date and time of disposition			
22. Complete name and credentials of Organization Staff UM Reviewer and Date (can be electronic Signature)			

DWMHA PRIOR AUTHORIZED SERVICE UM CHART REVIEW TOOL

Third Continued Stay Review

Enrollee/Member Name:	Name of Organization:
MHWIN ID No.:	Medicaid Number:
Level of Care:	Name of UM Staff Reviewer:
Admit Date:	Discharge Date:

	Documentation		
	Found	Found but Not Accurate/Complete	Not Found
1. Date and time of concurrent review was initiated			
2. Name and credentials of caller completing the review			
3. Telephone number of caller completing the review			
4. Current status of symptoms			
5. Treatment progress to date			
6. Baseline functioning			
7. Any changes to previous treatment plan/goals			
8. Goal statement			
9. Current medications, doses and frequency			
10. Any side effects from medications N/A ☐			
11. Any consultations and/or assessment results			
12. Presenting symptoms/current stressors			
13. Status of communication/Interactions with family, guardian, legal representative, CMH service provider or other identified support systems			
14. Presence of a Crisis Plan and/or Behavioral Plan N/A ☐			
15. SI/IS criteria identified and documented *(medical necessity criteria met for level of service) using MCG criteria*			
16. After Care/Discharge Plan *(indicate level of care, provider name and date and time of initial appointment with provider)*			
17. Placement Issues/Status of *Placement (if no placement issues, indicate where and with whom member will live after discharge)*			
18. Estimated Length of Stay (ELOS)			
19. Consult with Organization Supervisor and/or Physician N/A ☐			
20. Number of days/units authorized			
21. Date and time of disposition			
22. Complete name and credentials of Organization Staff UM Reviewer and Date (can be electronic Signature)			

Signature, title and credential of Staff Auditor
(person who completed the case audit)

Date of the case audit

For any areas where the documentation was not found or was not complete or not accurate please indicate the nature of the deficiency and any corrective action given to the Organization Staff:

_____

_____

_____

INSTRUCTIONS FOR COMPLETION OF PRIOR AUTHORIZED SERVICE UM CHART REVIEW TOOL

The purpose of these reviews are to ensure correct documentation, appropriate level of care decisions and to meet External Quality Review requirements relative to Utilization Management.

- On a quarterly basis, DWMHA and the Crisis Service Vendors shall review the following:
  - All (100%) denial and appeal cases based on all staff making Utilization Management decisions.
  - The Crisis Service Vendors -ten (10) approved cases (PAR Screenings) for all staff making Utilization Management decisions.
  - DWMHA- twenty-five (25) cases for all staff making Utilization Management decisions.

- Reviews should be completed on all levels of care requiring prior authorization, including Acute Inpatient, Partial Hospitalization, State Hospitalization, Crisis Stabilization, Intensive Crisis Residential and/or Child Caring Institutions.

- The Crisis Service Vendors must forward all the completed Prior Authorized Service UM Chart Review sheets to DWMHA's UM Department via fax or email each quarter.

- An Analysis of all Prior Authorized Service UM Chart Reviews for the fiscal year shall be included in the Crisis Service Vendors' Annual UM Evaluation.

ATTACHMENT #4

DWMHA ELIBILITY OF SERVICE REVIEW TOOL			
Enrollee/Member Name:			
Date of Birth:			
Medicaid ID No.:			
Date of Screening for Eligibility			
Name of Access Center Clinician			
	Documentation Found	Documentation Not Found	Not Applicable
1. Insurance Information			
2. Wayne County Residency			
3. Start time of screening			
4. Name, address and phone number of caller			
5. Documentation of call being an Emergency or Crisis			
6. Reason for call/presenting problem identified			
7. Type of Services Request			
8. Contact Information			
9. Guardianship			
10. Past Treatment History			
11. History of Abuse (Sexual/Physical/Emotional)			
12. Current living situation			
13. Financial Information including Income			
14. Education Information			
15. Current Health/Medical Problems			
16. Referral to ER for Treatment/Clearance			
17. Time ER Contacted and Consumer Referred			
18. Medications (name, dose, prescribing 19. physician)			
20. Primary care physician information			
21. Mental Health Symptoms Identified			
22. Substance Use Issues			
23. Risk (Suicidal/Homicidal) assessment			
24. Autism Screening Tool Completed			
25. IDD Screening Tool Completed			
26. Provisional Disability Designation			
27. Diagnoses			
28. Medical and/or Advance Directives			
29. Diagnoses			
30. Medical and/or Psychiatric Advance Directives			
31. Eligibility Criteria Met			
32. Eligibility Criteria Not Met			
33. If Eligibility Criteria not met, member was given community resource referrals.			
34. If Eligibility Criteria Not Met, Access Center Physician reviewed case and provided documentation.			
35. Adequate or Advance Notice Sent to the member (using DWMHA standard form)			

36. Notice of Denial of Medical Coverage form sent to the member for MI Health Link (using DWMHA standard form)			
37. Notice of Denial form sent to uninsured member (using DWMHA standard form)			

Signature, title and credential of Staff Auditor
(person who completed the case audit)

Date of the case audit

For any areas where the documentation was not found or was not complete or not accurate please indicate the nature of the deficiency and any corrective action given to the Access Center Staff:

INSTRUCTIONS FOR COMPLETION OF THE ELIGBILITY OF SERVICE REVIEW TOOL

The purpose of these reviews are to ensure correct documentation, appropriate level of Care decisions and to meet External Quality Review requirements relative to Utilization Management.

- On a quarterly basis, the Access Center shall review the following:
  - Ten (10) denial cases based on all staff making Utilization Management decisions.
  - Ten (10) approved cases for all staff making Utilization Management decisions.

- Reviews should be completed on all levels of care requiring prior authorization, including Acute Inpatient, Partial Hospitalization, State Hospitalization, Crisis Stabilization, Intensive Crisis Residential and/or Child Caring Institutions.

- The Access Center must forward all the completed Eligibility of Service Review sheets to DWMHA's UM Department via fax or email each quarter.

- An Analysis of all Eligibility of Service UM Reviews for the fiscal year shall be included in the Access Center's Annual UM Evaluation.

ATTACHMENT #5

DWMHA Quality Department's Case Record Review Tool

The Record Review tool is constructed to examine key supports, services, treatment and care. These areas should match the level of care established, should reflect natural and community supports and should clearly indicate progress or barriers to achieving the consumer's goals. Using the tool provides a standardized mechanism for specialists to determine if the consumer is getting the right service, the right amount of service, at the right time. Quality Management has implemented the tool which reviews the following areas as applicable to each consumer:

- General Record Documentation
- Assessment
- Substance Abuse Access and Treatment
- Person Center Planning Process
- Plan of Service Documentation Requirements
- Self-Determination
- Behavior Treatment Plan Review
- Coordination of Care
  - Medication/Psychiatric
  - Crisis residential
- Peer Delivered and Operated Drop In Centers
- Home Based
- Assertive Community Treatment
- Psychosocial Rehabilitation/Clubhouse
- Crisis Residential
- Targeted Case Management
- Personal Care in Residential Settings
- Inpatient Psychiatric Hospital Admission
- Intensive Crisis Stabilization
- Additional Mental Health Services
- HAB Supports Waiver

An aggregate review score is calculated for reach case record review. Service Providers are expected to conduct a statistically sound sample of case records quarterly to monitor the direct provision of services using the tool. This process shall be monitored by DWMH who, in turn, review a statistically sound sample of Service Providers' case records. A plan of correction shall be implemented for all staff scoring below 95%. DWMHA then analyzes the findings for trends and outliers which may also result in a plan of correction.

General Documentation

1. The Ability to Pay/Fee Agreement (including insurance information) is current, signed and dated.

Not Met/Partial/Met N/A

2. The annual consent for treatment is current, signed and dated.

Not Met/Partial/Met N/A

3. The State standardized "Consent to Share Behavioral Health Information for Care Coordination Purposes" form is complete with the individual/legal representative's dated signature(s).

Not Met/Partial/Met N/A

4. The individual's/legal representative's signature indicates that the DWMHA Member Handbook was offered annually.

Not Met/Partial/Met N/A

5. If the individual has a legal guardian, there is current court papers in the file.

Not Met/Partial/Met N/A

6. Advanced Directive were explained and offered to the individual and/or legal representative. (Adults only)

Not Met/Partial/Met N/A

7. Self Determination was explained and offered to the individual and/or legal representative. (Adults only)

Not Met/Partial/Met N/A

8. Peer support services was explained and offered to the individual and/or legal representative.

Not Met/Partial/Met N/A

9. The individual and family and/or legal representative were informed of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) process for recipients under 21.

Not Met/Partial/Met N/A

10. There is evidence that recipient's rights have been explained at the time of the initial intake and annually thereafter.

Not Met/Partial/Met N/A

11. The individual and/or family/legal representative is informed of Person Centered Planning at the time of the initial intake and annually thereafter.

Not Met/Partial/Met N/A

12. The individual and/or family /legal representative is informed of Confidentiality at the time of the initial intake and annually thereafter.

Not Met/Partial/Met N/A

Assessments

1. The Integrated Biopsychosocial Assessment/Re-assessment is completed or updated prior to the IPOS or when there are changes in the level of care and is located in MH-WIN.

Not Met/Partial/Met N/A

2. There is evidence that the appropriate Level of Care assessment is completed. Adults-Level of Care Utilization System (LOCUS), Supports Intensity Scale (SIS), or American Society of Addiction Medicine (ASAM), Children/Adolescents (excluding I/DD)-Child, Adolescent Functional Assessment Scale (CAFAS), Preschool and Early childhood Functional Assessment Scale (PECFAS), or Devereux Early Childhood Assessment (DECA-I, DECA-T, DECA-C).

Not Met/Partial/Met N/A

3. Adults with a serious mental illness (SMI) and/or substance use disorder (SUD) had a Patient Health Questionnaire (PHQ-9) completed at intake.

Not Met/Partial/Met N/A

4. Adults with a positive PHQ-9 screen, defined as a score of 10 or greater, have a follow up screen within three (3) months.

Not Met/Partial/Met N/A

5. Natural supports are assessed and documented in the Integrated Biopsychosocial Assessment.

Not Met/Partial/Met N/A

6. Health and safety needs, risk/at-risk behaviors are assessed and documented in the Integrated Biopsychosocial Assessment.

Not Met/Partial/Met N/A

7. Risk/at-risk behaviors are assessed and documented in the Integrated Biopsychosocial Assessment.

Not Met/Partial/Met N/A

8. Substance use, risk and patterns are assessed and documented in the Integrated Biopsychosocial Assessment.

Not Met/Partial/Met N/A

9. The Diagnostic Formulation/Summary which supports the diagnosis given and is documented in the Integrated Biopsychosocial Assessment.

Not Met/Partial/Met N/A

Implementation of Person-Centered Planning

1. Pre-planning meetings occur before a person-centered planning meeting, according to the individual's desires and needs.

Not Met/Partial/Met N/A

2. Independent facilitation is explained and offered to the individual and family/legal representative.

Not Met/Partial/Met N/A

3. Person-centered planning addresses and incorporates basic needs such as food, shelter, clothing and health care.

Not Met/Partial/Met N/A

4. Person-centered planning addresses and incorporates natural supports.

Not Met/Partial/Met N/A

5. Person-centered planning addresses and incorporates health and safety, including measures to minimize them, if applicable.

Not Met/Partial/Met N/A

6. Family-driven and youth-guided supports and services are provided for minor children.

Not Met/Partial/Met N/A

7. The person-centered planning process builds upon the individual's capacity to engage in activities that promote community life.

Not Met/Partial/Met N/A

8. The person-centered planning process is used to modify the individual plan of service in response to changes in the individual's preferences or needs.

Not Met/Partial/Met N/A

9. Individuals are provided with ongoing opportunities to provide feedback on how they feel about services, supports and/or treatment they are receiving, and their progress towards attaining valued outcomes.

Not Met/Partial/Met N/A

10. Individuals are provided an opportunity to develop a Crisis Plan.

Not Met/Partial/Met N/A

11. If a Crisis Plan was requested, it is located in MH-WIN.

Not Met/Partial/Met N/A

Plan of Service and Documentation Requirements

1. The individual plan of service addresses all needs, preferences, dreams and desires reflected in the planning process or provides an explanation for deferment.

Not Met/Partial/Met N/A

2. The individual plan of service contains measurable goals and objectives that are easily understandable by the individual and/or family with minimal clinical jargon

Not Met/Partial/Met N/A

3. Specific services, supports and treatment identified in the plan of service include the amount, scope and duration of services.

Not Met/Partial/Met N/A

4. The individual plan of service identifies the roles and responsibilities of the individual, the Supports Coordinator or Case Manager, the allies, and providers in implementing the plan.

Not Met/Partial/Met N/A

5. The plan of service includes an explanation of benefits and estimated/prospective cost of services.

Not Met/Partial/Met N/A

6. The plan of service identifies available Conflict Resolution processes.

Not Met/Partial/Met N/A

7. The individual plan of service is current and signed by the individual and/or legal representative, the Case Manager or Support Coordinator and the Support Broker/Agent (if one is involved).

Not Met/Partial/Met N/A

8. Individuals are provided a copy of their individual plan of service within fifteen business days after the planning meeting.

Not Met/Partial/Met N/A

9. There is evidence in the record that services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency as specified in the service plan.

Not Met/Partial/Met N/A

10. The individual plan of service is reviewed/updated at intervals as specified in the IPOS but no less than annually.

Not Met/Partial/Met N/A

11. Individuals are provided timely ADEQUATE Notice of Action.

Not Met/Partial/Met N/A

12. Individuals are provided timely ADVANCE Notice of Action.

Not Met/Partial/Met N/A

Coordination of Care

1. There is evidence of the Behavioral Health Provider coordinating treatment with the Primary Care Physician.

Not Met/Partial/Met N/A

2. There is evidence that the Behavioral Health Provider received information from the Primary Care Physician. Enter "Y" for "yes", or "N" for "no" in the text field.

Test field N/A

3. There is evidence of the Behavioral Health Provider coordinating treatment with the Substance Use Disorder (SUD) Provider.

Not Met/Partial/Met N/A

4. There is evidence that the Behavioral Health Provider received information from the SUD Provider.

Test field N/A

5. There is evidence of the Behavioral Health Provider coordinating services with natural and other community supports.

Met/Partial/Met N/A

6. There is evidence that the Behavioral Health Provider received information and/or communication from the consumer's natural/community supports. Enter "Y" for "yes" or "N" for "no".

Text field N/A

7. If the individual has not visited a Primary Care Physician for more than 12 months, there is evidence of a basic health care screening, including height, weight, BMI and blood pressure.

Met/Partial/Met N/A

8. For consumers prescribed an atypical antipsychotic medication, there is evidence that the psychiatrist or primary care physician ordered a diabetic screening that includes an HbA1C or fasting blood sugar (FBS), with results documented in the case record. Enter "Y" for "yes" or "N" for "no".

Text Feld N/A

Targeted Case Management/Supports Coordination

1. Case Management/Supports Coordination documentation includes the nature of the service, the date and location, who was present, and whether the contacts were face-to-face.

Not Met/Partial/Met N/A

2. Case Manager/Supports Coordinator documentation of face-to-face contacts identifies the goal(s) being addressed.

Not Met/Partial/Met N/A

3. The Case Manager/Supports Coordinator "regularly" reviews the individual's health status, noting any issues, visits to the emergency room and hospitalizations.

Not Met/Partial/Met N/A

Medication/Psychiatric

1. All medications, (such as OTC and those prescribed by external physicians), are documented and updated as necessary.

Not Met/Partial/Met N/A

2. Medication Consents for all program-prescribed medications are current, include dosage (if outside therapeutic range), documentation of the right to withdraw consent verbally, are signed by consumer/guardian and prescribing physician.

Not Met/Partial/Met N/A

3. Evidence of drug-specific patient education is provided to individuals prior to administering each new drug, if prescribed by a Program Physician.

Not Met/Partial/Met N/A

4. The Physician/Medical Professional's handwriting is legible.

Not Met/Partial/Met N/A

5. Laboratory results ordered by Program Physician are reviewed, signed off by a Physician.

Not Met/Partial/Met N/A

6. Quarterly Tardive Dyskinesia testing dates and results are documented by Program Physician.

Not Met/Partial/Met N/A

7. A copy of the prescription, medical orders, or evidence of an eScript, is present in the record (if prescribed by Program Physician).

Not Met/Partial/Met N/A

Behavioral Treatment Plan-This applies to restrictive/intrusive plans only, not positive support behavior plans.

1. A Functional Behavioral Assessment was completed prior to the development of the Behavior Treatment plan.

Not Met/Partial/Met N/A

2. The record contains evidence that physical, medical and environmental causes of the challenging behavioral have been ruled out.

Not Met/Partial/Met N/A

3. There is evidence of positive behavior supports or interventions that have been tried and have proved to be unsuccessful.

Not Met/Partial/Met N/A

4. There is evidence of a current "special consent" before the behavior treatment plan is implemented.

Not Met/Partial/Met N/A

5. There is evidence the plan was approved by the Behavior Treatment Plan review Committee before implementation.

Not Met/Partial/Met N/A

6. There is evidence in the clinical record to verify that all staff have been duty trained on each behavioral intervention identified in the plan.

Not Met/Partial/Met N/A

7. There is evidence that the Behavioral Treatment Plan has been followed and outcomes are documented.

Not Met/Partial/Met N/A

8. There is evidence of Behavior Treatment Plan Reviews being completed as identified by the committee, but not less than quarterly.

Not Met/Partial/Met N/A

Additional Mental Health Services (b)(3)'s

1. Assistive Technology & Environmental Modifications: The need for assistive technology/environmental modifications is identified in one or more goals in the individual plan of service. There is evidence of prior authorization in accordance with the provider's process, including the physician's prescription for modification or assistive technology purchased within the year.

Not Met/Partial/Met N/A

2. Supported Integrated Employment: The need for supported integrated employment is identified in one or more goals in the individual plan of service and assists the individual with obtaining and maintaining paid employment that would otherwise be unachievable without such supports.

Not Met/Partial/Met N/A

3. Enhanced Pharmacy: There is documentation of physician ordered, non-prescription "medicine chest" items Not Met/Partial/Met N/A

Not Met/Partial/Met N/A

4. Housing Assistance: The need for housing assistance is identified in one or more goals in the individual plan of service. There is documentation of the beneficiary's control (i.e. beneficiary-signed lease, rental agreement, deed) of his/her living arrangement in the individual plan of service, and documentation of assistance with short-term interim, or one-time-only expenses for individuals transitioning from restrictive settings into more independent, integrated living arrangements while in the process of securing other benefits (i.e. SSI).

Not Met/Partial/Met N/A

MI Health Link Required Documentation

1. The signed "Consent to Share Your Health Information" form has been uploaded as a PDF and submitted to the ICO via MHWIN.

Not Met/Partial/Met N/A

2. The current Integrated Biopsychosocial Assessment has been submitted to the ICO via MHWIN within 14 days of the initial referral, or annually. For non-PCE users, the assessment has been uploaded as a PDF in MHWIN and submitted to the ICO.

Not Met/Partial/Met N/A

3. The appropriate assessment (LOCUS, SID or ASAM) has been submitted to the ICO via MHWIN within 14 days of receipt of the referral or as required. For non-PCE users, the assessment has been uploaded as a PDF in MHWIN and submitted to the ICO.

Not Met/Partial/Met N/A

4. If the 14 day requirement for the assessment was not met, there is documentation in the case record regarding the barrier(s) to timely completion and submission.

Not Met/Partial/Met N/A

5. There is evidence of communication and collaboration with the Integrated Care Team (ICT), including contact with the Health Plan Care Coordinator, when there are status changes, such as discharge from inpatient hospitalization, change in treatment services and/or change in medications.

Not Met/Partial/Met N/A

Personal Care in Licensed Residential Settings

1. Personal care services, including amount, scope and duration are identified in the individual's IPOS.

Not Met/Partial/Met N/A

2. The authorization for Personal care services are current and align with the amount, scope and duration identified in the IPOS.

Not Met/Partial/Met N/A

Self- Determination

1. The individual participating in arrangements that support self-determination has a Self-Determination Agreement that complies with the requirements.

Not Met/Partial/Met N/A

2. The individual budget and the arrangements that support self-determination are included as part of the person-centered planning process

Not Met/Partial/Met N/A

3. Individuals participating in self-determination shall have assistance to select, employ, and direct his/her support personnel and to select and retain the chosen qualified provider entities.

Not Met/Partial/Met N/A

4. Fiscal Intermediary Services (FI): The need for FI services is identified in one or more goals in the individual plan of service and assists the individual with managing and distributing funds contained in the individual budget and choosing staff who will provide the services and supports identified in th4e IPOS.

Not Met/Partial/Met N/A

Habilitation Supports Waiver

1. Eligibility: The Habilitation Supports Waiver Eligibility Certification is current and signed by the Clinically Responsible Service Provider, and MDHHS if new enrollment, OR, the PIHP if recertification. Not Met/Partial/Met N/A

2. There is evidence that the annual Waiver Services Consent under the Habilitation Supports Waiver Eligibility Certification Section 3 is current. Note: Consents are valid up to 36 months.

Not Met/Partial/Met N/A

3. There is evidence that the individual and/or guardian were informed of their right to choose among various waiver providers and waiver services. Evidence may be found in the Pre-Plan and/or IPOS.

Not Met/Partial/Met N/A

4. The IPOS for individuals enrolled in the HSW is updated within 365 days of their last IPOS.

Not met/Partial/Met N/A

5. There is evidence of an annual physical exam.

Not Met/Partial/Met N/A

6. If the enrollee receives Environmental Modifications or Equipment, there is documentation that the selected modifications or equipment is the most cost-effective and fully functional option that meets the individual's needs.

Not Met/Partial/Met N/A

7. If the enrollee receives Environmental Modifications or Equipment, there is evidence of a physician's prescription for modifications or equipment purchased within the year.

Not Met/Partial/Met N/A

8. Physician prescriptions for PDN, OT and PT services, include the following: date of prescription, individual's diagnosis, the specific service or item being provided, expected start date of the order, and the amount and length of time that the service is needed.

Not Met/Partial/Met N/A

9. There is evidence that the member received at least one active habilitative treatment service per month as identified in the Individual Plan of Service (i.e. Community Living Supports, Out-of-Home Non-vocational Habilitation and Prevocational or Supported Employment).

Not Met/Partial/Met N/A

10. For individuals receiving Private Duty Nursing (PDN), there is evidence of the individual receiving at least one of the following habilitative services: Community Living Supports, Out-of-Home Non-vocational Habilitation and Prevocational or Supported Employment).

Not Met/Partial/Met N/A

Assertive Community Treatment (ACT)

1. Eligibility: There is evidence the individual has a primary diagnosis of a serious mental illness and, at the time of admission, demonstrated acute or severe psychiatric symptoms impairing the individual's ability to function independently, and whose symptoms impeded the return of normal function as a result of the diagnosis of a serious mental illness.

Not Met/Partial/Met N/A

2. There is evidence of a pre-admission screen completed by an ACT Team member.

Not Met/Partial/Met N/A

3. The IPOS addresses all services and supports to be provided to or obtained for the individual, including consultation with other disciplines and/or coordination of other supportive services as appropriate.

Not Met/Partial/Met N/A

4. The IPOS addresses both behavioral health and substance use disorders for individuals with co-occurring substance use disorders.

Not Met/Partial/Met N/A

5. The IPOS includes a discharge plan developed at the time of intake that includes a plan for transitioning from ACT to a less intensive service, and a plan for returning to Act should the need occur.

Not Met/Partial/Met N/A

6. There is evidence that a minimum of 80% of Act service contacts provided by the ACT team (as a whole) are in the individual's home or other agreed upon community location.

Not Met/Partial/Met N/A

7. There is evidence that services delivered and documented by the ACT team, promotes the individual's growth in recovery and progression into less intensive services.

Not Met/Partial/Met N/A

8. The individual's participation in the ACT program is documented in the ACT Team Meeting Minutes.

Not Met/Partial/Met N/A

9. If telemedicine is utilized, psychiatric services are the only ACT service provided in this manner.

Not Met/Partial/Met N/A

Intensive Crisis Stabilization Services

1. Eligibility: There is evidence in the clinical record that 1) the person has a diagnosis of mental illness or mental illness with co-occurring substance use disorder, or developmental disability, and 2) the person has been assessed to meet criteria for psychiatric hospital admission but who, with intense interventions, can be stabilized and served in their usual community environments. These services may also be provided to beneficiaries leaving inpatient psychiatric services if such services will result in a shortened inpatient stay.
Not Met/Partial/Met N/A

2. There is evidence that Intensive Crisis Stabilization services include intensive individual counseling/psychotherapy, assessments (rendered by the treatment team), family therapy, psychiatric supervision and therapeutic support services by trained paraprofessionals.

Not Met/Partial/Met N/A

3. The record reflects that the initial IPOS was completed within 48 hours.

Not Met/Partial/Met N/A

4. There is evidence that the IPOS clearly identifies follow-up services and outlines on-going sources of assistance (i.e. case management) and referrals to other providers as needed. The role of the case manager must be identified where applicable.

Not Met/Partial/Met N/A

5. For children's intensive crisis stabilization services, there is evidence that the plan addresses the child's needs in context with the family's needs; considers the child's educational needs; and is developed in context with the child's school district staff.

Not Met/Partial/Met N/A

Crisis Residential Services

1. Eligibility: There is evidence the individual meets psychiatric inpatient admission criteria, but has symptoms and risk levels that permit them to be treated in alternative settings.

Not Met/Partial/Met N/A

2. The record reflects that the initial IPOS was completed within 48 hours of admission and has been signed by the beneficiary (if possible), the parent or guardian, the psychiatrist and any other professionals involved in treatment planning.

Not Met/Partial/Met N/A

3. The IPOS clearly identifies the need for aftercare/follow-up services, and the role of, and identification of, the case manager.

Not Met/Partial/Met N/A

4. For children's intensive crisis residential services, there is evidence that the plan addresses the child's needs in context with the family's needs; considers the child's educational needs; and is developed in context with the child's school district staff.

Not Met/Partial/Met N/A

5. There is evidence the individual is receiving ALL of the following services: psychiatric supervision; therapeutic support services; medication management/stabilization and education; behavioral service and nursing services.

Not Met/Partial/Met N/A

6. The case manager is involved as soon as possible in treatment, as evidenced by the crisis residential notes as well as case management contact notes.

Not Met/Partial/Met N/A

7. If the length of stay in the crisis residential program exceeded 14 days, the interdisciplinary team developed a subsequent plan based on comprehensive assessments.

Not Met/Partial/Met N/A

Home-Based

1. Services provided by home-based service assistants/paraprofessionals must be clearly identified in the IPOS.

Not Met/Partial/Met N/A

2. There is evidence of an individualized and family-specific crisis plan.

Not Met/Partial/Met N/A

3. The record reflects a minimum of 4 hours of individual and/or family face-to-face home-based services per month are provided by the primary home-based services worker (or, if appropriate, the evidenced-based practice therapist).

Not Met/Partial/Met N/A

4. Home-based services are provided in the family's home or community.

Not Met/Partial/Met N/A

Wraparound Fidelity Standards

1. There is evidence that a Strength and Culture Discovery was completed for each member of the family, and for the family as a whole.

Not Met/Partial/Met N/A

2. There is evidence that results of the Strength and Culture Narrative has been incorporated in the Wraparound Plan of Care (POC).

Not Met/Partial/Met N/A

3. There is evidence that the child/youth and family chose who participates on the Wraparound Child and Family Team.

Not Met/Partial/Met N/A

4. There is evidence that the Wraparound Child and Family Team meetings were held at least weekly until the plan had been developed and implemented and then subsequently the meetings occurred no less than twice monthly while consumer was enrolled in the Wraparound/SEDW Program unless otherwise documented in a transition plan.

Not Met/Partial/Met N/A

5. There is evidence that a mission statement is developed/articulated for the Wraparound Child and Family Team.

Not Met/Partial/Met N/A

6. There is evidence that a Needs Assessment across all life domain areas is completed and prioritized by the family.

Not Met/Partial/Met N/A

7. There is evidence that the Wraparound Child and Family Team developed an action plan that identified alternative strategies (various ways) to meet identified needs.

Not Met/Partial/Met N/A

8. There is evidence that the Wraparound Plan of Care contains strategies or interventions that pertain to natural supports and/or other community resources, in addition to Medicaid services.

Not Met/Partial/Met N/A

9. There is evidence that the Pre-Plan Questionnaire, Plan of Care and Outcomes are written in the language of the family and are the result of families identifying their vision of how their lives will be different when the Wraparound Process is complete.

Not Met/Partial/Met N/A

10. There is evidence that the outcomes are measurable and method of measurement has been identified for each outcome.

Not Met/Partial/Met N/A

11. There is evidence that the Community Team reviews the Wraparound Plan/Plan of Care and budget on a regular basis. This means at least initially, every six (6) months and when developing the Continuing Care Plan.

Not Met/Partial/Met N/A

12. There is evidence that the Plan of Care and budget were updated to reflect new interventions and services.

Not Met/Partial/Met N/A

13. There is evidence that Flexible funds are used as a last resort and after community outreach efforts to meet some needs of the children and family.

Not Met/Partial/Met N/A

14. There is evidence that the Wraparound Child and Family Team identified and addressed crisis/safety risks in the Support Plan.

Not Met/Partial/Met N/A

15. There is evidence that an Initial Support Plan was completed and signed at the initial meeting with the family.

Not Met/Partial/Met N/A

16. There is evidence that the Support Plan identified both proactive and reactive steps/interventions and includes interventions that are culturally relevant and strength-based.

Not Met/Partial/Met N/A

17. There is evidence that all Wraparound Child and Family Team members have a defined role in implementing the Support Plan.

Not Met/Partial/Met N/A

18. There is evidence that a Continuing Care Plan was developed and approved by the Community Team.

Not Met/Partial/Met N/A

19. Services and supports are provided as specified in the plan including; type, amount, scope, duration and frequency.

Not Met/Partial/Met N/A

20. Level of Care evaluations are completed accurately.

Not Met/Partial/Met N/A

21. There is documentation that the Pre-Plan Questionnaire was completed.

Not Met/Partial/Met N/A

22. There is evidence that the Plan of Care (POC) was completed, signed, dated and a copy given to the family within 45 days of the Preliminary Plan.

Not Met/Partial/Met N/A

23. There is evidence that the medial care needs are coordinated and monitored to ensure health and safety.

Not Met/Partial/Met N/A

24. Prescriptions for Sensory integration and other OT services ordered by a physician meet all the required elements in the Medicaid Provider Manual.

Not Met/Partial/Met N/A

25. There is evidence that a Transition Plan was developed. The transition plan outlined how the family will continue to get their needs met after the child/youth ends Wraparound/SEDW. The transitional plan was approved by the Community Team.

Not Met/Partial/Met N/A

Serious Emotional Disturbance Waiver (SEDW)

1. The Initial Serious Emotional Disturbance (SEDD) Waiver Eligibility Certification is maintained in the child's case record. The Current Waiver Certification is signed and dated by the CRIPS, DWMHA and MDHHS. Services provided by home-based service assistants/paraprofessionals must be clearly identified in the IPOS.

Not Met/Partial/Met N/A

2. There is evidence that the SED Annual Re-certification is completed, signed and submitted to MDHHS within 365 days of the previous certification.

Not Met/Partial/Met N/A

3. Parent is informed of available options and chooses waiver services instead of psychiatric hospitalization; are aware of choices between and among qualified service providers.

Not Met/Partial/Met N/A

4. There is evidence that the consumer has received at least one SEDW service per month.

Not Met/Partial/Met N/

Autism Spectrum Disorder Program Requirements

1. There is evidence the individual, parent or guardian was informed of their right to choose among various Autism Spectrum Disorder Providers.

Not Met/Partial/Met N/A

2. The comprehensive diagnostic evaluation and psychological assessment were uploaded within 14 calendar days of the completed assessment.

Not Met/Partial/Met N/A

3. There is evidence that the ABA Assessment (ABLS, VB-MAPP, AFLS) was uploaded to MHWIN within 7 calendar days of the completed assessment.

Not Met/Partial/Met N/A

4. There is evidence that as part of the IPOS, there is a comprehensive individualized ABA behavioral plan of care that includes specific targeted behaviors for improvement, along with measurable, achievable and realistic goals.

Not Met/Partial/Met N/A

5. There is evidence that risk factors have been identified for the child/family, a description of how the risks may be minimized and the backup plan for each identified risk.

Not Met/Partial/Met N/A

6. There is evidence the Beneficiary's ongoing determination level of service (which occurs every six months) has evidence of measurable and ongoing improvement in targeted behaviors as demonstrated with the ABLLS-R or VB-MAPP.

Not Met/Partial/Met N/A

7. There is evidence the Individual Plan of Service has been updated within 365 days of the last plan of service.

Not Met/Partial/Met N/A

8. The average hours of ABA services during a quarter were within the suggested range for the intensity of services (+/-25%).

Not Met/Partial/Met N/A

9. The number of ABA hours of direction/observation during a quarter were equal to or greater than 10% of the total ABA direct service provided.

Not Met/Partial/Met N/A

10. There is evidence that the IPOS service reviews are completed on a quarterly basis (every 90 days).

Not Met/Partial/Met N/A

11. There is evidence that when three consecutive appointments were missed by the family (vacation, illness, etc.), inactivity was entered in the WSA.

Not Met/Partial/Met N/A

12. There is evidence of monthly contacts by the ABA provider and supports coordinator, regarding the consumer's progress, attendance (5), barriers to treatment, etc.

Not Met/Partial/Met N/A

13. There is evidence that the ABA provider made multiple attempts (weekly) to keep families engaged, when the family's attendance is sporadic.

Not Met/Partial/Met N/A

14. There is evidence the ABA provider's discharge policy was implemented when the consumer is inactive for 90 days.

Not Met/Partial/Met N/

ATTACHMENT #6

Template
(Name of Crisis Service Vendors)
Utilization Management
Annual Plan Evaluation

(FY Effective Date to FY End Date)

Name, Title of Person Submitting Report:

ANNUAL UTILIZATION MANAGEMENT (UM) PLAN EVALUATION

The Crisis Service Vendor's Utilization Management Plan shall be evaluated annually to determine its effectiveness in facilitating access, managing care, improving outcomes, and providing useful data for resource allocation, quality improvement and other management decisions.

Instructions: Please provide the requested qualitative and quantitative information as indicated in each section. Additionally, a description and narrative analysis of impact, trends or change from previous fiscal year is also required as appropriate. Portions of the information from the Crisis Service Vendor and the Access Center's Evaluation will be included in DWMHA's Annual UM Program Evaluation.

INTRODUCTION:

Describe your Organization's Vision, Purpose, Scope

ORGANIZATION'S UTILIZATION MANAGEMENT COMMITTEE:

Describe your UM Committee's functions, consumer involvement, role of your Chief Medical Director, frequency of meetings, storage of meeting notes, goals for (*insert current FY*) and goal status, significant activities/achievements and outstanding issues that have not been addressed or completed.

ORGANIZATION'S UM STAFF MEMBERS ASSIGNED ACTIVITIES AND PROFESSIONAL QUALFIICATIONS:

Provide a list of all UM staff who conduct Pre-Admission Reviews (PAR) during the (insert current FY) using the following format:

- ✓ Provider Name
- ✓ Employee Last Name
- ✓ Employee First Name
- ✓ Date of Hire
- ✓ Degree
- ✓ Title
- ✓ License Type
- ✓ License Number
- ✓ License Expiration Date
- ✓ Comments (i.e., If person has a limited license, indicate name and credentials of supervisor such as LMSW)
- ✓ Date Employee signed the new hire/annual "Affirmative Statement"

ANALYSIS OF INTER RATER RELIABILITY *(INSERT CURRENT FY)*:

Include data and analysis of your staff's results of the MCG inter rater reliability module. Detail any documentation issues and plans of correction (if applicable).

ANALYSIS OF PRE ADMISSION SCEENING REVIEWS (*INSERT CURRENT FY)*:

Include data and analysis of your case reviews using the DWMHA Prior Authorized Service UM Chart Review tool. Detail any documentation issues and plans of correction (if applicable).

(INSERT CURRENT FY) TURNAROUND TIME FOR EMERGENCE AND URGENT AUTHORIZATION REQUESTS:

Provide the annualized data for the Crisis Service Vendor's performance for the following:

Indicator #1a for **children**
Table #1:
The percentages of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within **three hours. Standard=95%**

Indicator #1b for **adults**
Table #1
The percentages of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within **three hours. Standard=95%**Provide an analysis of the annualized 1st – 4th (insert current FY) quarter performance.

(INSERT CURRENT FY) DIVERSIONS:

Document the annualized number of diversions per quarter by population (SMI, IDD, MI Health Link and SUD). Document the diversions per quarter by the type of recommended diversion (level of care) for each population (SMI, IDD, MI Health Link and SUD). Detail any trends. Document the number of inpatient admissions due to the lack of crisis residential service beds. Document the number of individuals waiting more than 23 hours from the time of request to the time of placement by population.

CONTINUOUS PERFORMANCE IMPROVEMENT:

Describe any performance improvement projects, including the problem statement, performance improvement statement, target populations, data sources(s), measurement periods, initial measurement, performance improvement activities, re-measurement period findings and explanation of those findings, status of project at time of annual UM report, next steps, etc.

CONSUMER SATISFACTION SURVEY RESULTS:

Summarize type of any consumer experience studies done during *(insert FY)*, targeted population(s), tool(s) used, survey methodology, survey time period(s), response rate, findings, any actions taken/to be taken as result of findings, recommendations, etc.

ANALYSIS OF THE PRE SCREENING REVIEW DENIALS FOR *(INSERT CURRENT FY)*

For **Medicaid covered services** include the number of denials and the number of action notices sent. Were the decisions made within the appropriate timeframes? Were the action notices sent within the appropriate timeframes? Discuss any trends.

For **General Fund covered services** include the number of denials and the number of action notices sent. Were the decisions made within the appropriate timeframes? Were the action notices sent within the appropriate timeframes? Discuss any trends.

REPORTING:

Which stakeholders have had an opportunity to review findings, provide comments on or provide input regarding each of these UM elements during the fiscal year?

Element	Consumers	Board of Directors	UM Committee	Providers	Crisis Service Vendor UM Staff
Utilization of different Levels of Care (Inpatient, PHP, ICR)					
Inter Rater Reliability					
PAR Case Reviews					
Performance Improvement Projects					
Customer Satisfaction Findings					
Who receives the UM (insert FY report?					

ADDITIONAL UTLIZATION MAGNEMENT INFORMATION OR DATA NOT COVERED IN THE ABOVE TOPICS:

ATTACHMENT #7

Template
Access Center Utilization Management
Annual Plan Evaluation

(FY Effective Date to FY End Date)

Name, Title of Person Submitting Report:

ANNUAL UTILIZATION MANAGEMENT PLAN EVALUATION

The Access Center's Utilization Management Plan shall be evaluated annually to determine its effectiveness in facilitating access to services and in determining eligibility of services.

Instructions: Please provide the requested qualitative and quantitative information as indicated in each section. Additionally, a description and narrative analysis of impact, trends or change from previous fiscal year is also required as appropriate. Portions of the information from the Crisis Service Vendor and the Access Center's Evaluation will be included in DWMHA's Annual UM Program Evaluation.

INTRODUCTION:

Describe your Organization's Vision, Purpose, Scope

ACCESS CENTER'S UTILIZATION MANAGEMENT COMMITTEE:

Describe your UM Committee's functions, consumer involvement, role of your Chief Medical Director, frequency of meetings, storage of meeting notes, goals for (*insert current FY*) and goal status, significant activities/achievements and outstanding issues that have not been addressed or completed.

ACCESS CENTER'S UM STAFF MEMBERS ASSIGNED ACTIVITIES AND PROFESSIONAL QUALFIICATIONS:

Provide a list of all UM staff who conduct Pre-Admission Reviews (PAR) during the (insert current FY) using the following format:

- ✓ Provider Name
- ✓ Employee Last Name
- ✓ Employee First Name
- ✓ Date of Hire
- ✓ Degree
- ✓ Title
- ✓ License Type
- ✓ License Number
- ✓ License Expiration Date
- ✓ Comments (i.e., If person has a limited license, indicate name and credentials of supervisor such as LMSW)
- ✓ Date Employee signed the new hire/annual "Affirmative Statement"

ANALYSIS OF THE ACCESS CENTER STAFF'S ELIGIBILITY REVIEWS FOR *(INSERT CURRENT FY)*

Complete an analysis of case reviews for all staff making eligibility, screening determinations and/or utilization management decisions. Include data and an analysis of the reviews for eligibility that have been re-reviewed by a second reviewer. Report the number of approved cases reviewed and the number of cases denied eligibility that were reviewed. For the denied cases, how many second reviews upheld the eligibility denial decision?
Include number of cases reviewed for each staff person. Include the number of face-to-face assessments that resulted in decision to deny CMHSP services.

Detail any issues, trends and plans of correction from the Unit Managers for the Customer Service and Clinical Units.

FOLLOW UP ON REFERRALS FOR CONSUMERS DETERMINED NOT BE ELIGIBLE:

Include the number and percentage of referral types for the following:

- Medicaid Health Plan
- ProtoCall for crisis intervention/911
- ProtoCall for information and referrals
- Commercial Insurance
- Coordinating Authority
- Primary Care Physician
- Emergency Room
- Other

Include the number and percentage of consumers who followed through with the referrals to Medicaid Health Plan, ProtoCall, Commercial Insurance, Coordinating Authority, Primary Care Physician, Emergency Room, Other.

Include the number and percentage of consumers who failed to follow through with the referrals to Medicaid Health Plan, ProtoCall, Commercial Insurance, Coordinating Authority, Primary Care Physician, Emergency Room, Other.

UTILIZATION MANAGEMENT CALL DATA:

The annualized percentage of compliance with the established standards per quarter:

- Total incoming calls
- Total calls handled
- Average call duration
- Average call duration
- Average time to answer
- Number/Percent of call backs for clinical screening within the same day
- Number/Percent of crisis calls received
- Average abandonment rate

CONTINUOUS PERFORMANCE IMPROVEMENT:

Describe any performance improvement projects, including the problem statement, performance improvement statement, target populations, data sources(s), measurement periods, initial measurement, performance improvement activities, re-measurement period findings and explanation of those findings, status of project at time of annual UM report, next steps, etc.

REVIEW OF CUSTOMER SATISFACTION SURVEYS:

The annualized percentage of compliance with the established standard, overall findings and any corrective action plans.

- The percentage of calls that were answered by live voice;
- Of the calls placed on hold, the percentage of persons reporting the hold time was too long;
- The percentage of persons served that report they were treated with politeness, respect, and dignity by staff;
- For those callers determined not eligible for services, the percentage that were offered alternative resources and referral information;
- For those callers determined not eligible for services, the percentage that were satisfied with alternative resources and referral information;
- For those callers determined not eligible for services, the percentage that were informed of right to a second opinion; and
- Access Center Silent Monitoring.

REVIEW OF PROVIDER SATISFACTION SURVEYS:

The annualized percentage of compliance with the established standard, overall findings and any corrective action plans.

- The percentage of providers who report satisfaction with response to concerns after talking with the Access Center staff;
- The percentage of providers who report satisfaction with being assisted in a timely manner by the Access Center staff;
- The percentage of providers who report/express a complaint broken down by quality categories (quality of care, access, attitude and service, billing/financial);
- The percentage of providers who report/express a compliment broken down by quality categories (quality of care, access, attitude and service, billing/financial);
- The percentage of providers who concur with Access Center staff eligibility determinations; and
- The percentage of providers who report satisfaction with the Access Center scheduling process.

ADDITIONAL UTLIZATION MANAGEMENT INFORMATION OR DATA NOT COVERED IN THE ABOVE TOPICS:

ATTACHMENT #8

(Access Center and Crisis Service Vendors)
Utilization Management Plan

(FY Effective Date to FY End Date)

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ATTACHMENT #9

Access Center and the Crisis Service Vendors UM Plan Audit Template

UM Element 1: The Organization's UM Program has clearly defined structures and processes and assigns responsibilities to appropriate individuals. ***Intent: The organization has a well-structured UM Program and makes utilization decisions affecting the health care of members in a fair, impartial and consistent manner.***				
	MET	***PARTIALLY MET***	***NOT MET***	***COMMENTS***
Introduction				
Access Center or Crisis Service Vendor Vision				
Access Center or Crisis Service Vendor's Authority				
Access Center or Crisis Service Vendor's Purpose				
Access Center or Crisis Service Vendor's Scope				
Systems Transformation				
Access Center or Crisis Service Vendor's Program Structure: **a. UM Staff Members' Assigned Activities including who has the authority to deny coverage** **b. UM Staff Members' Qualifications** **c. Process for evaluating, approving and revising the UM Program:** ➢ **Active involvement of a senior behavioral health practitioner**				
Access Center or Crisis Service Vendor's UM Committee Structure: **a. UM Committee Purpose** ***b.*** **UM Committee Membership** ***(must include a senior behavioral health care practitioner)*** **c. Frequency of Meetings** **d. Minutes are maintained, approved and distributed** **e. UM Committee Reporting Structure to other organization committees and administration**				
Access Center or Crisis Service Vendor's Program Goals ***(must be aligned with DWMHA's program goals)***				

Organization's Medical Necessity Criteria and Benefit: **a. Development, Selection and Description of Medical Necessity Criteria:** ➢ **Evidence based practices** ➢ **Objective** ➢ **Includes individual needs and circumstances** ➢ **Assessment of local delivery system** **b. Frequency and Process for Criteria Review, Approval and Distribution:** ➢ **Involvement of appropriate practitioners** ➢ **Staff training** ➢ **Methods of Availability to stakeholders**				
DWMHA's Delegation and Oversight: **a. Outline Delegated Functions by DWMHA** **b. DWMHA's Monitoring:** ➢ **Inter Rater Reliability Reviews** ➢ **Case Record Reviews**				
Access Center or Crisis Service Vendor's Delegation of UM Functions *(if applicable)*: **a. Identify Organizations** **b. Outline UM Delegated Functions** **c. Describe Methods and Frequency of Monitoring**				
Access Center or Crisis Service Vendor's UM Methods and Organizational Process for Making Medical Necessity and Benefit Coverage Determinations for In-Patient and Out-Patient Services: **a. Confidentiality parameters** **b. Define Emergent and Urgent Services**				
Access, Triage and Referral Process: **a. Role of Access Center** **b. Role of Crisis Service Vendors** **c. Standardized Assessment Tools *(if applicable)***				
Emergency Care Resulting in Admissions (Crisis Service Vendor): **a. Authorization process**				

Pre-Service Review Process (Crisis Service Vendor): **a. Identify Services Requiring Prior Authorizations for your organization** **b. Outline Clinical Information Collected to Determine *Initial* Medical Necessity Criteria and Level of Care** **c. Outline Clinical Information Collected to Determine *Concurrent (Continued)* Medical Necessity Criteria and Level of Care** **d. Physician to physician consultations** **e. Identify staff having the authority to deny coverage or services** **f. Turnaround Times for Decision** ➢ **Urgent pre-service** ➢ **Non urgent pre-service** **g. Turnaround Times for Notification** ➢ **Urgent pre-service** ➢ **Non urgent pre-service**				
Post-Service Review Process (Crisis Service Vendor): **a. Outline Clinical Information reviewed to Determine Medical Necessity Criteria and Level of Care** **b. Identify staff having the authority to deny coverage or services** **c. Turnaround Time for Decision** **d. Turnaround Time for Notification**				
Discharge Planning (Crisis Service Vendor)				
UM/Provider Denials and Dispute Resolution: - Types: ➢ **Administrative** ➢ **Benefit** ➢ **Medical Necessity** ➢ **Standard** ➢ **Expedited/Urgent**				
b. Description of Process including decision timeframes and notification timeframes and methods to practitioner and member ➢ **For Medicaid Covered Services** ➢ **For Medicare Covered Services** ➢ **For Uninsured or Under Insured Using General Funds**				

Access Center or Crisis Service Vendor's Continuous: Coverage and Service Requirements **a. Toll Free Number** **b. TYY services** **c. Language assistance**				
Access Center or Crisis Service Vendor's UM Role in the Quality Improvement (QI) Program: **a. Outline of Core Measures** **b. Process for collection of UM data and reports** **c. Methods for using UM data and reports within QI functions**				
Satisfaction with UM Process **a. Customer/Member** **b. Provider/Practitioner**				
Access Center or Crisis Service Vendor's Evaluation of UM Plan: **a. Frequency** **b. Responsible**				